

2004-2005 FLEXIBLE BENEFITS PLAN



Value Life's Benefits

Duval County Public Schools

*October 1, 2004 - September 30, 2005
Reference Guide*

Be the Boss of Your Benefits!

Open enrollment is here! From July 14 through September 3, 2004, employees can review current benefits, initiate benefit changes, and learn more about benefit options. Among the changes this year are an enhanced vision plan that now provides a larger selection of frames and increased contact lens allowances. Additionally, the calendar year maximum benefit for the dental DPO (Indemnity) plan has increased from \$1,500 to \$2,000.

All employees who meet with an Enrollment Counselor will have a chance to win special prizes. When reviewing benefits, employees should consider that renewal rates for some plans have increased, and FSA contribution rates may need to be adjusted. **Renewal rate increases will be made for medical, dental, vision, short-term disability and long-term disability benefits.**

Beat the Rush is Back!

Beat the Rush allows you to choose your benefits early AND ensure that your first benefit deduction is correct for the 2004-2005 Plan Year. Simply contact Risk Management at 904-390-2353 to schedule your appointment.

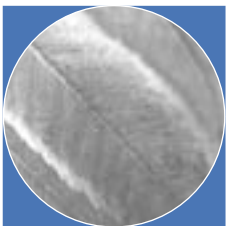
Appointments are available for *Beat the Rush* from July 14 through August 9, 2004.

EMPLOYEE AND DEDUCTION CATEGORIES	DEADLINE TO ENSURE CORRECT FIRST DEDUCTION	DATE BENEFIT DEDUCTIONS BEGIN
10-Month employees	August 9, 2004	August 27, 2004
11-Month employees	July 27, 2004	August 13, 2004
12-Month employees	July 27, 2004	August 13, 2004
Deferred Compensation and TSA (all employees)		August 27, 2004

While all employees are eligible to visit an Enrollment Counselor at any time during *Beat the Rush*, making an appointment during the appropriate times mentioned above will ensure proper benefit premiums are deducted from your first paycheck of the plan year.

Evening and Saturday appointments for all employees are also available.

Be sure your benefit deductions are correct...and *Beat the Rush!*



EMPLOYER	DEPARTMENT	HOURS	PHONE ADDRESS
Duval County Public Schools	Risk Management	M - F 7:30 a.m. - 5 p.m.	1-904-390-2353 www.educationcentral.org

PROVIDER COMPANIES	DEPARTMENT	HOURS	PHONE ADDRESS
AETNA (Medical Plan)	Customer Service AETNA Navigator	M - F 8 a.m. - 6 p.m.	1-877-791-6470 www.aetna.com
Primary Care Physician network listing			www.aetna.com/docfind
Rx Mail Order (Aetna RxHome Delivery)	Customer Service & Refills	24-hours a day	1-866-612-3862
Magellan Behavioral Services	Customer Service		1-800-424-5679
American Family Life Assurance Company of Columbus (AFLAC) (Personal Cancer Expense, Hospital Intensive Care)	Customer Service	M - F 8 a.m. - 8 p.m.	1-800-992-3522 www.aflac.com
Allstate Workplace Division, American Heritage Life Insurance Co. (Hospital Indemnity Insurance)	Claims (AWD)	M - F 8 a.m. - 8 p.m.	1-800-348-4489 www.ahllcorp.com
Delta Dental (DeltaCare Dental HMO) (Delta Dental DPO)	Customer Service	M - F 8 a.m. - 9 p.m. M - F 7:15 a.m. - 7:30 p.m.	1-800-422-4234 1-800-521-2651 www.deltadentalins.com
Fringe Benefits Management Co. (Flexible Spending Accounts)	FBMC Customer Service Interactive Benefits	M - F 7 a.m. - 10 p.m. 24-hours a day	1-800-342-8017 1-800-865-3262 www.fbmc-benefits.com
Trustmark Insurance Co. (Universal Life, Cancer Protector)	Customer Service	M - Th. 8 a.m. - 7 p.m. F 8 a.m. - 6 p.m.	1-800-918-8877 www.trustmarkins.com
UNUM Life Insurance Co. (Short-Term and Long-Term Disability) (Long-Term Care)	Customer Service	M - F 8 a.m. - 8 p.m.	1-800-858-6843 1-800-227-4165 www.unumprovident.com
VisionCare Plan (VCP) (Vision)	Customer Service	M - F 8 a.m. - 6 p.m.	1-800-865-3676 www.visioncare.com
Work & Family Benefits, Inc. (Dependent Care Consultation and Referral) (Legal & Credit Counseling)		M - F 8 a.m. - 9 p.m.	1-800-328-4071 www.wfbenefits.com

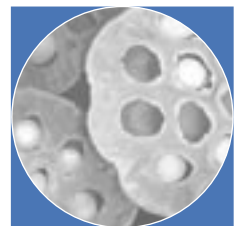




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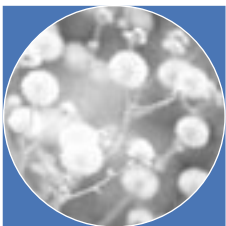
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Benefit Tip

All employees should meet with an Enrollment Counselor to enroll in this year's benefit plan.

It is your responsibility to respond to insurance companies' periodic inquiries about dependent eligibility. Failure to provide timely dependent verification information will result in loss of dependent coverage.



IMPORTANT DATES TO REMEMBER

Your Open Enrollment dates are:

July 14, 2004 through September 3, 2004

Your Period of Coverage dates are:

October 1, 2004 through September 30, 2005

Open Enrollment is Here!

One to One consultations with a Flexible Benefits Enrollment Counselor will be available from July 14, 2004 through September 3, 2004. See your Enrollment Schedule (located in your enrollment materials packet) to determine when the Enrollment Counselors will be at your location.

Your Enrollment Counselor will:

- Educate you on benefit changes
- Answer all benefit questions
- Help you complete your enrollment form
- Provide you with the copy of your confirmation notice.

Enrollment

- Your Enrollment Counselor will complete an Enrollment Form with you during Open Enrollment.
- If you do not re-enroll, your flexible benefits will remain in force as enrolled in the previous years enrollment. **However, you will incur all applicable rate increases for each benefit.** Please note that if you enrolled in a FSA, this amount will continue for the 2004-2005 Plan Year unless a new enrollment form is completed.
- Confirmation notices will be available from your Enrollment Counselor during open enrollment. **You will have 14 calendar days after your enrollment date to finalize any changes.**

How to Find Information About Your Benefits

There are three ways to receive benefit information:

1. You may contact the individual providers' customer service department about the specific plan for which you are inquiring (refer to the Employee Benefits Resource Directory on Page 3).
2. Visit www.fbmc-benefits.com to view a listing of your current benefits and to submit questions via e-mail to FBMC Customer Service.
3. For personal assistance, you may call FBMC Customer Service at 1-800-342-8017 Monday through Friday, 7 a.m. - 10 p.m. ET.
4. You may call the FBMC Information Line. FBMC's 24-hour automated phone system allows you to access your benefits information anytime to check on a claim, request a form and more! Getting connected to your benefits is easy. Call the Information Line at: 1-800-865 FBMC (3262). When you call, you will receive step-by-step instructions to access information on your benefits administered by FBMC.

Internet Access

You can access pertinent enrollment information via the Internet!

- Visit www.educationcentral.org
- Click on the tab labeled "Site Map."
- Select "Department Sites" under the subhead "Administration."
- Select "Risk Management/Employee Benefits."
- Scroll to the section on "Open Enrollment" for details on enrollment schedules, your enrollment booklet and medical plan options for the 2004-2005 Plan Year.



6 Meeting Your Changing Needs

Duval County Public Schools provides the following benefits free to all full-time, salaried employees:

- \$10,000 Group Term Basic Life insurance
- Employee-only Quality Point-of-Service (QPOS) Medical Plan
- \$250 Flex Dollars to defray the cost of voluntary benefit selections, or dependent coverage. Contribution is designed to reduce your out-of-pocket expenses for co-insurance and co-payments.
- \$500 contribution to a Medical Expense Flexible Spending Account. This \$500 contribution (employee) and additional \$500 (dependent/family unit) is designed to satisfy the annual deductible associated with the medical plan.

Duval County Public Schools recognizes that your needs change from year to year. Consequently, we are providing one-to-one benefits sessions. Your Enrollment Counselor will provide you with guidance on the following valuable benefits:

Vision Care — offers a larger selection of frames and increased contact lens allowance.

Long-Term Care — provides benefits for nursing homes, assisted living facilities and home healthcare for you and your parents.

Universal Life Insurance — features cash values that can increase during your lifetime. Other features include Accelerated Death Benefit, Home Health and Long-Term Care and Certificate Loans.

PremierSelectSM Critical Illness and Cancer — designed to pay you a lump-sum cash benefit (\$5,000 - \$100,000) upon first diagnosis of a covered critical illness or condition.

Disability Income Protection — can provide you with an adequate income if you become disabled and are unable to work. You do not have to exhaust your sick leave before taking advantage of this benefit.

Flexible Spending Accounts — can help you maximize your earnings with pre-tax savings.

Ask your Enrollment Counselor for more details on how to customize your benefits and protect your future.

What is an Enrollment Counselor?

An Enrollment Counselor is a Fringe Benefits Management Company representative available to answer your questions. He or she is highly trained in the insurance field and can help you decide which benefit selections are best for you. Your Enrollment Counselor can answer questions that are specific to you and your benefit needs.

Your enrollment consultation can provide you with all the information you need to enroll in benefits for the new year. It is your responsibility to make sure your enrollment is a success. You must review information prior to your appointment and come prepared to make critical decisions. If you wish to obtain benefits for any dependents, please bring their dates of birth and Social Security numbers. If adding a dependent for the first time, refer to Page 12 for required documentation.

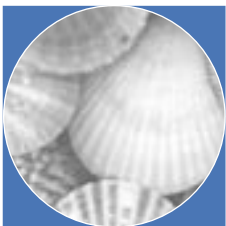
Who is Fringe Benefits Management Company (FBMC)?

FBMC is a Third Party Administrator specializing in payroll deduction benefit services. FBMC conducts the enrollment and offers a variety of management services for Duval County Public Schools.

Benefit Tip

Reviewing enrollment materials is a must before your enrollment meeting.

After enrolling, it is imperative that you retain your confirmation notice for future reference.



Getting answers to many of your benefit questions is now easier than ever. FBMC Customer Service offers you a variety of resources to make inquiries on your Flexible Spending Account, including information from the FBMC Web site, Interactive Voice Response system or Customer Service.

FBMC Web Site

FBMC's Web site provides information regarding your benefits and comprehensive details on your Flexible Spending Account(s).

By entering **www.fbmc-benefits.com** into your Internet browser, you will open FBMC's homepage. Answers to many of your benefit questions can be obtained by using the following navigational tabs located along the top portion of the home page.

Account Information

When you select the '**Account Information**' tab, you'll be prompted to enter your Social Security Number and Personal Identification Number (PIN). After this login, the following menu items will be available to you.

- **My Benefits**— includes information on current benefits, such as effective date, number of deductions and pre-tax annual contribution
- **My Account Transactions**— allows review of transactions from your current and previous plan years, including grace period information
- **Account Balance**— gives specifics about account availability, paid amounts and payment status
- **My Claims**— provides information on open and current reimbursement claims such as date received, status and amount authorized
- **Change In Status**— enables confirmation of request status, date received and effective date
- **Tax Savings Analysis**— calculates potential per-pay-period and annual tax savings as well as long-term savings (no login required)

Downloading Forms

When you select the '**Download Forms**' tab, a choice of forms, including a Letter of Medical Need, FSA Reimbursement Request Claim Form and Direct Deposit Form, are posted for your convenience.

Frequently Asked Questions

The '**Frequently Asked Questions**' tab provides answers to many of your general questions regarding Flexible Spending Accounts and enrollment information.

FBMC Customer Service

The '**Customer Service**' tab gives you a direct link to the FBMC Customer Service Center.

FBMC Interactive Benefits

FBMC's 24-hour automated phone system, Interactive Voice Response (IVR), can be reached by calling 1-800-865-FBMC (3262). This system allows you to access your benefits any time. By following the voice prompts, you can find out a great deal of information about your benefits.

- Current Account Balance(s)
- Claim Status
- Mailing Address Verification
- Obtain FSA Reimbursement Request Claim Forms
- Change Your PIN

Personal Identification Number (PIN)

To access both the FBMC Web site and the Interactive Voice Response (IVR) system, all you need is your Social Security Number (SSN). The last four digits of your SSN will be your first PIN, whether using the Web site or the IVR system. After your initial login, select your own confidential four-digit PIN to access both systems in the future. Your new PIN cannot be the last four digits of your SSN, as it was previously. If you forget your PIN, you may send an e-mail to a Customer Service Representative at webcustomerservice@fbmc-benefits.com. Once you've selected your new PIN, you may access information about your benefits.



Record PIN here.

Remember, this will be your PIN for both Web and IVR access.

Note: Please be sure to keep this Reference Guide in a safe, convenient place, and refer to it for benefit information.



8 Understanding "Flex Dollars"

Duval County Public Schools strives to provide competitive benefits for its full-time employees. As part of this effort, Duval County Public Schools provides you up to \$250 per year in "Flex Dollars" to help you pay for the benefits you need. This is funded on a bi-weekly basis, in accordance with the payroll deduction schedule.

Using Your Flex Dollars

1. If you add dependents to your medical plan, your \$250 "Flex Dollars" are automatically used to reduce your premium cost each pay period by \$12.50 (20 pay period) or \$10.42 (24 pay period).
2. If you do not add dependents to your medical plan, you must use the Flex Dollars for other pre-tax benefits.
3. If you choose pre-tax benefits that total less than \$250 per year, the balance is automatically placed in a Medical Expense Flexible Spending Account (FSA). If you select benefits that total more than \$250, then you pay the difference from your gross salary before taxes.
4. If you and your spouse are employed by Duval County Public Schools, one of you may give your Flex Dollars to the other to help reduce the amount of dependent medical premium.
5. The amount remaining in your paycheck is your take-home pay. With your benefits package, you pay less taxes and have more spendable income.
6. If you decide to pay for your benefits from your post-tax pay, however, you may not use your \$250 Flex Dollars to pay for post-tax benefits.
7. Premiums for life insurance may not be paid with your \$250 Flex Dollars.

Please note that the Duval County Public School's Flex Dollars and the Medical FSA are two different benefits.

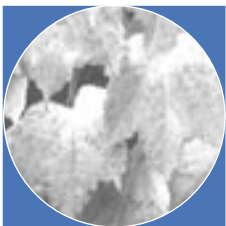
Benefit Tip

If you and your spouse work for Duval County Public Schools, the option to cover children under the medical plan may result in a significant rate deduction. Speak to an Enrollment Counselor for details about giving Flex Dollars to your spouse.

How your Flex Dollars work for you.

Duval County provides each full-time employee with Flex Dollars every pay period. The Flex Dollars are used to reduce the out of pocket expense to the employee. Please see the following example:

DeltaCare Dental Employee and Family	\$ 28.94
Vision Employee and Family	<u>\$ 10.31</u>
Total before Flex Money	\$ 39.25
Less Flex Dollars	<u>- 12.50</u>
Total Payroll Deduction	\$ 26.75



Who is Eligible?

All full-time salaried employees of Duval County Public Schools are eligible to enroll in the Flexible Benefits Plan.

When does Coverage Start?

Coverage for the 2004-2005 Plan Year begins October 1, 2004. Your participation becomes effective on the first day of the month following your first scheduled payroll deduction. New hire coverage will begin the first of the month following the first scheduled payroll deduction.

Period of Coverage

Your period of coverage is the same as the plan year, unless you terminate employment, go on a Board-approved unpaid leave of absence, change your pre-tax benefit elections through a valid election change in status request, or modify your post-tax benefits. If you experience an event permitting a mid-plan year election change, or have questions concerning your period of coverage, contact the Risk Management Department at 904-390-2353.

COBRA Coverage

Under certain qualifying events, covered employees may be eligible for continuation of group health plans covered under the COBRA law. Please contact FBMC Customer Service at 1-800-342-8017 or the Risk Management Department at 904-390-2353 for more information.

Leave of Absence

If you are going on unpaid Leave of Absence such as:

- on the job injury (OJI)
- family medical leave (FMLA)
- personal health leave
- personal leave
- professional leave
- educational leave
- military leave;

you **must** do the following:

- Contact Human Resources (904-390-2065) to notify them you are going on a Leave of Absence.
- Contact the Payroll Department at the School Board Administrative Building (904-390-2022) and ask the payroll clerk for your work location.
- Contact Risk Management (904-390-2353) about your insurance to notify them you are going on a Leave of Absence.

If your Leave of Absence is medical in nature and you have enrolled in the Short-Term Disability plan, please request the appropriate forms from Risk Management.

Deductible Year

The "Deductible Year" is defined as the calendar year (January 1 - December 31).

Terminating Employees

Provided that you have made the necessary contributions, your group health plans and flexible benefits will continue until the last day of the month in which termination occurs, unless you have completed your contract year, in which case your benefits will continue to the end of the plan year (September 30, 2005).

In order to continue your benefit coverage after the end of your month of termination, you will receive notification from Duval County Public Schools on your group health and life insurance plans. FBMC will contact you regarding the continuation of eligible flexible benefits.

Employees on Leave

If you go on a Board-approved, non-FMLA unpaid leave of absence, your group health plans and flexible benefits will continue for 30 calendar days from your last date compensated, provided all required premium payments have been made.

If you have properly completed all applicable Human Resource's leave forms for an approved unpaid leave of absence, you will be sent a payment schedule from the Risk Management Department for continuation of health, life and AD&D insurance premiums. FBMC will bill you for any flexible benefit deduction premiums due.

If you have questions concerning benefits, or you have not received payment information, contact:

- Risk Management at 904-390-2353 for questions concerning continuation of medical, term life, or Voluntary AD&D premium payments.
- FBMC at 1-800-342-8017 for questions concerning continuation of other flexible benefit deduction premium payments, including your Medical Expense FSA.
- A Dependent Care FSA is not continuable while you are on a Board-approved unpaid leave of absence.
- While out on Board-approved unpaid leave of absence, if you have not maintained a current premium status while on leave (excluding FMLA leave), you may be required to re-satisfy eligibility requirements when you return to active status, except as otherwise provided by law.
- To obtain information on the Family Medical Leave Act, call Human Resources at 904-390-2065.
- The benefit provider for your Long-Term Care Protection, Universal Life, Critical Illness, or the Cancer Protector Plan for continuation of premium payments.

Benefit Tip

To Make Changes: Within 30 days of an event, which is consistent with one of the event categories on Page 11, you must complete a Change In Status/Election Form and submit to the Risk Management Department in a timely manner.

Contact Risk Management to obtain this form. Documentation supporting your election change request is required.

10 Changing Your Coverage

Am I permitted to make mid-plan year election changes?

Under some circumstances, your employer's plan(s) and the IRS may permit you to make a mid-plan year election change to your FSA election, or vary a salary reduction amount, depending on the qualifying event and requested change.

Changes During the Plan Year

The IRS requires that any enrollment selections (contributions) you make in the pre-tax Flexible Benefits Plan remain the same for the entire plan year, which is October 1, 2004 through September 30, 2005. You can modify your contributions to the plan *only* during Open Enrollment or if you experience an event permitted under established IRS guidelines and your employer's plan.

For pre-tax benefits, if you experience an event permitting a mid-plan year election change, you must notify Duval County Public Schools within **30 days** of its occurrence. Requests for contribution changes made more than 30 days after a change in status event will not be processed.

How do I make a change?

You can change your Flexible Spending Account (FSA) election(s), or vary the salary reduction amounts you have selected during the plan year, only under *limited* circumstances as provided by your employer's plan(s) and established IRS guidelines. A partial list of permitted, and not permitted events under your employer's plan(s) appear on the following page. *Election changes must be consistent with the event.* Your employer's designee, **Fringe Benefits Management Company (FBMC), P. O. Box 1878, Tallahassee, FL 32302-1878—FBMC Customer Service at 1-800-342-8017**, will review on a uniform and consistent basis, the facts and circumstances of each properly completed and timely submitted mid-plan year election change form approved by Duval County Public Schools.

To Make a Change: Within **30 days** of an event that is consistent with one of the events on the following page, you must complete and timely submit to FBMC a Change in Status/ Election Form. Contact Risk Management to obtain this form. Documentation supporting your election change request is required. Upon the approval and completion of processing your election change request, your existing benefit plan elections will be stopped or modified (as appropriate) *at the first of the month immediately following approval and completion of processing.* Generally, mid-plan year pre-tax election changes can only be made prospectively, no earlier than the first payroll after your election change request has been received by FBMC, unless otherwise provided by law. If your benefit plan election change request is denied, you will have **30 days**, from the date you receive the denial, to file an appeal with FBMC.

Appeal Process

Approved appeals must comply with IRS regulations and the guidelines within your employer's plan(s). If you have an FSA reimbursement claim, a request for a mid-plan year election change, or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request for review to your employer's designee, **Fringe Benefits Management Company (FBMC), P.O. Box 1878, Tallahassee, FL 32302-1878 – FBMC Customer Service 1-800-342-8017**, within 60 days of your receipt of the denial. FBMC will in its sole discretion, review on a uniform and consistent basis, the facts and circumstances of each timely submitted and processable appeal request.

Your appeal must state:

- why you think your claim or request should not have been denied.
- the name of your employer
- the date of the services for which your claim or request was denied.
- a copy of the denied request
- the written denial you received
- any additional documents, information or comments you think may have a bearing on your appeal.

Call FBMC Customer Service at 1-800-342-8017 to discuss your appeal. Within **30 days** of FBMC's receipt of your processable appeal, FBMC will review your appeal and notify you of the results of its review. In unusual cases, as when review of your appeal requires additional documentation, the review may take longer. If your appeal is approved, additional processing time is required to modify your benefit elections.

What is my Period of Coverage?

Your period of coverage for incurring expenses is your full plan year, unless you make a permitted mid-plan year election change. A mid-plan year election change will result in split periods of coverage, creating more than one period of coverage within a plan year with expenses reimbursed from the appropriate period of coverage. Money from a previous period of coverage can be combined with amounts after a permitted mid-plan year election change. However, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the FSA prior to the change. Mid-plan year election changes are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

What are the IRS Special Consistency Rules governing Changes in Status?

1. **Loss of Dependent Eligibility**— If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to: your divorce or annulment from your spouse, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
2. **Gain of Coverage Eligibility Under Another Employer's Plan**— If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage if that individual gains coverage, or has coverage increased under the other employer's plan.
3. **Dependent Care Expenses**— You may change or terminate your Dependent Care FSA election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC § 129.
4. **Group-term Life Insurance, Dismemberment or Disability Coverage**— For any valid CIS event, you may elect either to increase or decrease these types of coverage.

Changes in Status:

Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.

Some Other Permitted Changes:

Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: <ul style="list-style-type: none"> • the other employer's plan has a different period of coverage (usually a plan year) or • the other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 30 days of one of the following CIS events: birth, adoption or placement for adoption. Note that a Medical Expense FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

* Does not apply to a Medical Expense FSA plan.

† Does not apply to a Dependent Care FSA plan.

12 Dependent Certification Requirements

WHO IS ELIGIBLE?

To be eligible to enroll a Covered Dependent, your dependent must be your legal spouse, or an unmarried dependent child for which you are financially responsible.

Dependent children are natural, foster, step, or legally adopted, a proposed adoptive child, a child under court order, and a dependent of a dependent, or any such child who is attending a recognized college or university, trade or secondary school.

When adding dependent children, bring one of the following:

- Birth Certificate
- Adoption papers
- Legal Custody papers
- Handicapped dependent certification

When adding a dependent spouse, please bring:

- Marriage license

Please see the chart below. After each critical topic, there is a space for you to fill in your personal information.

Bring this information with you when you enroll.

Employee Name _____ Social Security Number _____

Employee Primary Care Doctor _____ Dental Facility Number _____

Dependent Name	Birth Date	Social Security Number	Primary Care Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Dependent Eligibility

Eligible dependents are your legal spouse; your own unmarried children; children for whom you have been appointed legal guardian; stepchildren and legally adopted children (provided they reside in your household and primarily depend on you for support).

Until the following conditions are reached, eligible dependents will be covered from birth, adoption, or time of guardianship:

The following categories, Delta Care Dental, Hospital Intensive Care, and Hospital Indemnity, will cease at the end of the calendar year in which an eligible dependent reaches age 19 (21 for Hospital Indemnity), or age 25 (if a full-time student in an accredited school, college, or university, and provided they are unmarried and dependent on the participant for support). Your dependent children are eligible for coverage under the Medical Plans, Delta Dental Preferred Option (DPO), Vision, and Personal Cancer Plan to the end of the calendar year in which the child reaches age 25 if the child lives in your home and depends upon you for support or attends school full or part time.

Unmarried insured children who are physically or mentally handicapped and fully incapable of self-care will be covered until disablement becomes other than total. Proof of disability must be submitted to your insurance provider following the child's 19th birthday.

Benefit Tip

When adding new dependents to your Duval County Public Schools, Section 125 cafeteria plan, you must certify that your dependents are eligible.

If your dependents are currently covered under another insurance plan, be sure to bring that information with you to your enrollment session.

Duval County Public Schools provides all full-time salaried employees with a \$10,000 Group Term Life Insurance policy, including a double indemnity benefit for accidental death. This is provided at no cost to you.

New Hires Guaranteed Life Insurance Coverage

All newly-hired employees of Duval County Public Schools are able to elect up to three times their annual salary in life insurance coverage with no medical questions asked.

Existing Employees

During Open Enrollment, you may upgrade your coverage by one level without medical review. For example, if you currently have coverage equal to one times your salary, you may increase to two times your salary without EOI (Evidence of Insurability).

Additional Purchasing Options

You can purchase additional term life coverage equal to one, two, or three times your salary, up to a maximum of \$310,000. This includes your board-paid \$10,000 of basic life insurance.

You may also purchase a flat \$50,000 of coverage which does not include your basic board-paid coverage.

Premiums for life insurance may not be paid with your \$250 Flex Money. In accordance with IRS regulations, any premiums for amounts exceeding \$50,000 (which includes your school board-provided \$10,000) must be paid with after-tax dollars. For additional term life insurance, see your Enrollment Counselor or contact the Risk Management Department, Duval County Public Schools, at 904-390-2353.

Benefit Tip

Purchase of additional life insurance coverage, outside of a new hire event, could be subject to individual underwriting at the time of application.

Premium Waiver

Your premiums may be waived after a six month period of disability. Please contact Risk Management at 390-2353 for the required paper work.

Terminating Employment

If you terminate your employment from Duval County Public Schools, you may elect to continue coverage one of two ways:

- port a minimum of \$10,000 Term Life and Accidental Death and Dismemberment (AD&D) coverage at the group portability rates in force at the time, or
- convert your Group Term Life coverage to a Whole Life contract in any amount at rates effective at such time.

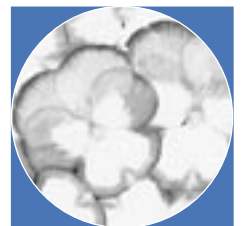
All current employees who retire with Duval County Public Schools may retain their Basic Life amount under the Retiree group insurance plan. A retiree may also elect to port their optional Term Life and AD&D or convert any portion of optional coverage to a Whole Life contract.

Premium Conversion

Premium conversion allows you to set aside money from your salary to pay your family's benefit premiums before federal income and Social Security taxes are calculated. You may also choose to pay your premiums with your after-tax salary and receive no tax savings. For your free premium conversion tax-saving analysis, visit www.fbmc-benefits.com/customer/taxanalysis.asp or call FBMC Customer Service at 1-800-342-8017.

Plan Provider

UNUM Life Insurance Company of America underwrites this plan. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates UNUM "A-" Excellent.



Our goal is simple - to provide you with access to quality healthcare benefits, so you and your doctor can focus on your health. We offer you the medical coverage, the healthcare information and the support needed to get the most from your health benefits plan.

For the 2004-2005 Plan Year, Aetna will continue to offer the Quality Point-of-Service® (QPOS) plan. The QPOS plan provides you with two levels of benefits. The first level of benefits is a network plan similar to the current HMO. Each participant selects a Primary Care Physician (PCP) who coordinates all of your medical care. This in-network benefit plan provides the highest level of coverage and lowest out of pocket cost offered by the program. We encourage you to use this benefit level. The plan also provides the flexibility for access to out-of-network physicians and medical facilities. If you choose to utilize the out-of-network benefits of the Plan, your share of your medical costs are significantly increased and you experience a higher out of pocket cost for your health care. A detailed QPOS medical benefits summary is enclosed in the enrollment materials.

- A listing of network participating PCPs is available at www.aetna.com/docfind.
- Our 24-hour Informed Health Line® (1-800-556-1555) is your direct link to a team of experienced registered nurses (RN) who will provide health care information, day or night. **
- You may purchase 3 months of maintenance prescription drugs through our convenient mail order vendor, AETNA Rx Home Delivery.

** Informed Health Line nurses cannot diagnose, prescribe, or give medical advice. Contact your physician first with any questions or concerns regarding your healthcare needs.

How Your Rates Were Calculated

	2004-2005 Renewal Monthly Rate	Allocation of Unclaimed FSA Funds*	Your Adjusted Monthly Rates
Employee Only	\$345.76	\$11.90	\$333.86
Employee/Children	\$526.96	\$18.14	\$508.82
Employee/Spouse	\$589.86	\$20.31	\$569.55
Family	\$804.43	\$27.69	\$776.74

* The allocated funds represent unused/unclaimed Employee and Employer contributions to the Flexible Spending Accounts. This amount is returned to the Plan to reduce future costs.

We provide other Special Programs and Services:

- DocFind®, our online provider directory.
- Aetna Navigator™, our online tool for health and benefits information (Go to www.aetna.com then click on Aetna Navigator)
- Savings on health club memberships and exercise equipment
- Savings on alternative health services and products
- Discounts on eyeglasses and contact lenses
- Savings on LASIK surgery
- Moms-to-Babies™ Maternity Management Program
- Education and support for chronic conditions
- Preventive Pap, mammography and colorectal screenings
- Disease Management

For questions or additional information regarding your Open Enrollment Medical Health Plan options through Aetna, you may contact Aetna Member Services (Monday - Friday 8:00 A.M. to 6:00 P.M.) at 1-877-791-6470.

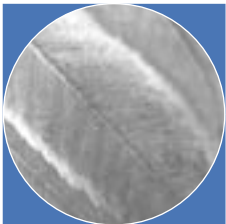
Your Rates*

AETNA POINT OF SERVICE	PLAN	COVERAGE
	20 Pay	24 Pay
Employee Only	— Board Paid —	
Employee & Child(ren)	\$104.98	\$87.48
Employee & Spouse	\$141.42	\$117.85
Employee & Family	\$265.73	\$221.44

* Premiums are paid either before or after taxes are deducted from your salary. The adjusted medical premiums reflected above include the allocation of unclaimed flexible spending account funds.

Benefit Tip:

Florida KidCare offers four programs designed to provide medical coverage for children through age 18. KidCare Medicaid has ongoing enrollment and is open to those who meet income eligibility. MediKids, Florida Healthy Kids, and Children's Medical Services Network offer additional coverage alternatives, but are also subject to income eligibility and restrictions if other health insurance coverage is available. Enrollment is restricted to open periods only; the next anticipated enrollment period is January 2005.



Are you spending time trying to find solutions to your child, adult and elder care needs? Do you have a legal issue or credit concern? With a simple toll-free phone call, you can have all the answers you need. The Work & Family Benefits, Inc. Values Package[®] is provided to all employees. **The cost of this valuable benefit is paid for by Duval County Public Schools.**

Plan Features

Dependent Care Consultation & Referral

We provide convenient access to a comprehensive, confidential telephone consultation with an expert counselor who will do all the research for you. What does this mean? The counselor calls each potential provider to see if the provider matches your need and has an opening for you. Within 48-72 hours, you will receive a comprehensive referral packet which includes:

- Personalized WFB Provider ProfilesSM for services and caregivers identified by the counselors during their research.
- Educational materials to help you ask the right questions and make the best decisions for your family.

This saves you significant time and provides solutions to you.

Legal Services and Credit Counseling

Our legal services are designed to help you prevent a small concern from becoming a major problem. Services include:

- An unlimited number of initial consultations with a plan attorney on each new legal matter each year. The plan covers up to one-half hour by telephone or in person. Certain exclusions apply.
- For more complex legal situations, guaranteed reduced hourly rates for plan attorneys.
- Preparation of a simple will.
- Review of documents of up to six pages.
- Online legal library and sample legal documents addressing consumer rights, family law, property issues and small claims.

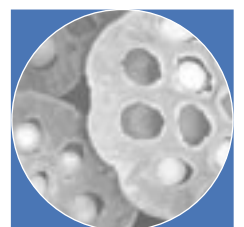
If you are faced with a credit or debt problem, you can talk with a certified credit counselor to assist you with credit concerns and debt management.

WFB's Online Resources at www.wfbenefits.com

- **WFB Topline SearchSM** – Enter your address for a mapped list of the 20 closest providers. You can search for childcare centers, family childcare homes, assisted living, nursing homes, home health care and retirement communities.
- **Information Resources** – These include WFB NotesSM, guidebooks, and e-seminars which cover a broad range of dependent care topics.
- **Adoption Resources** – Learn about the adoption process and support available to you. Link to searchable photolisting databases of children who are waiting for adoption, maintained by the National Adoption Center and the Children's Bureau.
- **Schools & Colleges** – Search for the right school or college, use the award-winning College Aid Calculator[®], and link to resources for federal financial aid.
- **WFB FitFindSM** – Locate a health club or fitness center near you.
- **Health & Wellness Links** – Learn more about health and wellness topics.
- **WFB's PetCaresSM** – Enter your address to find a veterinarian, pet-sitting service, boarding, grooming and training for your pets.

Plan Provider

Work & Family Benefits, Inc. provides this plan. Call 1-800-328-4071 for all of WFB's Values PackageSM services. Employees may access WFB's Online Resources at: www.wfbenefits.com. Then, select "Information for Employees" and enter **DCPS** to log in.



Dental Care Benefit Options

Delta Dental Insurance Company offers two choices for dental coverage:

- DeltaCare Option (Managed Care) and
- Delta Dental Preferred Option (DPO – Indemnity).

The DeltaCare Option plan features no deductible and low out-of-pocket costs for your basic dental care, however, you must select a panel dentist from Page 18.

The DPO Plan allows you the flexibility of choosing an in-network or out-of-network dentist at the time of service.

Selecting a Dentist

DeltaCare Option—Under this option, each family member can select a dentist, up to three dentists per family, from the DeltaCare Provider List (see Page 18 of this booklet) or call 1-800-422-4234 for additional providers.

Delta Dental Preferred Option (DPO)—Under this option, you can receive services from a DPO dentist or the dentist of your choice.

To obtain a list of DPO dentists, please see Pages 21-25 of this booklet (Indemnity Preferred Provider Directory) or visit www.deltadentalins.com. If you use a non-Delta dentist, you may have to pay up-front costs and file the claim form yourself.

DPO dentists will file claims on your behalf and have agreed to charge no more than the predetermined DPO fee schedule.

All benefits are subject to limitations and exclusions and governing administrative policies of the plan. The dental health plan contract must be consulted to determine the exact terms and conditions of coverage. A Certificate of Coverage will be sent to you upon enrollment.

If you have dental or vision coverage, your co-pays or uninsured out-of-pocket expenses may be eligible for reimbursement through your Medical Expense FSA.

See Page 37 for a partial list of eligible expenses or call FBMC Customer Service at 1-800-342-8017.

Your Tax-free Rates*

DELTACARE	20 Pay	24 Pay
Employee	\$11.76	\$ 9.80
Employee + one	\$19.67	\$16.39
Employee + family	\$28.94	\$24.12
DELTA DENTAL (DPO)		
	20 Pay	24 Pay
Employee	\$26.75	\$22.29
Employee + one	\$53.26	\$44.38
Employee + family	\$69.41	\$57.85

*Premiums may be paid either before or after taxes are deducted from your salary.

For the 2004-2005 Plan Year (October 1, 2004 through September 30, 2005), all rates are shown for 20 or 24 payroll deduction cycles.

Benefit Tip

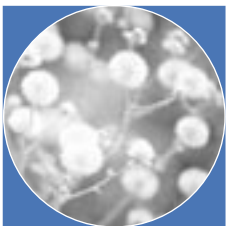
Delta Dental (DPO) provides an automated eligibility and benefit information line. You may also print ID cards.

Delta DPO:

Monday through Friday,
7:15 a.m. to 7:30 p.m. ET at
1-800-521-2651.

DeltaCare:

Monday through Friday,
8 a.m. to 9 p.m. ET at
1-800-422-4234.



DeltaCare Benefits

- **No maximum benefit**
- **No claim forms to complete**
- **Budgetable and predictable**
- **Co-pay for orthodontics - No waiting periods**
- **No co-pays for basic cleanings (two per year)**
- **Specialty care is covered by referral from your primary dentist at the same defined co-pays as general dentists**

DeltaCare

The health plan contract must be consulted to determine the exact terms and conditions of coverage.

Benefit	DeltaCare
	Plan A30
	Choose a panel dentist
Deductible	None

(Calendar Year is Jan. 1 - Dec. 31)
 Calendar Year Maximum
 Claim Forms

None
 None

Procedures	You Pay
Office visit	no cost
Routine exams	no cost
Prophylaxis (cleaning) - basic	no cost (one per six months)
Emergency treatment	\$10 (regular office hours)
X-ray and complete series including bitewings**	no cost (one series per six months)
Fluoride application	no charge to age 19 (one per six months)

Basic/restorative procedures	
Simple extractions	\$6
Amalgam fillings - 1 surface perm	no cost
Resin based fillings - posteriors	\$15 - \$35
Root canal - anterior***	\$75
Root canal - molar***	\$180

Major procedures	
Crowns - porcelain, base metal	\$195
Crowns - porcelain, high noble metal	\$295
Dentures - upper/lower	\$225
Bridges - porcelain, base metal	\$195
Bridges - resin, high noble metal	\$295

Periodontics	
Scaling and root planning	\$45 per quadrant

Orthodontics	
Start up fee	\$350
Routine 24 month fully banded case	
Adult	\$2,000
Child	\$1,800

** Under the DeltaCare plan, bitewing x-rays (code D0274) are limited to not more than one series of four films in any six-month period.

*** Excluding final restoration

DeltaCare - Accident Injury Benefit

This year, a new benefit has been added to provide accidental oral coverage for injuries. An accidental oral injury is damage to the hard and soft tissue of the mouth caused directly and independently of all other causes by external forces.

Damage to the hard and soft tissue of the mouth from any normal chewing function is covered under your Plan A30 patient charge schedule.

Plan Features

- DeltaCare will pay up to 100 percent of the Contract Dentist's "filed fees,"* for expenses an enrollee occurs for an accident injury, less any applicable co-payment, up to a maximum of \$1600 in any 12-month period.
- Accident injury benefits include tooth re-implantation and/or stabilization of accidentally evulsed (lost) or displaced tooth and/or alveolus (bone). This includes splinting and/or stabilization. (CODE D7270)

Family Coverage

This plan covers:

- Your spouse
- Your unmarried dependent children to age 19 (or until the end of the calendar year in which the child turns age 25, providing he/she is still dependent and living at home or the child is a full-time student)
- Disabled dependent children are covered as long as disability remains total.

Limitations

Accidental injury benefits are limited to services provided as a result of an accident which occurred:

- while the enrollee was covered under the DeltaCare program or
- while the enrollee was covered under another DeltaCare program, and if the benefits for the expenses incurred would have been paid if the enrollee had remained covered under that program.

Exclusions

- Prophylaxis
- Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue)
- Replacement of existing restorations due to decay
- Orthodontic services (treatment of malalignment of teeth and/or jaws)
- Replacement of existing restorations, crowns, bridges, dentures and other dental or orthodontic appliances damaged by accident injury

What if I have questions about this benefit?

After you enroll, you can get answers by calling Delta Dental's Customer Relations department at 1-800-422-4234.

* "Filed fees" are the contract dentist's fees on file with DeltaCare.



18 DeltaCare Plan A30 Panel List & General Providers

FERNANDINA

#951801
W D RODEFFER, DDS
1010 S 14TH ST
(904) 261-3306 F/T 1

GAINESVILLE

#004649
TROPICAL CTR COSMETIC & FMLY
2516 NW 43RD ST
(352) 375-1400 P/T 1

#887801
BERTRAM HUGHES, DMD
316 SW 16TH AVE
(352) 378-3323 F/T 1

JACKSONVILLE

#001624
THOMAS MEGAR, DDS
2166 CASSAT AVE
(904) 384-5700 P/T 1

#005795
OPTIMUM DENTAL CARE CENTER
8011 MERRILL RD STE 2
(904) 744-9994 P/T 1

#006472
ALL SMILES DENTAL CENTER
1147 EDGEWOOD AVE S
(904) 388-1421 F/T 1

#801201
RAMSEY SALEM, DDS
6237 MERRILL RD
(904) 744-2111 F/T 1

#821101
STEPHEN DRAPER, DDS
7410 MERRILL RD
(904) 745-5118 F/T 1

#831701
SMILE CARE DENTAL ASSOCIATES
3704 HEATH RD
(904) 743-6380 F/T 3

#831801
SMILECARE/MERRILL
9119 MERRILL RD STE 29
(904) 744-7202 F/T 3

#831901
SMILECARE/BAY
9000 GOLFSIDE DR # A
(904) 731-4343 F/T 4 P/T 1

#832001
SMILECARE/NS
1403 DUNN AVE STE 10
(904) 751-3444 F/T 3

#832101
SMILECARE/JAMMES
5218 JAMMES RD STE D
(904) 778-0990 F/T 2 P/T 1

#832201
SMILECARE/NORMANDY
7909 NORMANDY BLVD
(904) 786-1309 F/T 1 P/T 1

#841201
GARY MALOWITZ, DDS
4124 UNIVERSITY BLVD S
(904) 733-3763 F/T 1

#903201
DTL SERVICES OF JACKSONVILLE
3505 SOUTHSIDE BLVD STE 5
(904) 564-1888 F/T 1 (CH, SP)

#926001
DR SMITH & DTL ASSOCIATES
1190 EDGEWOOD AVE W STE B
(904) 764-4549 F/T 1 P/T 2

#927401
PRIME CARE DENTAL CENTER PA
5652 TIMUQUANA RD
(904) 777-5444 F/T 1

#929801
NABIL HIREZI, DDS
4495 BAYMEADOWS RD
(904) 733-9191 F/T 2 (AR)

#936401
NABIL HIREZI, DDS
1301 26 MONUMENT RD
(904) 725-7117 F/T 1 P/T 1 (AR)

#942401
JOHN LEWIS, DDS
1646 N DAVIS ST
(904) 355-1423 F/T 1 (SP)

#943101
DENTAL HEALTH GROUP
751 OAK ST STE 601
(904) 354-4031 F/T 5 P/T 3

#944201
JAMES HENDERSON, DDS
1366 KINGS RD
(904) 355-2660 P/T 1

#960401
WESTSIDE DENTAL CARE CENTER
4116 BLANDING BLVD
(904) 771-1630 F/T 1

#961001
FREDERICK NEWTON, DDS
1190 EDGEWOOD AVE W STE C
(904) 765-4406 F/T 1

#962101
BOB DEASON PA & ASSOCIATES
765 MILL CREEK RD
(904) 724-6321 F/T 1 P/T 1 (SP)

#964101
SMILECARE
3733 SOUTHSIDE BLVD
(904) 996-0111 F/T 1 P/T 1

#964201
SMILECARE
3706 BLANDING BLVD
(904) 777-1477 F/T 1 P/T 1

#964301
SMILECARE
14286 BEACH BLVD
(904) 821-9555 P/T 1

#968901
KEVIN VERA, DMD
3245 SOUTHSIDE BLVD
(904) 565-1800 F/T 1 (SP)

JACKSONVILLE BEACH

#902501
SMILECARE/JACKSONVILLE BEACH
1125 3RD ST N
(904) 241-0880 F/T 2 P/T 1

ORANGE PARK

#005796
OPTIMUM DENTAL CARE CENTER
1543 KINGSLEY AVE STE 19
(904) 269-1973 P/T 1

#927501
PRIME CARE DENTAL CENTER PA
1101 BLANDING BLVD STE 106
(904) 272-9595 F/T 1

#960901
A-1 DENTAL CARE
168 BLANDING BLVD STE 4
(904) 276-5143 F/T 1

#961901
CNS DENTAL
1409 KINGSLEY AVE STE 7 A
(904) 269-1419 F/T 1 (SP)

PONTE VEDRA

#903701
SMILECARE/PONTE VEDRA BEACH
238 SOLANA RD
(904) 280-1717 F/T 1 P/T 2

SAINT AUGUSTINE

#944301
JAMES HENDERSON, DDS
837 S PONCE DE LEON BLVD
(904) 824-9777 P/T 1

#902401
SMILECARE/ST AUGUSTINE
9 ST JOHNS MEDICAL PARK B
(904) 797-4108 F/T 2

CLOSED OFFICES

This office is presently serving members, but is closed to further enrollment at this time. This office may open to new enrollment in the future if office capacity permits.

JACKSONVILLE

#003451
DUNN DENTAL SERVICES
1680 DUNN AVE STE 31
(904) 696-6767 F/T 1

#940501
LEONARD DAVIS, DDS
8727 OLD KINGS RD S
(904) 731-5000 F/T 1

#946001
HARVEY EBER, DDS
3667 CROWN POINT RD
(904) 268-4904 F/T 1

#946101
EDWARD GELMAN, DDS
4521 ATLANTIC BLVD
(904) 398-0200 F/T 1

#950401
CHESTER AIKENS, DDS
305 UNION ST E
(904) 358-3827 F/T 1

#963501
ANTHONY FRANKLIN, DMD
6344 103RD ST
(904) 778-4748 F/T 1

#973701
C GRIER, DDS
8383 BAYMEADOWS WAY
(904) 731-8765 F/T 1 (SP)

#979001
AA PRIME CARE DENTAL ASSOC
12276 SAN JOSE BLVD STE 101
(904) 886-3342 P/T 1 (SP)

ORANGE PARK

#841001
SMILECARE DENTAL ASSOC
1950 MILLER ST STE 4
(904) 269-3488 F/T 1 P/T 1

PONTE VEDRA

#961701
JOHN DELLA PORTA, DMD
135 PROFESSIONAL DR STE 107
(904) 280-4151 F/T 1 (SP)

Foreign languages spoken in the dental office are listed by code in (.). Below is a key to the foreign language codes.

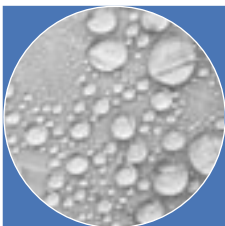
F/T - Full Time Dentist, P/T - Part Time Dentist, Δ - New Office

PE - Persian	EI - East Indian
RU - Russian	FR - French
SP - Spanish	GE - German
TA - Tagalog	GR - Greek
SP - Spanish	HE - Hebrew
AM - Armenian	IT - Italian
AR - Arabic	JA - Japanese
CA - Cantonese	KO - Korean
CH - Chinese	

NOTE: Contact the provider before making your choice if you have a scheduling problem or small children.

Additional Dental Offices will be added as required. You may call the DeltaCare Customer Service department at (800) 422-4234 for updates to the provider list. If any office is closed to further enrollment, PMI reserves the right to assign you another dental office as close to your home as possible.

Visit our Web site: www.deltadentalins.com



DPO Dentist Benefits

- **No hassle administration: Claim forms are completed and submitted by the DPO dental office - not the patient.**

Delta Dental DPO Option

The health plan contract must be consulted to determine the exact terms and conditions of coverage.

BENEFIT

DELTA INDEMNITY (DPO OPTION)**

Use dentist of choice	
Deductible*	\$75 per year, individual \$150 per year, per family (Calendar Year is January 1 - December 31)
Calendar Year Maximum	\$2,000 per person
Claim Forms	None if using Delta dentists
Procedures	Delta reimbursement according to PPO fee schedule
Office visit	100%
Routine exams	100%
Prophylaxis (cleaning) - basic	100% (limit 2 in 12 months)
Emergency treatment	80%
X-ray and complete series including bitewings	100% (1 per 36 months- full)
Under 18	(2 per 12 months - bitewing)
Over 18	(1 per 12 months - bitewing)
Fluoride application	100% (2 per 12 months, children under 19 only)
Basic/restorative procedures	
Simple extractions	80%
Amalgam fillings	80%
Root canal	80%
Major procedures	
Crowns	50%
Dentures	50%
Bridges	50%
Periodontics	50%
Orthodontics	50% up to \$1,000 lifetime maximum after 1 year waiting period (dependent children only)
Waiting Period	Applies to new participants (orthodontics only)

* Note the deductible does not apply to diagnostic & preventative services, orthodontics

** Delta Preferred Dentists are limited to the PPO fee.
Delta Premier Dentists are limited to the least of: the dentist's filed fee, submitted fee, or Delta's UCR (Usual, Customary, and Reasonable) fee.
Non-Delta Dentists may balance bill for amounts over Delta's UCR (Usual, Customary and Reasonable) fee.



CONTINUED

How the DPO Program Works

The DeltaPreferred Option Plan allows each person covered under the plan to have the freedom to visit any dentist. There may be a savings advantage to receiving care from a DPO Dentist because your out-of-pocket costs tend to be lower.

When you visit a DPO dentist, payment is based on the DPO fee schedule. The DPO Dentist has agreed to accept this fee as the Approved Amount. Although you are responsible for deductibles, co-insurances and any expenses above the maximum, a DPO Dentist cannot bill you for any covered charges above the approved amount.

In addition to DPO Dentists, Delta Dental has Participating (DeltaPremier) Dentists. You can search for a Delta dentist (DeltaPremier and DPO) by visiting our Web site at www.deltadentalins.com.

Although you are responsible for deductibles, co-insurances and any expenses above the maximum, DeltaPremier dentists have an agreement with Delta Dental not to charge you more than the Approved Amount.

Family Coverage

This plan covers:

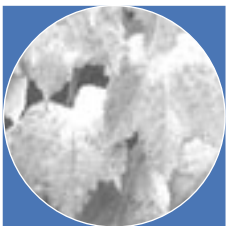
- Your spouse
- Your unmarried dependent children to age 25, providing that the child is still dependent and living at home or the child is a full or part-time student
- Disabled dependent children are covered as long as disability remains total.

Sample Claim Payment

(Assuming deductible and contract provisions are met)
 Example: Procedure 2150, two surface amalgam (filling)

	DPO Dentist	DeltaPremier Dentist	Non-Delta Dentist
Dentist Submitted Amount	\$100.00	\$100.00	\$100.00
Delta Approved Amount	\$68.00	\$85.00 (Filed Fee)	\$100.00
Delta Allowed Amount	\$68.00	\$68.00	\$68.00
Delta Payment	\$54.40	\$54.40	\$54.40
Patient Payment	\$13.60*	\$30.60*	\$45.60*

*The difference between the Approved Amount and the Delta Payment.



DPO Providers & Premier Providers

All dentists listed below are Premier Dentists. The Premier Dentist Listing includes general dentists and specialists. Please be sure that the dentist participates with Delta before receiving care. Dentists from this list may only be selected if you have enrolled in the Indemnity Plan. If "DPO" is listed below the dentist's name, the dentist is also a DPO Dentist. This listing is current as of July 2004, and is subject to change. For more up to date information please access our Web site at www.deltadentalins.com or contact your provider.

ALACHUA General Dentists ADEL, DM 14211 NW 150TH AVE (386) 462-4635	GARI, GJ 1205 NW 9TH AVE (352) 376-2755	DPO	WATSON, W 4040 W NEWBERRY RD #1200 (352) 376-3400	ABOOD, PJ 9309 SAN JOSE BLVD (904) 733-3391	DPO	BLISS, RQ 2700 RIVERSIDE AVE #12 (904) 387-0469	DPO
ATLANTIC BCH General Dentists DUKES, MW 100 ROYAL PALMS DR (904) 241-5342	GODET, Y 150 NW 75TH DR #B (352) 333-9898		WEBER, TJ 2845 NW 41ST ST (352) 384-0050	ABOOD, TB 9307 SAN JOSE BLVD # 9 (904) 733-1900	DPO	BOALES, OJ 10920 BAYMEADOWS RD #5 (904) 363-3559	
Pedodontists PEREZ, R 645 MAYPORT RD #2 (904) 242-0010	GOTTS, AW 4965 NE 8TH AVE #B (352) 375-1966	DPO	WILLIS, TW 1205 NW 9TH AVE (352) 376-2755	AIKENS, CA 305 UNION ST E (904) 358-3827	DPO	BRADY, L 3676 CROWN POINT CT (904) 268-2011	
CALLAHAN General Dentists HARRISON, JR 5424 GREEN AVE (904) 879-1893	HARRIETT, WE 1230 NW 9TH AVE (352) 376-5661		WITT, WM 5622 NW 43RD ST (352) 378-3139	AKEL, FA 7724 LEM TURNER RD (904) 765-5573		BREITMOSER, HG 1716 UNIVERSITY BLVD S (904) 724-1055	DPO
RICE, KA 450100 SR 200 (904) 879-6998	HESS, RT 4436 NW 23RD AVE (352) 376-3216	DPO	Oral Surgeons STOROE, WC 3500 SW 2ND AVE #2 (352) 371-4111	ALNITI, DP 9208 ARLINGTON EXPY (904) 721-1601	DPO	BRODY, R 751 OAK ST #601 (904) 354-4031	DPO
SHAFFER, PW 542182 US HIGHWAY 1 (904) 879-3786	HUGHES, BJ 316 SW 16TH AVE (352) 378-3323		Endodontists GOLDFADEN, SL 1905 NW 13TH ST (352) 375-7776	ALNITI, DP 12276 SAN JOSE BLVD #101 (904) 805-8823	DPO	BROTMAN, SG 3647 HENDRICKS AVE (904) 396-4091	
GAINESVILLE General Dentists AMUNDSON, EJ 4040 W NEWBERRY RD #1200 (352) 376-3400	KASSABIAN, KN 5021 NW 34TH ST #A (352) 371-7766	DPO	Orthodontists COHEN, DA 1010 NW 76TH BLVD (352) 332-7911	ALTON, HL 3434 ATLANTIC BLVD #6 (904) 396-2747		BURNSIDE, LD 12708 SAN JOSE BLVD (904) 268-0904	
BANFIELD, GW 5347 SW 91ST TER # B (352) 375-6116	KU-TORRES, AM 7733 W NEWBERRY RD #B3 (352) 331-4700		PAPPAS, JN 320 NW 75TH DR # B (352) 332-7466	ANAND, S 1420 SAN MARCO BLVD (904) 399-3632	DPO	BURNSIDE, LD 301 W BAY ST (904) 634-0460	
BEACH, DA 1205 NW 9TH AVE (352) 376-2755	LANGHAM, SE 2727 NW 43RD ST #8 (352) 376-5120		TAPLEY, PM 320 NW 76TH DR (352) 332-7466	BAHRI, S 8131 BAYMEADOWS CIR #102 (904) 744-2111	DPO	CAVENDISH, M 137 W ADAMS ST (904) 353-3303	
BEAUFIT, N 2341 NW 41ST ST (352) 336-3939	NEW, SL 4909 NW 27TH CT #A (352) 373-3178	DPO	GREEN CV SPGS General Dentists MCCABE, JB 407 WALNUT ST (904) 284-0773	BARD, BJ W 8TH ST (904) 356-8077		CIRIC, R 3504 CARDINAL POINT DR (904) 730-2266	DPO
COAST DENTAL 5021 NW 34TH ST #A (352) 371-7766	PALADINO, JC 1204 NW 69TH TER #E (352) 331-9992	DPO	SMALL, LJ 708 SPRING ST (904) 284-6688	BARIUAN, NR 6144 GAZEBO PK PL #210 (904) 262-9466	DPO	CIRIC, S 3504 CARDINAL POINT DR (904) 730-2266	DPO
COSBY, EA 635 NW 6TH ST (352) 372-2030	PASTORA, Y 3601 SW 2ND AVE #C (352) 335-3003	DPO	VERVILLE, JD 7055 US HIGHWAY 17 S (904) 284-9911	BARKET, TA 3965 CONFEDERATE PT RD (904) 772-0508	DPO	CLARK, BC 3539 UNIVERSITY BLVD N (904) 745-0243	DPO
DAVILA-RIVERA, JL 4001 W NEWBERRY RD #B4 (352) 377-8678	PERINI, CA 5021 NW 34TH ST #A (352) 371-7766	DPO	HAWTHORNE General Dentists GARLITZ, JH 6605 SE 221ST ST (352) 481-2741	BAUKNECHT, AJ 3434 ATLANTIC BLVD (904) 396-1758		CLARK, BC 5475 SOUTEL DR (904) 764-4576	DPO
DAY, RC 1410 NW 13TH ST #8 (352) 376-8207	POMERANZ, A 7575 W UNIVERSITY AVE #P (352) 331-4626	DPO	JACKSONVILLE General Dentists ABID, JJ 1185 LANE AVE S STE 6 (904) 783-1422	BAXTER, WD 1566 DUNN AVE # 3 (904) 751-4958	DPO	CLARK, LP 5475 SOUTEL DR (904) 764-4576	DPO
DECKER, BC 7575 W UNIVERSITY AVE #P (352) 331-4626	RILEY, CK 7733 W NEWBERRY RD #B3 (352) 331-4700	DPO	ABOOD, MP 9307 SAN JOSE BLVD # 9 (904) 733-1900	BEAVER III, HA 3434 ATLANTIC BLVD #7 (904) 396-1758		CLARK, LP 3539 UNIVERSITY BLVD N (904) 745-0243	DPO
DELL III, JM 2516 NW 43RD ST (352) 376-2409	THOMAS, PA 230 NW 76TH DR # B (352) 378-0111	DPO		BIBB, J 6001 ARGYLE FOREST BLVD (904) 771-6838	DPO	CLARK, PL 10950 SAN JOSE BLVD #64 (904) 260-4244	DPO
	TRAN, LT 1014 NW 23RD AVE (352) 373-1884	DPO		BILOTTI, JS 11518 SAN JOSE BLVD (904) 268-5600		CLARK, PL OAK ST #601 (904) 354-4031	DPO

DPO Providers & Premier Providers

CLARK, SA 9141 CYPRESS GREEN DR #4 (904) 737-1232	ELROD, K 9119 MERRILL RD #29/30 (904) 744-7202	DPO	GULLY, JR 41 SARA DR (904) 757-1555	DPO	KELLEY, JR 9000 GOLFSIDE DR #A (904) 731-4343	DPO	LOTT, EG 10028 SAN JOSE BLVD (904) 268-1498
CLEMENT, WJ 4006 BLANDING BLVD (904) 771-0367	FARNHAM, JG 11528 SAN JOSE BLVD (904) 262-2551		GUPTON, F 7301 MERRILL RD (904) 743-3114		KELLEY, JR 5218 JAMMES RD #D (904) 778-0990	DPO	LUECK, AJ 8131 BAYMEADOWS CIR W (904) 448-9669
COAST DENTAL DPO 10950 SAN JOSE BLVD #64 (904) 260-4244	FARNHAM, SB 11528 SAN JOSE BLVD (904) 262-2551		HALADY, P 7301 MERRILL RD (904) 743-3114		KELLEY, JR 3706 BLANDING BLVD (904) 777-1477	DPO	MAGOS, M 1151 CASSAT AVE (904) 384-5543
COAST DENTAL DPO UNIVERSITY BLVD N (904) 722-0104	FETNER, DL 8255 BAYBERRY RD (904) 636-0000		HANNA, SK 2135 BLANDING BLVD (904) 384-5571		KELLEY, JR 3704 HEATH RD (904) 743-6380	DPO	MAHJOORY, A DPO 3733 SOUTHSIDE BLVD #5/6 (904) 996-0111
CROUCH, EC 6073 SAN JOSE BLVD W (904) 737-2111	FETNER, HA 5212 WESCONNETT BLVD (904) 778-1455		HASTINGS, AG 1147 EDGEWOOD AVE S (904) 268-0904	DPO	KELLEY, JR 14286 BEACH BLVD #23 (904) 821-9555	DPO	MALOWITZ, GH DPO 4124 UNIVERSITY BLVD S (904) 733-3763
DANG, MT DPO OAK ST #601 (904) 354-4031	FLORO, BE 6144 GAZEBO PK PL #210 (904) 262-9466		HASTINGS, G 5218 JAMMES RD #D (904) 778-0990	DPO	KELLEY, JR 1403 DUNN AVE #10 (904) 751-3444	DPO	MARCHAN, SL 701 MAYPORT CROSSING #7 (904) 246-2603
DAVID, JA DPO 10991 SAN JOSE BLVD #20 (904) 268-0606	FOLSTEIN, RJ 10302 SOUTHSIDE BLVD (904) 363-3366		HERRERA, EL 2292 MAYPORT RD #17 (904) 249-1302	DPO	KELLEY, JR 7909 NORMANDY BLVD (904) 786-1309	DPO	MARMUR, FT DPO 14286 BEACH BLVD #23 (904) 821-9555
DAVIS, LC 8727 OLD KINGS RD S (904) 731-5000	FORD-EDWARDS, RT 137 W ADAMS ST (904) 353-3303		HINDER, PR 9000 GOLFSIDE DR #A (904) 731-4343	DPO	KELLY, JC 3675 HENDRICKS AVE (904) 398-1549		MARSHALL, BT 10302 SOUTHSIDE BLVD (904) 363-3366
DAVIS, RB 4402 SALISBURY RD (904) 296-7757	FOSS, DF DPO 3245 SOUTHSIDE BLVD (904) 565-1800	DPO	HIREZI, FD 1301 MONUMENT RD #26 (904) 733-9191		KILCOYNE, JM DPO 9109 BAYMEADOWS RD #2 (904) 731-0311	DPO	MCKINNEY, JJ 7410 MERRILL RD (904) 745-5115
DEAN, AT LANE AVE S (904) 781-4011	FRANKLIN, AJ DPO 6344 103RD ST (904) 778-4748	DPO	HIREZI, FD 4495 BAYMEADOWS RD (904) 733-9191		KOKAL JR, A DPO 1540 MONUMENT RD #1 (904) 646-0671	DPO	MILLER, TR DPO 9501 ARLINGTON EXPY (904) 725-4433
DEASON, BW DPO MILL CREEK RD (904) 724-6321	FULLER III, JW DPO 2078 ROGERO RD (904) 743-9222	DPO	HIREZI, NJ 4495 BAYMEADOWS RD (904) 733-9191	DPO	KROMBACH, MA DPO 1774 UNIVERSITY BLVD S (904) 725-7085	DPO	MOORE, MR DPO 5607 UNIVERSITY BLVD W (904) 733-5533
DELUCIA, JW 14185 BEACH BLVD #2 (904) 223-9999	FULLER III, JW DPO 3706 BLANDING BLVD (904) 777-1477	DPO	HIREZI, NJ 1301 MONUMENT RD #26 (904) 733-9191	DPO	KROMBACH, MA DPO 520 JACKSONVILLE DR (904) 249-3696	DPO	MORRISON, WS 5425 VERNA BLVD (904) 783-1633
DELUCIA, JW 2204 ROGERO RD (904) 744-2000	GARI, GJ DPO 9501 ARLINGTON EXPY (904) 725-4433	DPO	HOANG, TT 1329 LANE AVE S #1 (904) 786-5850	DPO	KUROSKO, WA DPO 1550 FOURAKER RD (904) 783-0917		MURRAY JR, EP DPO 3704 HEATH RD (904) 743-6380
DEPAUL, BM DPO 10490 BALMORAL CIR E #E (904) 751-6733	GARNER, D 2363 DUNN AVE (904) 751-6030		HULFELD, JR 7451 103RD ST #18 (904) 777-4622	DPO	LEE, SJ DPO 3599 UNIVERSITY BLVD S (904) 391-0005	DPO	NARDUCCI, NA DPO 10302 SOUTHSIDE BLVD (904) 363-3366
DESAI, BD DPO 1440 DUNN AVE #1 (904) 757-2500	GATLING, RS 1413 DUNN AVE (904) 751-4556		JONES, DW 6514 SAN JUAN AVE (904) 786-5221		LEE, YH 11250 SAINT AUGUSTINE RD (904) 262-1737		NARDUCCI, NA DPO 9995 GATE PKWY #310 (904) 646-2737
DRAPER, SW DPO 7410 MERRILL RD (904) 745-5115	GELMAN, ES DPO 4521 ATLANTIC BLVD (904) 398-0200	DPO	JOSEPH JR, B 3704 HEATH RD (904) 743-6380	DPO	LEIBOWITZ, RB 301 W BAY ST (904) 634-0460		NERIKAR, V 3434 ATLANTIC BLVD #7 (904) 396-1758
EBER, HR DPO 3667 CROWN POINT RD (904) 268-4904	GERRY, CY 7505 ARLINGTON EXPY (904) 731-8745		KAROL, RE 200 W FORSYTH ST #1550 (904) 356-1010		LEONARD, JW 563 UNIVERSITY BLVD N (904) 724-7190		NEWTON, F DPO 1190 EDGEWOOD AVE W #C (904) 765-4406
EDWARDS JR, CM DPO 774 EDGEWOOD AVE N (904) 388-9038	GIRARDEAU, AE DPO 3505 SOUTHSIDE BLVD #5 (904) 564-1888	DPO	KATIBAH, EW 943 CESERY BLVD (904) 744-6244	DPO	LEVIN, HR 8255 BAYBERRY RD (904) 636-0000		NGUYEN, DD DPO 6491 103RD ST (904) 779-9999
EDWARDS JR, CM DPO 8354 BAYMEADOWS RD (904) 737-7436	GLOSTER, KR DPO 5255 DUNN AVE (904) 751-6211	DPO	KELLEY, JR 3733 SOUTHSIDE BLVD #5/6 (904) 996-0111	DPO	LEVY, RM DPO 9000 GOLFSIDE DR #A (904) 731-4343	DPO	NGUYEN, DD DPO 7855 ARGYLE FOREST BLVD (904) 777-3308
ELGEZIRY, SA DPO 3837 SOUTHSIDE BLVD #5 (904) 642-2010	GREENBURG, MM 6820 ST AUGUSTINE RD (904) 733-3110		KELLEY, JR 9119 MERRILL RD #29/30 (904) 744-7202	DPO	LEWIS JR, JW DPO 1646 N DAVIS ST (904) 355-1423	DPO	OLINZOCK, DR 12620 BEACH BLVD #18 (904) 620-0404
ELINOFF, R 9776 SAN JOSE BLVD #7 (904) 268-6751	GRIER, CN DPO 8383 BAYMEADOWS WAY (904) 731-8765	DPO					

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DPO Providers & Premier Providers

OLITSKY, JS 9000 GOLFSIDE DR #A (904) 731-4343	DPO	SABOL, CM 9000 GOLFSIDE DR #A (904) 731-4343	DPO	SHIVASHANKAR, N 12421 SAN JOSE BLVD (904) 268-7552	DPO	TURSUNOV, A 10950 SAN JOSE BLVD #64 (904) 260-4244	DPO	WOODWARD, WR 3704 HEATH RD (904) 743-6380	DPO
OSSI, EJ 4244 UNIVERSITY BLVD S (904) 733-2213		SABOL, CM 9119 MERRILL RD #29/30 (904) 744-7202	DPO	SMITH, AL 1190 EDGEWOOD AVE W #B (904) 764-4549	DPO	TURSUNOV, AC 25 UNIVERSITY BLVD N (904) 722-0104	DPO	WOODWARD, WR 1403 DUNN AVE #10 (904) 751-3444	DPO
PARK, YS 12220 ATLANTIC BLVD #128 (904) 221-8221	DPO	SABROSKE, RP 10302 SOUTHSIDE BLVD (904) 363-3366		SMITH, DE 1190 EDGEWOOD AVE W #B (904) 764-4549	DPO	UNDERKOFER, SJ 1746 UNIVERSITY BLVD S (904) 724-3023	DPO	WOODWARD, WR 3733 SOUTHSIDE BLVD #5/6 (904) 996-0111	DPO
PARSA, M 8131 BAYMEADOWS CIR W (904) 448-9669	DPO	SABROSKE, RP 7451 103RD ST #18 (904) 777-4622		SMITH, IJ 1190 EDGEWOOD AVE W #B (904) 764-4549	DPO	VANOVER, MD 7909 NORMANDY BLVD (904) 786-1309	DPO	WYCALL, BT 8131 BAYMEADOWS CIR #102 (904) 744-2111	DPO
PATCH, GR 10609 ST AUGUSTINE RD #3 (904) 268-1331		SALEM, RB 6237 MERRILL RD (904) 744-2111	DPO	SOLIMAN, A 9501 ARLINGTON EXPY (904) 725-4433	DPO	VERA, K 3245 SOUTHSIDE BLVD (904) 565-1800	DPO	YORKO, SE 10490 BALMORAL CIR E #E (904) 751-6733	DPO
PATEL, JA 5310 TIMUQUANA RD (904) 771-0933	DPO	SARGI, EM 2700 RIVERSIDE AVE #10 (904) 384-0383	DPO	SPENCER, MD 800 LOMAX ST #109 (904) 355-5531		VERRETTE, RM 456 UNIVERSITY BLVD N (904) 721-1400	DPO	YOUNG, LC 4487 BAYMEADOWS RD (904) 731-9833	
PATEL, TC 2262 DUNN AVE #1 (904) 757-7940		SAYAF, K 1147 EDGEWOOD AVE S (904) 307-0767	DPO	SPURLING, JE 2500 MONUMENT RD #102 (904) 641-0651		WAGNER JR, RF 3434 ATLANTIC BLVD (904) 396-2747		ZIMMERMAN, R 3676 CROWN POINT CT (904) 268-2011	
PERRIN, JH 4765 HODGES BLVD #5 (904) 992-9396	DPO	SAYRE, LM 2301 PARK ST (904) 387-3333		STEVENSON, RA 6851 BELFORT OAKS PL (904) 281-2566		WAGNER, WS 14333 BEACH BLVD #6 (904) 223-5644		Oral Surgeons CHERRY, JE 4100 SOUTHPOINT DR E #5 (904) 281-2225	DPO
PHILIPS, BA 2166 CASSAT AVE (904) 384-5700	DPO	SCALES, KI 4116 BLANDING BLVD (904) 771-1630	DPO	STRICKLAND JR, JA 4001 CONFEDERATE PT RD (904) 772-8060	DPO	WALLACE, RC 445 SR 13 #22 (904) 287-0033		GESEK, DJ 2047 PARK ST (904) 388-7665	DPO
PHILLIPS, GL 3665 HENDRICKS AVE (904) 396-2929	DPO	SCARLETT, GT 10302 SOUTHSIDE BLVD (904) 363-3366		STRICKLAND, PD 4001 CONFEDERATE PT RD (904) 772-8060	DPO	WALO, R 9041 SOUTHSIDE BLVD #176 (904) 363-2121		GROSHAN, GJ 9550 REGENCY SQUARE BLVD (904) 724-5020	DPO
POLITE, LR 1680 DUNN AVE #31 (904) 696-6767		SCHLOTH, P 10490 BALMORAL CIR E #E (904) 751-6733	DPO	TABA, FP 12420 SAN JOSE BLVD (904) 268-3002	DPO	WITTEN, AL 223 W ADAMS ST (904) 356-0072	DPO	GROSHAN, GJ 4131 UNIVERSITY BLVD S (904) 737-6733	DPO
PRIETO, R 25 UNIVERSITY BLVD N (904) 722-0104	DPO	SCHNEIDER, T 6476 FORT CAROLINE RD (904) 743-0900		TANNEN, MK 3810 WILLIAMSBURG PK #5 (904) 733-3360		WITTEN, PJ 223 W ADAMS ST (904) 356-0072	DPO	GROSHAN, GJ 3007 HARTLEY RD (904) 886-4558	DPO
RAJ, RR 9343 LEM TURNER RD (904) 764-3844	DPO	SCHULTZ, JB 8789 SAN JOSE BLVD #107 (904) 737-8081	DPO	TAPNIO, LO 10909 ATLANTIC BLVD #15 (904) 641-0944		WOHLGEMUTH, PE 13170 ATLANTIC BLVD #60 (904) 220-0595	DPO	HARTLEY, GW 4131 UNIVERSITY BLVD S (904) 737-6733	DPO
RILEY, CK 13170 ATLANTIC BLVD #60 (904) 221-0120	DPO	SCHUMACHER, JL 4201 ROOSEVELT BLVD (904) 388-3559		THOMAS JR, HF 3325 HENDRICKS AVE # 2 (904) 398-6444		WOHLGEMUTH, PE 751 OAK ST #601 (904) 354-4031	DPO	HARTLEY, GW 3007 HARTLEY RD (904) 886-4558	DPO
RITTENBERG, HL 5417 ORTEGA BLVD (904) 384-4391		SCHUTT, CE 2801 ST JOHNS BLUFF RD S (904) 641-3777		THOMASINO, M 563 UNIVERSITY BLVD N (904) 724-7190		WOODWARD, WR 9000 GOLFSIDE DR #A (904) 731-4343	DPO	HARTLEY, GW 9550 REGENCY SQUARE BLVD (904) 724-5020	DPO
RODEFFER, SH 2363 DUNN AVE (904) 751-6030		SEARS, C 751 OAK ST #601 (904) 354-4031	DPO	TITUS, WD 1403 DUNN AVE #10 (904) 751-3444	DPO	WOODWARD, WR 7909 NORMANDY BLVD (904) 786-1309	DPO	IMRAY, S 2047 PARK ST (904) 388-7665	DPO
ROESSLER, RK 1529 MARGARET ST (904) 356-4880	DPO	SHAEFFER, LB 2711 ST JOHNS BLUFF RD S (904) 642-1139	DPO	TITUS, WD 14286 BEACH BLVD #23 (904) 821-9555	DPO	WOODWARD, WR 5218 JAMMES RD #D (904) 778-0990	DPO	KHAN, ZU 14286 BEACH BLVD #23 (904) 821-8881	DPO
ROMEU, E 10415 OLD ST AUGUSTINE (904) 262-9464		SHAEFFER, MJ 3599 UNIVERSITY BLVD S (904) 391-0005	DPO	TRAN, VH 7855 ARGYLE FOREST BLVD (904) 777-3308	DPO	WOODWARD, WR 9119 MERRILL RD #29/30 (904) 744-7202	DPO	MIDDLEBROOKS, ML 4232 BAYMEADOWS RD (904) 739-0690	DPO
RONDON, OD 1329 LANE AVE S #1 (904) 786-5850	DPO	SHAH, BR 3000 DUNN AVE #38 (904) 768-3790	DPO	TRAN, VH 6491 103RD ST (904) 779-9999	DPO	WOODWARD, WR 3706 BLANDING BLVD (904) 777-1477	DPO	O'BRIEN, DA 3007 HARTLEY RD (904) 886-4558	DPO
ROSNER, JH 7332 LEM TURNER RD (904) 764-2422	DPO	SHARP, AN 3557 HENDRICKS AVE (904) 396-1023		TROTTER, LA 2532 OAK ST (904) 389-3451		WOODWARD, WR 14286 BEACH BLVD #23 (904) 821-9555	DPO	O'BRIEN, DA 9550 REGENCY SQUARE BLVD (904) 724-5020	DPO

DPO Providers & Premier Providers

O'BRIEN, DA 4131 UNIVERSITY BLVD S (904) 737-6733	DPO	YOUNG, AR 4211 SOUTHPOINT PKWY #A (904) 296-8884	DPO	HUBBARD, KA 8355 BAYBERRY RD (904) 733-7254	DPO	MAKSOU, MA 9109 BAYMEADOWS RD #3 (904) 731-4347	DPO	ARIAS, MA 473 BLANDING BLVD (904) 272-7170	DPO
PARKER, TJ 8259 BAYBERRY RD # 1 (904) 737-3263	DPO	Orthodontists BAHRI, G 1185 LANE AVE S STE 6 (904) 783-1422	DPO	MCLELLAN, MA 9501 ARLINGTON EXPY (904) 725-4433	DPO	NEMETZ, RJ 5218 JAMMES RD #D (904) 737-8410	DPO	BUNYI, DP 1543 KINGSLEY AVE #19 (904) 269-1973	DPO
ROTHSTEIN, JP 943 CESERY BLVD (904) 743-5604	DPO	BAHRI, G 765 MILL CREEK RD (904) 724-6321	DPO	NEMETZ, MM 9501 ARLINGTON EXPY (904) 725-4433	DPO	RICE JR, GW 11560 OLD ST AUGUSTINE (904) 262-4844	DPO	CIOFFI, GA 767 BLANDING BLVD #108 (904) 272-6244	
SKIGEN, AL 8708 PERIMETER PARK BLVD (907) 565-1505	DPO	BAHRI, G 8131 BAYMEADOWS CIR W (904) 448-9669	DPO	NEMETZ, MM 9857 OLD ST AUGUSTINE (904) 880-5437	DPO	SLATER JR, CK 252 15TH AVE S (904) 249-8448	DPO	CLARK, PK 1590 ISLAND LN #12 (904) 278-7422	DPO
STAKEM, TE 3706 BLANDING BLVD (904) 777-1477	DPO	BAHRI, G 6237 MERRILL RD (904) 744-2111	DPO	NEMETZ, MM 12421 SAN JOSE BLVD #320 (904) 292-2210	DPO	SLATER JR, CK 3434 ATLANTIC BLVD (904) 398-1810	DPO	COAST DENTAL 410 BLANDING BLVD #6 (904) 276-5950	DPO
STRENTA, VR 5218 JAMMES RD #B (904) 573-9560	DPO	BURNS, AS 8259 BAYBERRY RD (904) 731-4002		PEREZ, R 2771 MONUMENT RD #23 (904) 645-9555	DPO	Prosthodontists AZARI-SAMANI, R 10601 SAN JOSE BLVD #115 (904) 880-8955		COAST DENTAL 5000 US HIGHWAY 17 #4 (904) 215-7855	DPO
TAYAPONGSAK, P 7101 NORMANDY BLVD (904) 786-9200	DPO	BURNS, AS 4612 SAN JUAN AVE (904) 387-3300		SCHNEIDER, HS 1871 UNIVERSITY BLVD S (904) 721-2565	DPO	AZARI-SAMANI, R 14444 BEACH BLVD # 401 (904) 992-8900		CROVATTO, RC 105 FOXRIDGE RD (904) 272-0800	
WOODS, DD 4131 UNIVERSITY BLVD S (904) 737-6733	DPO	CARDEN, DR 3540 3RD ST S (904) 241-2471		SETZER, BP 8355 BAYBERRY RD (904) 733-7254	DPO	ELIAS, NS 9250 BAYMEADOWS RD #300 (904) 731-2120		CROVATTO, SE 105 FOXRIDGE RD (904) 272-0800	
WOODS, DD 9550 REGENCY SQUARE BLVD (904) 724-5020	DPO	HAYES JR, RJ 13170 ATLANTIC BLVD #55 (904) 221-6446		SUGGS, S 10302 SOUTHSIDE BLVD (904) 363-3366	DPO	NEMETZ, RJ 12421 SAN JOSE BLVD #320 (904) 292-2210	DPO	FEDERICO, RA 1409 KINGSLEY AVE #9F (904) 264-5806	DPO
WOODS, DD 3007 HARTLEY RD (904) 886-4558	DPO	KAPLEY, K 9272 ARLINGTON EXPY (904) 725-6262	DPO	SWITKES, MD 9857 OLD ST AUGUSTINE (904) 880-5437	DPO	OLSON, EM 2078 ROGERO RD (904) 743-9222		HEIN, ME 1910 WELLS RD (904) 269-7004	
Endodontists BERNSTEIN, DI 751 OAK ST #601 (904) 354-4031	DPO	KAPLEY, K 4184 3RD ST S # SC2 (904) 270-8750	DPO	ZAHEDI, M 10601 SAN JOSE BLVD #115 (904) 880-8955	DPO	SAYOC, AM 4940 BLANDING BLVD (904) 777-1112	DPO	HUDGINS, CH 767 BLANDING BLVD #109 (904) 276-0000	
BOWDEN, JW 5218 JAMMES RD #C (904) 777-5878	DPO	KIMMEL, S 3714 HEATH RD (904) 743-4423	DPO	ZAHEDI, M 14444 BEACH BLVD # 401 (904) 992-8900	DPO	SAYOC, AM 13167 ATLANTIC BLVD (904) 221-0054	DPO	JOHNS-STOUTAMIRE, LC 1543 KINGSLEY AVE #10 (904) 264-7516	
JONES, HL 9501 ARLINGTON EXPY (904) 725-4433	DPO	LEVINE, MR 8355 BAYBERRY RD (904) 733-7254		Periodontists AMBROSE, JM 751 OAK ST #601 (904) 354-4031	DPO	LIVE OAK General Dentists MANTOOTH, HC 602 RAILROAD AVE SE (386) 362-6556		KELLER, PJ 2301 PARK AVE #201 (904) 269-1048	
JONES, HL 7301 MERRILL RD (904) 743-3114	DPO	LEVINE, MR 3600 CARDINAL POINT DR (904) 737-4626		BERDY, CS 1511 STOCKTON ST (904) 389-1376	DPO	MIDDLEBURG General Dentists HUAMAN, KA 4075 COUNTY ROAD 218 (904) 282-9371		KELLEY, JR 1950 MILLER ST #3/4 (904) 269-3488	DPO
MAVEC, JC 9109 BAYMEADOWS RD #5 (904) 733-5721	DPO	MITCHELL, OD 1190 EDGEWOOD AVE W #A (904) 766-6000		COLEMAN, JR 765 MILL CREEK RD (904) 724-6321	DPO	MATE, SM 4075 COUNTY ROAD 218 (904) 282-9371		KELLEY, JR 1605 COUNTRY RD 220 #110 (904) 215-3533	DPO
O'CONNELL, TP 5218 JAMMES RD #C (904) 777-5878	DPO	NG, KT 4131 UNIVERSITY BLVD S (904) 731-0521	DPO	FETNER, AE 4211 SOUTHPOINT PKWY #B (904) 296-8343	DPO	NEWBERRY General Dentists RICHTER, HM 12 SW 250TH ST (352) 472-4444		KLEMENT, BD 2140 KINGSLEY AVE #4 (904) 272-7277	
SMITH, MR 5218 JAMMES RD #C (904) 777-5878	DPO	PONTIER, JM 2800 UNIVERSITY BLVD N (904) 256-7851		FETNER, AE 5110 SAN JUAN AVE (904) 389-2276	DPO	ORANGE PARK General Dentists ALON-ALON, MR 1543 KINGSLEY AVE #19 (904) 269-1973	DPO	LE, LT 868 BLANDING BLVD #128 (904) 276-9402	DPO
SWINDLE, RB 4337 PABLO OAKS CT (904) 992-8000	DPO	WEAVER, PM 11571 SAN JOSE BLVD # 1 (904) 268-1285	DPO	FORREST, AD 10302 SOUTHSIDE BLVD (904) 363-3366	DPO	ARCHAMBAULT, GA 1414 KINGSLEY AVE #3 (904) 269-3842		LINDER, JL 784 BLANDING BLVD #110 (904) 272-2438	
TOPCIK, PL 8810 GOODBYS EXEC DR #B (904) 739-2422	DPO	WEAVER, PM 5218 JAMMES RD #A (904) 268-1285	DPO	HARTIGEN, MS 5110 SAN JUAN AVE (904) 389-2276	DPO			LINDHARDT, V 1406 KINGSLEY AVE #A (904) 269-2185	
YANG, SC 7301 MERRILL RD (904) 743-3114	DPO	Pedodontists COCHRAN, S 8355 BAYBERRY RD (904) 733-7254	DPO	HARTIGEN, MS 4211 SOUTHPOINT PKWY #B (904) 296-8343	DPO			MACLEOD, PJ 1406 KINGSLEY AVE #C (904) 264-9911	

CONTINUED

DPO Providers & Premier Providers

MAPP, SN 1515 BUSINESS CTR DR #1 (904) 215-3323	STANDISH, CM 1700 WELLS RD #17 (904) 269-6558	STRATTON, MW 1584 KINGSLEY AVE # 1 (904) 264-5437	DPO	Oral Surgeons AKERS, JO 9 PINE CONE DR (386) 252-6438	DPO	SHEEHAN, JJ 1081 A1A BEACH BLVD #32 (904) 471-3291	DPO
MARSHALL, BT 1910 WELLS RD (904) 269-7004	WOODWARD, WR 1605 COUNTRY RD 220 #110 (904) 215-3533	SUGGS, S 1910 WELLS RD (904) 269-9299	DPO	FLEUCHAUS, PT 9 PINE CONE DR (386) 252-6438	DPO	SINDAD, J 72 VALENCIA ST (904) 829-2032	
MCRAE, TE 637 BLANDING BLVD (904) 272-1564	WOODWARD, WR 1950 MILLER ST #3/4 (904) 269-3488	WALL, T 1910 WELLS RD (904) 269-9299	DPO	GAINES, RT 9 PINE CONE DR (386) 252-6438	DPO	WOODWARD, WR 9 ST JOHNS MED PK DR (904) 797-4108	DPO
MURRAY JR, EP 1605 COUNTRY RD 220 #110 (904) 215-3533	Oral Surgeons CAPUTA JR, LA 1409 KINGSLEY AVE #5 (904) 264-7383	WEAVER, GK 1584 KINGSLEY AVE # 1 (904) 264-5437	DPO	JOHNSON, DL 9 PINE CONE DR (386) 252-6438	DPO	Oral Surgeons JOHNSON, DL 1301 PLANTATION ISL DR S (904) 460-0505	DPO
NERIKAR, VV 1910 WELLS RD (904) 269-7004	FRANCOIS, K 1910 WELLS RD (904) 363-3366	Periodontists FORREST, AD 1910 WELLS RD (904) 269-9299	DPO	SCHALIT, CJ 9 PINE CONE DR (386) 252-6438	DPO	Orthodontists GLENOS, WJ 22 ST JOHNS MED PK DR (904) 797-6453	
PATEL, BB 1580 WELLS RD #20 (904) 278-9011	GROSHAN, GJ 2141 LOCH RANE BLVD #122 (904) 276-0200	SALLOUM, L 1542 KINGSLEY AVE #135 (904) 278-6980	DPO	Pedodontists MCLELLAN, BA 3 CYPRESS BRANCH WAY (386) 447-8728	DPO	WEAVER, PM 150 S PARK BLVD #201 (904) 268-1285	DPO
PATEL, RR 168 BLANDING BLVD #4 (904) 276-5143	HADDAD, RD 1910 WELLS RD (904) 269-9299	PALATKA General Dentists ARCHAMBO, NF 500 S HIGHWAY 19 (904) 325-5467	DPO	MCLELLAN, MA 3 CYPRESS BRANCH WAY (386) 447-8728	DPO	Pedodontists MCLELLAN, BA 1100 S PONCE DE LEON #2A (904) 829-6321	DPO
PEARSON, ML 38 BLANDING BLVD #A (904) 272-9440	HARTLEY, GW 2141 LOCH RANE BLVD #122 (904) 276-0200	PERALLON, RA 205 ZEAGLER DR #301 (386) 325-4504		ST AUGUSTINE General Dentists BAILEY, MS 75 SAN MARCO AVE (904) 810-1002	DPO	MCLELLAN, MA 1100 S PONCE DE LEON #2A (904) 829-6321	DPO
PEARSON, RA 38 BLANDING BLVD #A (904) 272-9440	O'BRIEN, DA 2141 LOCH RANE BLVD #122 (904) 276-0200	Orthodontists CHAPMAN, SA 3520 SAINT JOHNS AVE (904) 328-8351		BAKER, KE 2199 A1A S (904) 471-3300	DPO	Prosthodontists ELIAS, NS 150 SOUTH PARK BLVD #203 (904) 826-0307	
RAMSEY, TJ 410 BLANDING BLVD #6 (904) 276-5950	SEVETZ, EB 2140 KINGSLEY AVE #7 (904) 272-8484	FAUNCE, RA 6061 SAINT JOHNS AVE # B (386) 325-9988		COAST DENTAL 1081 A1A BEACH BLVD #32 (904) 471-3291	DPO	STARKE General Dentists CUNNINGHAM, T 459 W CALL ST (904) 964-5152	
ROESSLER, RK 1910 WELLS RD (904) 269-7004	WOODS, DD 2141 LOCH RANE BLVD #122 (904) 276-0200	PALM COAST General Dentists ANGELOV, D 114 PALM COAST PKWY NE (386) 446-5595	DPO	DAVID, A 1971 OLD MOULTRIE RD (904) 829-5111		MARCHESE, W 315 W CALL ST (904) 965-7501	
ROSENBERG, SR 1725 VILLAGE WAY (904) 264-6500	Endodontists JONES, HL 1910 WELLS RD (904) 269-9299	COAST DENTAL 114 PALM COAST PKWY NE (386) 446-5595	DPO	GOSSELIN, PF 9 ST JOHNS MED PK DR (904) 797-4108	DPO	STARLING, T 315 W CALL ST (904) 965-7501	
ROSENBLUM, RL 390 JEFFERSON AVE (904) 272-1588	Orthodontists BROWN, AB 2217 KINGSLEY AVE (904) 272-1165	GORDON, VL 114 PALM COAST PKWY NE (386) 446-5595	DPO	KELLEY, JR 9 ST JOHNS MED PK DR (904) 797-4108	DPO	YULEE General Dentists POTTER, S 1561 E SR 200 (904) 225-0607	DPO
SABROSKE, RP 1910 WELLS RD (904) 269-7004	FIELDS, R 2245 PLANTATION CTR DR (904) 269-2022	LACY, BW 1 FLORIDA PARK DR #224 (386) 446-5141		MORSE, D 2199 A1A S (904) 471-3300		SLAVKOVSKY, JR 85029 TRINITY CIR (904) 225-4999	
SANTIAGO, C 1409 KINGSLEY AVE #7A (904) 269-1419	LAZARRA, G 1910 WELLS RD (904) 269-2002	NAZ, O 7 OLD KINGS RD #10 (386) 445-0977		NEMECEK, M 2199 A1A S (904) 471-3300			
SCALES, DK 4609 HWY 17 S #2 (904) 278-7567	PEDEN, JP 1530 BUSINESS CENTER DR (904) 215-5256	OLSON, EJ 1 FLORIDA PARK DR #224 (386) 446-5141		PAINTER, RB 10 DOLPHIN DR (904) 824-8652			
SEARS, BD 5000 US HIGHWAY 17 #4 (904) 215-7855	PEDEN, JP 1406 KINGSLEY AVE (904) 264-4510	TAYLOR, JA 1 FLORIDA PARK DR #224 (386) 446-5141		POULOS, S 804 16TH ST (904) 471-3344	DPO		
SHERMAN, MA 2233 PARK AVE #401 (904) 269-5520	PRIETO, JS 1950 MILLER ST #3/4 (904) 269-3488	WATSON, DA 1 FLORIDA PARK DR #224 (386) 446-5141		SANTIAGO, R 5 ARREDONDO AVE # A (904) 824-0990			
SINGLE, JA 1910 WELLS RD (904) 269-7004	Pedodontists FRASER, MS 1584 KINGSLEY AVE # 1 (904) 264-5437						
SKAGGS, DE 3168 US HIGHWAY 17 (904) 278-7308							

Your vision is one of the most important aspects of your health. VisionCare Plan (VCP) offers a network of eye doctors in Duval and surrounding counties who provide your eye care needs at affordable prices.

Once you pay your network doctor a small co-payment, your vision care services are provided at no cost up to the plan allowance.

If you prefer to use a non-network doctor, you will be reimbursed up to the amounts in the following reimbursement schedule on Page 27, minus the applicable co-payments.

Family Coverage

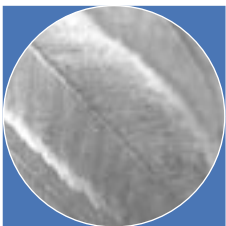
This plan covers:

- Your spouse
- Your unmarried dependent children to age 25, providing that the child is still dependent and living at home or the child is a full or part-time student
- Disabled dependent children are covered as long as disability remains total.

Plan Features

- Examination - Paid in full under Preferred Panel option; non-network maximum of \$30 reimbursement.
- Lenses - Paid in full under Preferred Panel option; non-network maximum of up to \$20 for Single vision, up to \$40 for Bifocals, up to \$60 for Trifocal, and up to \$100 for Lenticular.
- Frames - Paid in full (please contact VCP for plan limit amounts) under Preferred Panel option; non-network maximum of \$40 reimbursement.
- Elective Contact Lenses - Exam plus \$105 for fitting, follow-up and lenses. This is in lieu of frames and lenses.
- Medically Necessary Contacts - Paid in full under the Preferred Panel option; non-network option will pay up to \$150.

If you have dental or vision coverage, your co-pays or uninsured out-of-pocket expenses may be eligible for reimbursement through your Medical Expense FSA. See Page 37 for a partial list of eligible expenses or call FBMC Customer Service at 1-800-342-8017.



Refractive Care Program (LASIK)

VCP has a Refractive Care Program available to plan members who are nearsighted or have astigmatism and wear glasses or contacts. VCP has contracted with LASIK facilities and eye doctors to offer LASIK surgery to covered employees and family members at substantially reduced fees. Plan members will pay no more than \$1,800 for treating one eye, or \$3,600 for both eyes.

To utilize this program, first contact VCP to request a LASIK ID card and a list of network eye doctors for initial screening and approval. If you qualify, your doctor will make arrangements for the procedure, or you may go directly to one of the participating RefractiveCare ophthalmologists.

Frequency

- Examination - Once every 12 calendar months.
- Lenses - Once every 12 calendar months, if needed.
- Frames - Once every 24 calendar months, if needed.

VisionCare Plan Extras

- 20 percent discount on a second pair of eyeglasses
- 15 percent discount on professional service fees for elective contact lenses

What's Not Covered

- Orthoptics or vision training
- Lost or broken frames, except at the noted intervals
- Medical or surgical treatment of the eyes
- Services or materials provided by Workers' Compensation
- Services or materials obtained under preferred panel without following plan procedures
- Employer-required eye exams
- Any service or material provided by another group plan
- Two pair of glasses in lieu of bifocals

Plan Comparison - Reimbursement Schedule

CO-PAYMENTS

Exam	\$12	\$12
Materials	\$15	\$15

	VCP Network Doctor (Plan Pays)	Non-network Doctor (Plan Pays)
VISION EXAMINATION*	Covered in full	up to \$30

MATERIALS

Single Vision Lenses*	Covered in full	up to \$20
Bifocal Lenses*	Covered in full	up to \$40
Trifocal Lenses*	Covered in full	up to \$60
Lenticular Lenses*	Covered in full	up to \$100
Frames**	Covered in full (up to plan allowance)	up to \$40

CONTACT LENSES*

(in lieu of frames and lenses)

Medically Necessary†	Covered in full	\$150
Elective	Exam PLUS \$105 for fitting, follow-up and lenses	Exam PLUS \$105 for fitting, follow-up and lenses

* Every 12 months (based on calendar year months, not plan year months)

** Every 24 months (based on calendar year months, not plan year months)

† Medically necessary contact lenses are provided for in the following cases:

- following cataract surgery
- when visual acuity cannot be corrected to 20/70 in the better eye except by their use
- anisometropia of greater than 3.5 diopters and asthenopia or diplopia, with spectacles
- keratoconus diagnosis where contact lenses are treatment of choice; and/or
- monocular aphakia and/or biocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life.

In any of the cases above, it is required that they be pre-approved prior to the doctor filling your prescription.

How do I use this benefit?

There are no benefit forms or claim forms when you use VCP network doctors. All you need is your Vision Care ID card, which will be mailed to you prior to your effective date. Here's how it works:

Visit the VCP Web site at www.compbenefits.com for an up-to-date provider directory.

Choose a network doctor and call to make an appointment. Have your ID card ready so that you can give the doctor's office your policy number and member number, which are on the card. The doctor's office will also ask for the patient's name (that is, you or a covered family member) and your employer's name. The doctor's office will verify your eligibility and your plan benefits before your visit.

After your exam, the doctor will have you sign a VisionCare Plan form. At that time, you will also pay any co-payments and the cost of any extras you may have selected. VisionCare Plan will pay the network doctor directly, according to the plan's agreement with the doctor.

Your Rates*

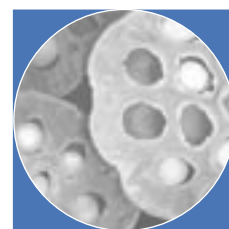
	20 Pays	24 Pay
Employee	\$3.77	\$3.14
Employee + Family	\$10.31	\$8.59

*Premiums may be paid either before or after taxes are deducted from your salary.

For the 2004-2005 Plan Year (October 1, 2004 through September 30, 2005), all rates are shown for 20 or 24 payroll deduction cycles.

If you have dental or vision coverage, your co-pays or uninsured out-of-pocket expenses may be eligible for reimbursement through your Medical Expense FSA.

See Page 37 for a partial list of eligible expenses or call FBMC Customer Service at 1-800-342-8017.



28 VisionCare Plan Providers

BAKER

Maccleddy

Frank A Broome, III, OD
31 S 6th St
Maccleddy, FL 32063-2311
(904)259-6259

Mary M Futch, OD
31 S 6th St
Maccleddy, FL 32063
(904)259-6259

Julie L Owens, OD
31 S 6th St
Maccleddy, FL 32063-2311
(904)259-6259

Robert L Phillips, OD
1183 S 6th St
Maccleddy, FL 32063-4620
(904)259-6797

CLAY

Keystone Heights

James H Minesinger, OD
260 S Lawrence Blvd
Keystone Heights, FL 32656
(352)473-2600

Orange Park

Kyle D Abshire, OD
905 Park Ave Ste 100
Orange Park, FL 32073-4110
(904)264-1206

Kyle D Abshire, OD
784 Blanding Blvd Ste 100
Orange Park, FL 32065-7724
(904)272-3937

Edwin N Anguas, OD
28 Blanding Blvd
Orange Park, FL 32073
(904)264-5483

Mary J M Ayer, OD
1515 Business Ctr Dr Ste 4
Orange Park, FL 32003-4401
(904)278-1760

Christina B Bowman, OD
905 Park Ave Ste 100
Orange Park, FL 32073-4110
(904)264-1206

Christina B Bowman, OD
784 Blanding Blvd Ste 100
Orange Park, FL 32065-7724
(904)272-3937

John P Donovan, MD
2023 Professional Ctr Dr
Orange Park, FL 32073-4461
(904)272-2020

John P Donovan, MD
1615 County Rd 220 Ste 140
Orange Park, FL 32073
(904)272-2020

Clarence M Harris, MD
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(904)272-2020

Clarence M Harris, MD
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(904)264-1206

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Dana Marie Nolan, OD
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(904)272-2020

John D Wilcox, Jr, MD
1615 County Rd 220 Ste 140
Orange Park, FL 32073
(904)272-2020

DUVAL

Jacksonville

John M Aimino, OD
2001 College St
Jacksonville, FL 32204-3703
(904)355-5555

Edward F Akel, OD
5205 Normandy Blvd Ste 3
Jacksonville, FL 32205-4840
(904)781-7717

Gary M Akel, OD
953 Lane Ave S
Jacksonville, FL 32205
(904)786-4442

Norman S Bateh, OD
1233 Lane Ave S Ste 15
Jacksonville, FL 32205-6254
(904)781-6770

Norman S Bateh, OD
5162 Norwood Ave
Jacksonville, FL 32208
(904)764-2591

Samuel Todd Bowman, OD
1500 Riverside Ave
Jacksonville, FL 32204-4125
(904)356-7101

Bruce M Caperton, OD
1840 Dunn Ave Ste 4
Jacksonville, FL 32218-4785
(904)751-4483

Melanie J Carvell, OD
8102 Blanding Blvd
Jacksonville, FL 32244-7500
(904)777-3937

Paul J Cone, OD
961 Cesery Blvd
Jacksonville, FL 32211-5607
(904)743-1311

Mary Eliza V Del Campo, OD
9400 Atlantic Blvd Ste 62
Jacksonville, FL 32225-8245
(904)721-7700

John C Derickson, OD
4131 Southside Blvd Ste 201
Jacksonville, FL 32216-5440
(904)997-8585

Janis L Dorsey, OD
719 N Edgewood Ave
Jacksonville, FL 32254
(904)338-9777

Paul T Fulghum, OD
4225 Lakeside Dr
Jacksonville, FL 32210-3305
(904)387-5704

Rod L Gabel, OD
2036 Forbes St
Jacksonville, FL 32204-3802
(904)387-4057

Robert Gerson, OD
3737 Blanding Blvd
Jacksonville, FL 32210-5242
(904)771-8321

Richard S Grimshaw, OD
5238 Norwood Ave Ste 17
Jacksonville, FL 32208-5099
(904)768-1757

Muneer N Hanna, OD
2292 Mayport Rd Ste 6
Jacksonville, FL 32233
(904)246-3550

Samuel Hathy, III, OD
11111 San Jose Blvd Ste 44
Jacksonville, FL 32223-7274
(904)292-3976

Frank E Houser, OD
13170 Atlantic Blvd Ste 53
Jacksonville, FL 32225-4151
(904)221-6500

Charles N Howell, Jr, OD
2115 University Blvd S Ste 1
Jacksonville, FL 32216-8936
(904)725-2300

James C Lanier, Jr, OD
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(904)356-7101

Tammy A Laramie, OD
4205 Belfort Rd Ste 3026
Jacksonville, FL 32216-1402
(904)296-1980

Gayle P Leinwohl, OD
9400 Atlantic Blvd Ste 62
Jacksonville, FL 32225-8245
(904)721-7700

Gayle P Leinwohl, OD
9397 San Jose Blvd Ste 2
Jacksonville, FL 32257
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Peter D Liane, OD
100 W Bay St
Jacksonville, FL 32202-3838
(904)356-9431

Linda L Marks, OD
9397 San Jose Blvd Ste 2
Jacksonville, FL 32257
(904)730-2299

John W McClane, III, OD
8626 Baymeadows Rd
Jacksonville, FL 32256-7424
(904)739-2050

David E Miles, OD
1403 Dunn Ave Ste 15
Jacksonville, FL 32218-4870
(904)696-0883

William F Miles, OD
1403 Dunn Ave Ste 15
Jacksonville, FL 32218-4870
(904)696-0883

Janet M Mint, OD
4131 Southside Blvd Ste 203
Jacksonville, FL 32216-5439
(904)646-9737

Douglas F Parker, OD
2415 University Blvd W
Jacksonville, FL 32217-2001
(904)733-5100

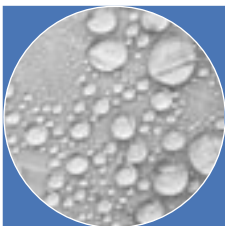
Robert L Phillips, OD
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Jacksonville, FL 32225-8245
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32034-3212
(904)261-5741

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Fernandina Beach, FL
32034-3212
(904)261-5741

Stephen D Stubits, OD
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Fernandina Beach, FL
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J William Wesley, OD
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Fernandina Beach, FL
32034-3711
(904)261-7102

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Jay P Crump, OD
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Yulee, FL 32097
(904)225-1997

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(Jacksonville)

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Jacksonville, FL 32259
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Sharokh N Kapadia, OD
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32082-6609
(904)280-9000

Gilbert Houston, OD
330 A1A N Ste 202
Ponte Vedra Beach, FL
32082-1824
(904)285-8448

James C Lanier, Jr, OD
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Ponte Vedra Beach, FL
32082-6609
(904)280-9000

Ellen L Rogers, OD
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32082-6609
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Saint Augustine, FL 32080-2917
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R Andrew Wiles, OD
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Saint Augustine, FL 32086
(904)797-4628



The Hospital Indemnity Insurance policy supplements your medical insurance by providing additional insurance every day that you or your covered dependents are in the hospital for a covered accident or illness, from the first day of hospitalization (subject to the pre-existing condition limitation) up to 365 days of each period of continuous hospital confinement.

You may choose between two daily coverage amounts (\$75 or \$150) up to 365 days of continuous hospital confinement to supplement any other coverage you have. Your benefit amounts double if you are confined in a hospital intensive care unit. This benefit is payable for up to 60 days of continuous intensive care confinement.

In cases when a covered person has an outpatient surgical procedure performed in an ambulatory surgical center as defined in the policy, the Ambulatory Surgical Benefit will pay \$150 per occurrence, per unit of coverage.

Why Do I Need this Benefit?

Duval County Public Schools' medical plan pays 80 percent of in-patient hospitalization. This benefit can be used to supplement the remaining 20 percent that is not covered.

Waiver of Premium

After the insured has been confined for 30 consecutive days, the premiums that become due on the policy and rider are waived during a primary insured's continued hospital confinement. Once the hospital confinement ends, premium payments must begin again.

What's Not Covered

The policy and rider do not pay benefits for conditions caused by or resulting from:

- any act of war, whether declared or undeclared, participation in a riot, insurrection or rebellion
- intoxication or being under the influence of drugs not prescribed or recommended by a physician
- an attempted suicide or an intentional self-inflicted injury
- nervous or mental disorders
- alcoholism or drug addiction
- dental or plastic surgery for cosmetic purposes. This exclusion does not apply to such surgery required by (a) an injury, or (b) correction of disorders of normal bodily functions.
- a newborn child's routine nursing or routine well baby care
- childbirth occurring during the first 10 months of the policy date (complications of pregnancy are covered to the same extent as a sickness)
- hospitalization that begins before the policy date.

No benefits are paid under the hospital intensive care confinement benefit for confinement that does not qualify as a hospital intensive care unit as defined or which has been excluded. The exclusions and other limitations provisions of the policy also apply to the riders.

Surgery and Anesthesia Benefit Rider

If you undergo surgery in a hospital or an ambulatory surgical center, your surgical benefit pays you \$15-\$375, depending on the surgery.

Two or more procedures done at the same time through one incision are considered one operation. The rider will pay the amount shown in the Schedule of Operations for the operation with the largest benefit. If any operation other than those listed is performed, the rider pays an amount based on the amount stated in the Schedule of Operations for the most comparable procedure.

If you require anesthesia during the course of a covered operation, your anesthesia benefit pays you an additional 30 percent of the surgical benefit.

Optional Initial Hospitalization Rider

One or two units of this rider are available. The Initial Hospitalization Benefit pays \$375 (one unit) or \$750 (two units) on the first continuous confinement to a hospital during a calendar year, provided a benefit is paid under the Hospital Confinement Benefit policy. This benefit is payable only once for each covered person for each continuous hospital confinement and for each calendar year.

Family Coverage

If family coverage is selected, the policy covers your spouse if he or she is under age 65. It also covers your unmarried dependent children until the end of the calendar year in which they reach age 25, so long as the child is a full-time student. Unmarried dependent children who are not full-time students but living in your household are covered until the age of 21.

Renewability

Issue ages are 18-64. Guaranteed renewable to age 65 subject to change in premiums by class. A notice will be mailed in advance of any change.

Taxable Benefits and the IRS

Please refer to *Beyond Your Benefits* section for further details.

Pre-existing Conditions

Coverage under the policy and any riders attached to the policy is not applicable to pre-existing conditions. Coverage pertains solely to hospital confinement resulting from accidental bodily injuries occurring after the effective date of coverage, or sickness limited to those which first manifest themselves subsequent to the date of coverage. If a covered person has a pre-existing condition as defined, benefits are not paid for such condition during the 12-month period beginning on the date that person became a covered person.

Policy Provider

Allstate Workplace Division is the marketing name for American Heritage Life Insurance Company (Home Office: Jacksonville, FL), a wholly owned subsidiary of The Allstate Corporation. American Heritage Life Insurance Company underwrites the policy and riders. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies rates American Heritage Life "A+" Superior. Benefits are provided by Policy CHCFL and riders IHR1 and SAR1FL. The policy and riders are not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide, available from Allstate Workplace Division.

20 Pay Rates

**Base Policy (choice of \$75 or \$150 day HIP) plus Surgery/Anesthesia Rider (1 unit)
Policy CHCFL with SAR1FL (1 unit) rider only**

Issue Age	18-35	36-49	50-59	60-64
Employee Only - \$75	\$3.90	\$4.50	\$5.64	\$7.50
Employee + Children - \$75	\$6.54	\$7.20	\$7.38	\$7.86
Employee + Spouse - \$75	\$7.80	\$9.00	\$11.28	\$15.00
Employee + Family - \$75	\$10.44	\$11.70	\$13.02	\$15.36
Employee Only - \$150	\$7.08	\$8.10	\$10.26	\$13.80
Employee + Children - \$150	\$11.94	\$13.08	\$13.38	\$14.28
Employee + Spouse - \$150	\$14.16	\$16.20	\$20.52	\$27.60
Employee + Family - \$150	\$19.02	\$21.18	\$23.64	\$28.08

Base Policy (choice of \$75 or \$150 day HIP), Surgery/Anesthesia Rider (1 unit), and Hospitalization Rider (1 unit - \$375)

Policy CHCFL with SAR1FL rider and IHR1 (1 unit) rider

Issue Age	18-35	36-49	50-59	60-64
Employee Only - \$75	\$5.76	\$6.60	\$8.22	\$10.62
Employee + Children - \$75	\$9.84	\$10.62	\$10.92	\$11.52
Employee + Spouse - \$75	\$11.52	\$13.20	\$16.44	\$21.24
Employee + Family - \$75	\$15.60	\$17.22	\$19.14	\$22.14
Employee Only - \$150	\$8.94	\$10.20	\$12.84	\$16.92
Employee + Children - \$150	\$15.24	\$16.50	\$16.92	\$17.94
Employee + Spouse - \$150	\$17.88	\$20.40	\$25.68	\$33.84
Employee + Family - \$150	\$24.18	\$26.70	\$29.76	\$34.86

Base Policy (choice of \$75 or \$150 day HIP), Surgery/Anesthesia Rider (1 unit), and Hospitalization Rider (2 units - \$750)

Policy CHCFL with SAR1FL rider and IHR1 (2 units) rider

Issue Age	18-35	36-49	50-59	60-64
Employee Only - \$75	\$7.62	\$8.70	\$10.80	\$13.74
Employee + Children - \$75	\$13.14	\$14.04	\$14.46	\$15.18
Employee + Spouse - \$75	\$15.24	\$17.40	\$21.60	\$27.48
Employee + Family - \$75	\$20.76	\$22.74	\$25.26	\$28.92
Employee Only - \$150	\$10.80	\$12.30	\$15.42	\$20.04
Employee + Children - \$150	\$18.54	\$19.92	\$20.46	\$21.60
Employee + Spouse - \$150	\$21.60	\$24.60	\$30.84	\$40.08
Employee + Family - \$150	\$29.34	\$32.22	\$35.88	\$41.64



24 Pay Rates

**Base Policy (choice of \$75 or \$150 day HIP) plus Surgery/Anesthesia Rider (1 unit)
Policy CHCFL with SAR1FL (1 unit) rider only**

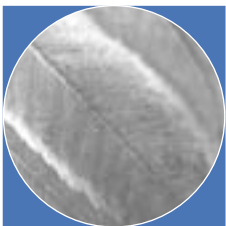
Issue Age	18-35	36-49	50-59	60-64
Employee Only - \$75	\$3.25	\$3.75	\$4.70	\$6.25
Employee + Children - \$75	\$5.45	\$6.00	\$6.15	\$6.55
Employee + Spouse - \$75	\$6.50	\$7.50	\$9.40	\$12.50
Employee + Family - \$75	\$8.70	\$9.75	\$10.85	\$12.80
Employee Only - \$150	\$5.90	\$6.75	\$8.55	\$11.50
Employee + Children - \$150	\$9.95	\$10.90	\$11.15	\$11.90
Employee + Spouse - \$150	\$11.80	\$13.50	\$17.10	\$23.00
Employee + Family - \$150	\$15.85	\$17.65	\$19.70	\$23.40

**Base Policy (choice of \$75 or \$150 day HIP), Surgery/Anesthesia Rider (1 unit), and Hospitalization Rider
(1 unit - \$375)
Policy CHCFL with SAR1FL rider and IHR1 (1 unit) rider**

Issue Age	18-35	36-49	50-59	60-64
Employee Only - \$75	\$4.80	\$5.50	\$6.85	\$8.85
Employee + Children - \$75	\$8.20	\$8.85	\$9.10	\$9.60
Employee + Spouse - \$75	\$9.60	\$11.00	\$13.70	\$17.70
Employee + Family - \$75	\$13.00	\$14.35	\$15.95	\$18.45
Employee Only - \$150	\$7.45	\$8.50	\$10.70	\$14.10
Employee + Children - \$150	\$12.70	\$13.75	\$14.10	\$14.95
Employee + Spouse - \$150	\$14.90	\$17.00	\$21.40	\$28.20
Employee + Family - \$150	\$20.15	\$22.25	\$24.80	\$29.05

**Base Policy (choice of \$75 or \$150 day HIP), Surgery/Anesthesia Rider (1 unit), and Hospitalization Rider
(2 units - \$750)
Policy CHCFL with SAR1FL rider and IHR1 (2 units) rider**

Issue Age	18-35	36-49	50-59	60-64
Employee Only - \$75	\$6.35	\$7.25	\$9.00	\$11.45
Employee + Children - \$75	\$10.95	\$11.70	\$12.05	\$12.65
Employee + Spouse - \$75	\$12.70	\$14.50	\$18.00	\$22.90
Employee + Family - \$75	\$17.30	\$18.95	\$21.05	\$24.10
Employee Only - \$150	\$9.00	\$10.25	\$12.85	\$16.70
Employee + Children - \$150	\$15.45	\$16.60	\$17.05	\$18.00
Employee + Spouse - \$150	\$18.00	\$20.50	\$25.70	\$33.40
Employee + Family - \$150	\$24.45	\$26.85	\$29.90	\$34.70



A disability can put a lot of things in your life on hold. Statistics show that 25 percent of all employees who are at least age 35 will suffer a disability lasting 90 days or longer before they reach age 65.

The following Disability Income Protection plans provide you with a weekly (STD) or monthly (LTD) income if you become disabled. Choose short-term or long-term disability income protection, or both.

What are Deductible Sources of Income?

Deductible Sources of Income (payments received through another type of disability plan) will reduce the amount of the benefit paid. Deductible Sources of Income include:

- workers compensation (LTD only)
- retirement plans (FRS)
- Social Security awards
- other group insurance.

The Short-Term Disability (STD) Income plan provides:

Injury and Sickness Benefits

The STD monthly benefit of the level selected (refer to the rates at the end of this section) is payable during each period of total disability. STD benefits start after you are certified disabled and satisfy a 14-consecutive-day waiting period. Short-Term Disability payments are received weekly and benefits continue for each period of total, certified disability but not beyond the maximum benefit period of 24 weeks. The Short-Term Disability minimum weekly benefit is 25 percent of your gross disability payment.

Benefit Tip

To determine your need for short-term or long-term disability protection, consider how you would pay monthly expenses if you had no income due to an accident or illness.

The Long-Term Disability Plan (LTD) provides:

Injury and Sickness Benefits

The LTD monthly benefit of the level selected is payable during each period of total disability. LTD benefits start after you are certified disabled and satisfy a 180-consecutive-day waiting period. In addition, the Long-Term Disability minimum monthly benefit is 25 percent of your gross disability payment. Benefits will continue for each period of total disability according to the schedule below.

After 24 months of payments, you are disabled when UNUM determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training, or experience.

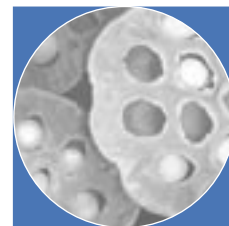
Length of Benefit

Age at the time of disability	LTD Benefits payable for the following maximum*
Under 60	To Age 65, but not less than 5 years
60	60 Months
61	48 Months
62	42 Months
63	36 Months
64	30 Months
65	24 Months
66	21 Months
67	18 Months
68	15 Months
69 and Over	12 Months

*The maximum benefit period is the period in which the benefit will be paid to you.

Benefit Tip

Periodic medical certification of disability will be requested to continue benefit payments.



CONTINUED

Mental Illness and Self-reported Systems Limitation

Disabilities, due to sickness or injury which are primarily based upon self-reported symptoms, and disabilities due to mental illness have a limited pay period up to 24 months. However, if at any time you are confined in a hospital for at least 14 consecutive days due to this total disability, the monthly LTD benefit will be payable for the period of hospital confinement and for up to 90 days following your discharge, provided you remain totally disabled. UNUM will not pay beyond the limited pay period, or the maximum period of payment, whichever occurs first.

What's Not Covered

Benefits will not be paid for disabilities resulting from:

- Intentionally self-inflicted injuries
- Acts of war (declared or undeclared), riots or military action
- Incarceration
- The attempt or commission of a crime for which you have been convicted under state or federal law
- Occupational sickness or injury (STD only)
- Workers Compensation (STD only)
- The loss of a professional license or certification

In addition, benefits will not be paid for a total disability if you are not receiving regular in-person medical treatment from a legally qualified physician during the period of disability or if the total disability is not certified by a legally qualified physician.

Taxable Benefits and the IRS

The benefits you receive under this plan will be taxable as income, if you pay your premiums on a pre-tax basis. You may receive a separate W-2 form from the carrier. Please refer to *Beyond Your Benefits* section of this booklet for more information. If you have questions, consult your personal tax advisor.

DEFINITIONS

Accident means an unintentional and unforeseeable event caused directly or indirectly by external forces.

Accidental Injury means a physical disorder, caused by an accident, which solely and independently of all other causes, results in a period of total disability beginning within 90 days of the accident. Any period of total disability or hospital confinement beginning after 90 days from the date of the accident will be considered a sickness under this policy. Accidental injury benefits will be payable only if the accident occurs while this insurance is in effect.

Certification of Total Disability means that you have an in-person visit with a legally qualified physician during which he or she prescribes medical treatment for the disabling condition and attests to your total disability based on objective medical evidence.

Deductible Sources of Income means payments received from other sources that will reduce the amount paid to the employee.

Hospital means an institution for medical care and treatment of sick or injured persons which functions within the law, has a means for diagnosis, is supervised by a staff of legally qualified physicians, and has 24-hour nursing service; or, is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, or a Christian Science Sanatorium, operated or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts. Hospital does not mean a convalescent, nursing or rest home, home for the aged, or a place mainly providing custodial, educational or rehabilitative care.

Hospital Confinement or Hospital-Confined means a period of at least 24 hours during which you are a registered bed patient in a hospital and charged for daily room and board.

In-Person means in the presence of a legally qualified physician.

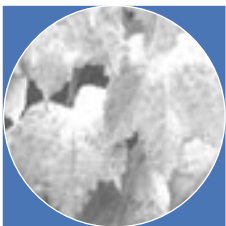
Legally Qualified Physician means a doctor or a licensed practitioner whose inclusion in this definition is required by law; practicing within the scope of his or her license.

Medical Treatment means the application, by a legally qualified physician, of remedies which are medically necessary.

Monthly Salary shall be your annual salary (excluding overtime and bonuses) from the Board of Education divided by 12. During a covered leave of absence your monthly salary means your annual salary (excluding overtime and bonuses), immediately prior to such leave, divided by 12. Daily benefits are computed by dividing the monthly benefit by 30.

Period of Disability means a continuous length of time during which you are totally disabled due to any one accidental injury or sickness. Under both the STD and LTD Plans, successive periods of disability will be considered as one period of disability unless they are due to separate and unrelated causes or separated by a period of at least six consecutive months that you are at work full-time. However, benefits will only be payable for one period of total disability at a time, even if total disability results from two or more causes.

Sickness means a physical disorder caused by an illness or disease which does not qualify as an accident and which is not excluded under this policy. Sickness also includes normal pregnancy, complications of pregnancy and childbirth.



Important Information for Both Long-Term & 35 Short-Term Income Protection Plans

What is a Pre-Existing Condition?

A pre-existing condition is a sickness or accidental injury for which medical treatment is received or prescription drugs taken during the six-month period prior to your coverage effective date.

All new employees and employees who have bypassed or cancelled disability coverage must satisfy the following pre-existing condition clause:

Benefits will not be paid if you are disabled by a pre-existing condition during the first 12 months of coverage.

In addition, if you increase your benefit level and become disabled due to a pre-existing condition within 12 months, the amount of the increase will not be paid at any time during that disability.

Waiver of Premium

After you have received benefits payments, premium payments for the rest of the period of certified disability will be waived.

Short-Term Disability: You are disabled when UNUM determines that due to sickness or injury:

- you are unable to perform the material and substantial duties of your regular occupation, and
- you are not working in any occupation.

Long-Term Disability: You are disabled when UNUM determines that:

- you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury, and
- you have a 20 percent or more loss in your indexed monthly earnings due to the same sickness or injury.

Coverage Levels

You may participate in the plans under any one of the benefit levels outlined below, provided the Monthly Disability Benefit level selected does not exceed 66 2/3 percent of your regular monthly salary from the Duval County Public Schools at the time you apply.

Policy Provider

UNUM Life Insurance Company of America underwrites this plan. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies rates UNUM Life Insurance Company of America "A-" Excellent.

Your Rates and Disability Benefit Amount

Rate Per 20 Pay Periods

Short-Term (14th day)	Long-Term (180th day)
\$4.82	\$3.98
\$7.22	\$5.99
\$9.62	\$7.97
\$12.03	\$9.98
\$14.44	\$11.99
\$18.06	\$14.98
\$21.66	\$17.98
\$28.90	\$23.96

Benefit Amount

If your gross annual is at least:	You are eligible for a monthly accident and sickness disability benefit of:
\$7,200	\$400
\$10,800	\$600
\$14,400	\$800
\$18,000	\$1,000
\$21,600	\$1,200
\$27,000	\$1,500
\$32,400	\$1,800
\$43,200	\$2,400

Rate Per 24 Pay Periods

Short-Term (14th day)	Long-Term (180th day)
\$4.02	\$3.32
\$6.02	\$4.99
\$8.02	\$6.64
\$10.03	\$8.32
\$12.03	\$9.99
\$15.05	\$12.48
\$18.05	\$14.98
\$24.08	\$19.97



What is a Flexible Spending Account?

Fringe Benefits Management Company (FBMC) provides you with tax-favored Flexible Spending Accounts (FSAs) to stretch your medical expense and dependent care dollars.

Flexible Spending Accounts feature:

- IRS-approved reimbursement of eligible expenses tax free
- per-pay-period deposits from your pre-tax salary
- savings on federal and Social Security taxes and
- security of paying anticipated expenses with your FSA.

Is an FSA right for me?

If you spend \$250 or more on recurring eligible expenses during your plan year, you may save money by paying for them with an FSA. A portion of your salary is deposited into your FSA each pay period.

- You decide the amount you want deposited.
- You are reimbursed for eligible expenses before income and Social Security taxes are deducted.
- You save income and Social Security taxes each time you receive wages.
- Determine your potential savings with a Tax Savings Analysis at www.fbmc-benefits.com/customer/taxanalysis.asp.

What types of FSAs are available?

Your employer offers you a Medical Expense FSA as well as a Dependent Care FSA. If you incur both types of expenses during a plan year, you can establish both types of FSAs.

Medical Expense FSAs

Medical expenses not covered by your insurance plan may be eligible for reimbursement using your Medical Expense FSA, including:

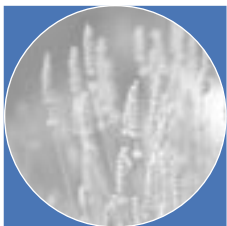
- birth control pills
- eyeglasses
- orthodontia (medical necessity proof will be required) and
- Over-the-Counter items.

Dependent Care FSAs

Dependent care expenses, whether for a child or an elder, include any expense that allows you to work, such as:

- day care services
- in-home care
- nursery and preschool and
- summer day camps.

Refer to the *Medical Expense FSA* and *Dependent Care FSA* sections of this Reference Guide for specifics on each type of FSA.



Receiving Reimbursement

Your reimbursement will be processed within five business days from the time FBMC receives your properly completed and signed FSA Reimbursement Request Form. To avoid delays, follow the instructions for submitting your requests located in the FSA materials you will receive following enrollment.

Direct Deposit

Enroll in Direct Deposit to expedite the time of your reimbursement.

- FSA reimbursement funds are automatically deposited into your checking or savings account.
- There is no fee for this service.
- You don't have to wait for postal service delivery of your reimbursement (however, you will receive notification that the claim has been processed).

To apply, complete the Enrollment Form available from your Enrollment Counselor, visit www.fbmc-benefits.com or call FBMC Customer Service at 1-800-342-8017. Please note that processing your Direct Deposit enrollment may take between four to six weeks.

Where can I get information about FSAs?

If you have specific questions about FSAs, contact FBMC Customer Service.

- Visit www.fbmc-benefits.com.
- E-mail webcustomerservice@fbmc-benefits.com.
- Call 1-800-342-8017 (Monday-Friday, 7 a.m.-10 p.m. ET).

Please note that due to FBMC's Privacy Policy, we will not discuss your account information with others without your verbal or written authorization.

FSA Savings Example*

\$31,000	Annual Gross Income	\$31,000
<u>- 5,000</u>	FSA Deposit for Recurring Expenses	<u>- 0</u>
\$26,000	Taxable Gross Income	\$31,000
<u>- 5,889</u>	Federal, Social Security Taxes	<u>-7,021</u>
\$20,111	Annual Net Income	\$23,979
<u>- 0</u>	Cost of Recurring Expenses	<u>-5,000</u>
\$20,111	Spendable Income	\$18,979

By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of **\$1,132!**

* Based upon a 22.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year.

Minimum Annual Deposit: None
Maximum Annual Deposit: \$4,250

What is a Medical Expense FSA?

A Medical Expense FSA is an IRS tax-favored account you can use to pay for your eligible medical expenses not covered by your insurance or any other plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

Your Medical Expense FSA may be used to reimburse eligible expenses incurred by:

- yourself
- your spouse and
- your tax dependents.

To qualify as your tax dependent, an individual must:

- be your relative, or
- live with you for the entire calendar year if not your relative.

In either case, the individual must also be:

- a U.S. citizen or a resident of the U.S., Mexico or Canada and
- the recipient of at least half of their total support and/or expenses during the calendar year from you.

An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Medical Expense FSA.

When are my funds available?

Once you sign up for a Medical Expense FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of your deductions.

Are prescriptions eligible for reimbursement?

Yes, most filled prescriptions are eligible for Medical Expense FSA reimbursement, as long as you properly substantiate the expense. Proper submission of the reimbursement request is needed to ensure that the drug is eligible for reimbursement. The IRS requires that the complete name and prescription number of all medicines and drugs be obtained and documented on pharmacy receipts. This information must be included when submitting your request to FBMC for reimbursement.

Partial List of Medically Necessary Eligible Expenses*

Acupuncture
 Ambulance service
 Birth control pills and devices
 Chiropractic care
 Contact lenses (corrective)
 Dental fees
 Diagnostic tests/health screening
 Doctor fees
 Drug addiction/alcoholism treatment
 Drugs
 Experimental medical treatment
 Eyeglasses
 Guide dogs
 Hearing aids and exams
 Injections and vaccinations
 In vitro fertilization
 Nursing services
 Optometrist fees
 Orthodontic treatment
 Over-the-Counter drugs
 Prescription drugs to alleviate nicotine withdrawal symptoms
 Smoking cessation programs/treatments
 Surgery
 Transportation for medical care
 Weight-loss programs/meetings
 Wheelchairs
 X-rays

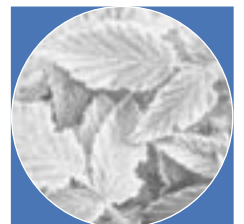
Note: Budget conservatively. No reimbursement or refund of Medical Expense FSA funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

Can travel expenses for medical care be reimbursed?

Travel expenses primarily for, and essential to, receiving medical care, including health care provider and pharmacy visits, may be reimbursable through your Medical Expense FSA. With proper substantiation, eligible expenses can include:

- actual round-trip mileage
- parking fees
- tolls and
- transportation to another city.



CONTINUED

Benefit Tip

If you are thinking of putting money into a Medical Expense FSA to pay for a planned surgical procedure, please verify with your healthcare provider (prior to the start of the upcoming plan year) that you are a suitable candidate for the procedure before committing the money to your FSA.

Is orthodontic treatment reimbursable?

Orthodontic treatment designed to treat a specific medical condition is reimbursable if the proper documentation is attached to the initial FSA Reimbursement Request Form each plan year:

- a written statement from the treating dentist/orthodontist showing the type and date the service incurred, the name of the eligible individual receiving the service and the cost for the service
- a Letter of Medical Need from the treating dentist/orthodontist and
- a copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment.

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed. For reimbursement options available under your employer's plan, including care that extends beyond one or more plan years, refer to the information provided following your enrollment, or call FBMC Customer Service at 1-800-342-8017.

Should I claim my expenses on IRS Form 1040?

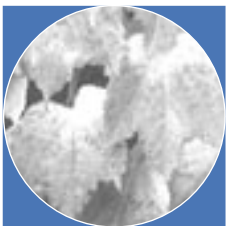
With a Medical Expense FSA, the money you set aside for health care expenses is deducted from your salary before taxes. It is always tax free, regardless of the amount. By enrolling in a Medical Expense FSA, you guarantee your savings.

Itemizing your health care expenses on your IRS Form 1040 may give you a different tax advantage, depending on the percentage of your adjusted gross income. You should consult a tax professional to determine which avenue is right for you.

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Medical Expense FSA include:

- insurance premiums
- vision warranties and service contracts and
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition.



When do I request reimbursement?

You may use your Medical Expense FSA to reimburse eligible expenses after you have sought (and exhausted) all means of reimbursement provided by your employer and any other appropriate resource. Also keep in mind that some eligible expenses are reimbursable on the date available, not the date ordered.

How do I request reimbursement?

Requesting reimbursement from your Medical Expense FSA is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form along with the following:

- a receipt, invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided and
- an Explanation of Benefits (EOB) from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost or
- a written statement from your health care provider indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the receipt, invoice or bill for the service.

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 850-425-4608

Visit www.fbmc-benefits.com for a list of frequently asked questions.

You must keep your receipts for a minimum of one year and submit to FBMC upon request.

Over-the-Counter Expenses

Your Over-the-Counter (OTC) items, medicines and drugs may now be reimbursed through your Medical Expense FSA! Save valuable tax dollars on certain categories of OTC items, medicines and drugs. You may be reimbursed for OTCs through your Medical Expense FSA if:

- the item, medicine or drug was used for a specific medical condition for you, your spouse and/or your dependent(s)
- the submitted receipt clearly states the purchase date and name of the item, medicine or drug
- the reimbursement request is for an expense allowed by your employer's Medical Expense FSA plan and IRS regulations and
- you submit your reimbursement request in a timely and complete manner already described in your benefits enrollment information.

Note: OTC items, medicines and drugs, including bulk purchases, must be used in the same plan year in which you claim reimbursement for their cost. The list of eligible OTC categories will be updated on a quarterly basis by FBMC. It is your responsibility to remain informed of updates to this listing, which can be found at www.fbmc-benefits.com. As soon as an OTC item, medicine or drug becomes eligible under any of the categories below, it will be reimbursable retroactively to the start of the then current plan year.

Newly eligible OTC items, medicines and drugs are not considered a valid change in status event that would allow you to change your annual Medical Expense FSA election or salary reduction amount. Be sure to maintain sufficient documentation to submit receipts for reimbursement. You may resubmit a copy of your receipt from your records if a rejected OTC expense becomes eligible for reimbursement later in the same plan year.

Eligible Expense Categories

Allergy

Antihistamines
Nasal sprays

Antacids

Heartburn medicines

Cold Remedies

Cough drops
Decongestants
Nasal strips
Nasal sprays
Sinus medications
Throat lozenges

Pain Relief

Bug bite medication
Fever reducers
First aid creams (diaper, fever blister, poison ivy)
Menstrual cycle products for pain and cramp relief
Products for muscle or joint pain
Special ointments or creams for sunburn
Topical creams

Other Medical Remedy Items

Anti-diarrheals
Anti-fungals
Antibiotics
Asthma medications
Bandages, gauze pads, rubbing alcohol, liquid adhesives

Carpel tunnel wrist supports
Cold/hot packs for injuries
Corn/callus removers
Eye products (including reading glasses, contact lens cleaning solutions)
First aid kits
Hemorrhoid treatments
Laxatives
Motion sickness treatments
Nicotine gum or patches for smoking cessation purposes
Thermometers
Wart removers

Items Requiring Special Documentation*

Botanicals/herbals
Feminine hygiene products
Hormones
Minerals
Nasal sprays for snoring
Sunscreens
Vitamins
Weight-loss drugs to treat a specific disease

Ineligible OTC Expenses

Cosmetics
Toiletries
OTC items primarily for general health and well-being

* Contact FBMC Customer Service at webcustomerservice@fbmc-benefits.com or call FBMC Customer Service at 1-800-342-8017 for more information or to obtain a sample Letter of Medical Need or Personal Use/Capital Expenditures Statement.



Minimum Annual Deposit: \$250

Maximum Annual Deposit: The maximum contribution depends on your tax filing status as the list indicates.

What is a Dependent Care FSA?

A Dependent Care FSA is an IRS tax-favored account you can use to pay for your eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if married) are working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

Under the Dependent Care FSA, you may be reimbursed for eligible dependent care expenses incurred by individuals residing in your household for at least eight hours a day including:

- children 12 years or younger and
- adults/children mentally or physically incapable of self-care.

What is my maximum annual deposit?

- If you are married and filing separately, your maximum annual deposit is \$2,500.
- If you are single and head of household, your maximum annual deposit is \$5,000.
- If you are married and filing jointly, your maximum annual deposit is \$5,000.
- If either you or your spouse earn less than \$5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is \$3,000 a year for one dependent and \$5,000 a year for two or more dependents.

When are my funds available?

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Medical Expense FSA, the entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.

Partial List of Eligible Expenses*

After school care
 Baby-sitting fees
 Day care services
 In-home care/au pair services
 Nursery and preschool
 Summer day camps

Note: Budget conservatively. No reimbursement or refund of Dependent Care FSA funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

Should I claim tax credits or exclusions?

Since money set aside in your Dependent Care FSA is always tax free, you guarantee savings by paying for your eligible expenses through your IRS tax-favored account. Depending on the amount of income taxes you are required to pay, participation in a Dependent Care FSA may produce a greater tax benefit than claiming tax credits or exclusions alone.

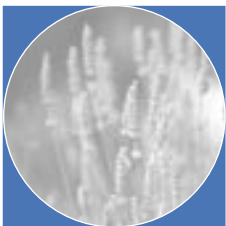
Remember, you cannot use the dependent care tax credit if you are married and filing separately. Further, any dependent care expenses reimbursed through your Dependent Care FSA cannot be filed for the dependent care tax credit, and vice versa.

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information. You may also visit www.fbmc-benefits.com to complete a Tax Savings Analysis.

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Dependent Care FSA include:

- books and supplies
- child support payments or child care if you are a non-custodial parent
- health care or educational tuition costs and
- services provided by your dependent, your spouse's dependent or your child who is under age 19.



Will I need to keep any additional documentation?

To claim the income exclusion for dependent care expenses on IRS Form 2441 (Child and Dependent Care Expenses), you must be able to identify your dependent care provider. If your dependent care is provided by an individual, you will need their Social Security number for identification, unless he or she is a resident or non-resident alien who does not have a Social Security number. If your dependent care is provided by an establishment, you will need its Taxpayer Identification number.

If you are unable to obtain a dependent care provider's information, you must compose a written statement that explains the circumstances and states that you made a serious and earnest effort to get the information. This statement must accompany your IRS Form 2441.

When do I request reimbursement?

You can request reimbursement from your Dependent Care FSA as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Also, remember that for timely processing of your reimbursement, your payroll contributions must be current.

Benefit Tip

Be certain you obtain and submit all needed information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

A properly completed request will help speed along the process of your reimbursement, allowing you to receive your check or Direct Deposit promptly.

How do I request reimbursement?

Requesting reimbursement from your Dependent Care FSA is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form along with receipts showing the following:

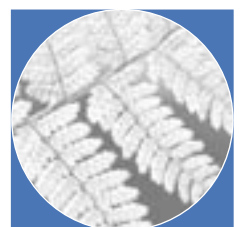
- the name, age and grade of the dependent receiving the service
- the cost of the service
- the name and address of the provider
- the beginning and ending dates of the service

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 850-425-4608

Note: If you elect to participate in the Dependent Care FSA, or if you file for the Dependent Care Tax Credit, you must attach IRS Form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this may result in the IRS denying your pre-tax exclusion.



To figure out how much to deposit in your FSA, refer to the following worksheets. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed established IRS and plan limits. (Refer to the individual FSA descriptions in this Reference Guide for limits.)

Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.

MEDICAL EXPENSE FSA WORKSHEET

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	\$ _____
Coinsurance or co-payments	\$ _____
Vision care	\$ _____
Dental care	\$ _____
Prescription drugs	\$ _____
Travel costs for medical care	\$ _____
Other eligible expenses	\$ _____

TOTAL Cannot exceed \$4,250 \$ _____

DIVIDE by the number of paychecks you will receive during the plan year (20, 24).* \$ _____

This is your pay period contribution.† \$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

† This amount includes any applicable Flex Dollars or Employer Contributions.

DEPENDENT CARE FSA WORKSHEET

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

CHILD CARE EXPENSES

Day care services	\$ _____
In-home care/au pair services	\$ _____
Nursery and preschool	\$ _____
After school care	\$ _____
Summer day camps	\$ _____

ELDER CARE SERVICES

Day care center	\$ _____
In-home care	\$ _____

TOTAL Remember, your total contribution cannot exceed IRS limits for the plan year and calendar year. \$ _____

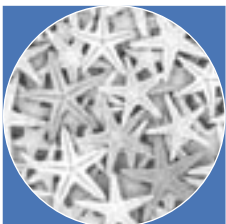
DIVIDE by the number of paychecks you will receive during the plan year (20, 24).* \$ _____

This is your pay period contribution.† \$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

† This amount includes any applicable Flex Dollars or Employer Contributions.

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit.



FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA. Refer to the "Written Certification" portion of the *Beyond Your Benefits* section of this Reference Guide for more specifics.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Medical Expense FSA or vice versa.
3. You have a 90-day grace period (until December 31, 2005) at the end of the plan year for reimbursement of eligible FSA expenses incurred during your period of coverage within the 2004-2005 Plan Year.
4. You may not receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
5. You cannot deduct reimbursed expenses for income tax purposes.
6. You may not be reimbursed for a service which you have not yet received.
7. Be conservative when estimating your medical and/or dependent care expenses for the 2004-2005 Plan Year. IRS regulations state that any unused funds which remain in your FSA after a plan year ends and all reimbursable requests have been submitted and processed cannot be returned to you nor carried forward to the next plan year.

What documentation of expenses do I need to keep?

The IRS requires FSA customers to maintain complete documentation, including keeping copies of receipts for reimbursed expenses, for a minimum of one year.

How do I get the forms I need?

To obtain forms you will need after enrolling in either a Medical Expense or Dependent Care FSA, such as an FSA Reimbursement Request Form, Letter of Medical Need or Direct Deposit Form, you can visit FBMC's Web site, **www.fbmc-benefits.com**, or call FBMC Customer Service at 1-800-342-8017. For more information, refer to the *Getting Answers* section of this Reference Guide.

Will contributions affect my income taxes?

Salary reductions made under a cafeteria plan, including contributions to one or both FSAs, will lower your taxable income and taxes. These reductions are one of the money-saving aspects of starting an FSA. Depending on the state, additional state income tax savings or credits may also be available. Your salary reductions will reduce earned income for purposes of the federal Earned Income Tax Credit (EITC).

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information.

Written Certification

When enrolling in either or both FSAs, written notice of agreement with the following will be required:

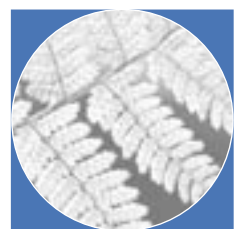
- I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA
- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to validate the foregoing.

Benefit Tip

Be sure to check your FSA contributions to ensure they will meet your changing needs.

Visit FBMC's tax savings calculator to learn about potential savings:

www.fbmc-benefits.com/customer/taxanalysis.asp



The EZ REIMBURSE® Card electronically debits funds from your Medical Expense Flexible Spending Account when it is presented to pay for any eligible medical expense.

Much like other stored-value cards, there is no risk of overspending. If funds are not available, the transaction will be denied. When the card is presented to an eligible provider/service vendor who accepts MasterCard®, your account is automatically debited. There is no cash outlay and you do not have to wait for reimbursement.

All administrative and transaction fees will be absorbed by Duval County Public Schools.

All newly eligible employees participating in the Duval County Public Schools medical plan will receive their own EZ REIMBURSE® Card. If you already have a card, you may retain it for three years. However, you may only use the card for expenses that occur within the current plan year, if funds are available. One additional card (for your dependent) is available upon request. Call FBMC Customer service at 1-800-342-8017 for more details.

Medical Deductible - Point of Service Plan (QPOS)

In addition to the Point of Service medical plan, Duval County Public Schools provides each employee and dependent/family unit (if participating in the plan) with a \$500 contribution to a Medical Expense Flexible Spending Account. This \$500 contribution (employee) and additional \$500 (dependent/family unit) is designed to satisfy the annual deductible associated with the medical plan. The contribution will automatically be placed in your MFSA and will be available for use when the medical plan begins on October 1, 2004.

Co-payments for wellness visits and prescription drugs do not count toward the annual plan deductible. Therefore, this card cannot be used at a pharmacy for prescriptions.

Additional information about when to send receipts to FBMC will be sent to you via monthly activity statements.

You must keep your receipts for a minimum of one year and submit to FBMC upon request.

The EZ REIMBURSE® MasterCard® Card is issued by BANKFIRST

Flexible Spending Accounts - Medical Expense and Dependent Care

In addition to the District's contribution, you may also contribute your own funds to a flexible spending account (FSA) for eligible uninsured medical expenses. IRS regulations require that these plans be administered within established guidelines and annual dollar limits. Your enrollment counselor will assist you in determining amounts appropriate for your personal situation.

Please note your EZ REIMBURSE Card is only available for use with your Medical Expense FSA.

How do I get an EZ REIMBURSE® Card?

All benefit eligible employees will automatically receive their cards in the mail. When you receive the card, call the toll free number on the front to activate the card. Retain this card in a safe place since it should be used when accessing services under your Medical Expense FSA.

For additional information regarding the EZ REIMBURSE® Card, call FBMC Customer Service at 1-800-342-8017, Monday through Friday, 7 a.m. - 10 p.m. ET. You may also visit www.fbmc-benefits.com for a detailed list of frequently asked questions about the EZ REIMBURSE® Card.

What agreement am I making when I use the EZ REIMBURSE® Card?

By using the EZ REIMBURSE® Card, you are agreeing to the certification set out in the "Written Certification" portion of the *Flexible Spending Accounts* section of this Reference Guide.

How do I submit a claim?

- When the EZ REIMBURSE® Card is used at a MasterCard® service vendor, no cash outlay is required and your account is automatically debited. However, IRS regulations require that this transaction be properly documented. All documentation must include date of service, type of service and total dollar amount.
- If a merchant or vendor does not accept the EZ REIMBURSE® Card, you must submit a paper claim. This form is called the Flexible Spending Account Reimbursement Form and is available from the District's Risk Management office or from FBMC Customer Service. Once the properly completed form is processed, reimbursement will be mailed. This form can only be used for expenses **not** paid for with the EZ REIMBURSE® Card.
- If you are paying for over-the-counter medicines or drugs, you must submit a completed Flexible Spending Account Reimbursement Form and wait for reimbursement. **You may not use your card as a form of payment for over-the-counter medicines and drugs.**
- If you are paying for dependent care services, you must follow the claims process above: fill out a claim form and send in your receipts. You have a 90 day grace period after the plan year ends in which you can still send in claims.

What do I do if I lose my card?

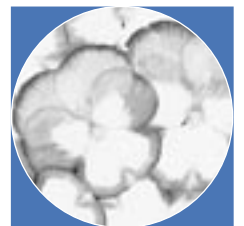
If your card is lost or stolen, call 1-866-785-3621 immediately.

Processing Claims for Debit Card Transactions

The IRS requires all FSA expenses be substantiated by an independent third party review of the required supporting documentation. Recent IRS guidance permits this review to be conducted electronically when certain expenses are paid with a debit card that is used in conjunction with an FSA. Generally, this applies to known co-payment amounts and recurring expenses. However, some expenses that fall into any of these categories may still require documentation be submitted for further review. All expenses that fall outside these categories require documentation be submitted to FBMC.

The IRS guidance requires FSA customers keep the required documentation for a minimum of one year and submit immediately to FBMC upon request. Any customer who refuses to comply with such request or who uses his/her card for unqualified expenses may experience any or all of the following actions:

- suspension of card privileges
- offset to paper claim reimbursements (automatic substitution)
- salary deduction of unqualified or unsubstantiated expenses (as permitted by law)
- tax consequences at the end of the calendar year.



CONTINUED

Automatic Substitution for Debit Card Receipts

The IRS requires documentation of all Flexible Spending Account transactions. FBMC will continue notifying you in writing that documentation is needed/required to validate your debit card transactions (e.g. original receipts, substitute receipts, medical needs letter or payments, etc.).

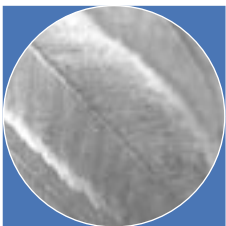
For your convenience, FBMC will apply approved paper claim requests to any outstanding debit card transactions. After receiving and processing approved debit card receipts, a payment will be made to you representing the difference between the approved paper claim(s) and any outstanding debit card transactions (if applicable).

Example: A debit card participant, John, has not submitted receipts for three (3) debit card transactions, each in the amount of \$10.00. Later, John submits a paper reimbursement request form for an eligible, out-of-pocket expense totaling \$120.00 and the entire amount is authorized for reimbursement. John will receive a reimbursement payment of \$90.00. The remaining \$30.00 of the \$120.00 reimbursement request will be used to offset the outstanding debit card transactions.

Automatic Adjudication of Medical Expenses

Automatic adjudication is a procedure in which certain EZ REIMBURSE® Card transactions are substantiated without the need of an Explanation of Benefits (EOB) or documentation. FBMC is able to do this by matching known co-payments from an employee's medical plan to the merchant from which service was received. For example, a doctor's office visit may have a standard co-payment of \$15 per visit during normal office hours. When a transaction is received at FBMC, the co-payment amount is recognized and the transaction can be automatically substantiated.

To assist employees in knowing when documentation is needed and when it is not, FBMC will send you a monthly statement outlining which transactions were processed and which are outstanding.



EZ REIMBURSE® Card Transmittal Sheet Instructions

- You must keep a copy of all documentation for your records for a minimum of one year and submit to the IRS and/or FBMC upon request.
- Make sure all fields on front side of this sheet are properly completed.
- The IRS does not consider charge receipts (or copies) as acceptable documentation to support the substantiation of a transaction.
- Any card charges requiring after-the-fact substantiation will be treated as conditional transactions pending submission of: a copy of a receipt, invoice, or bill from a provider showing the type of service(s) received, the date service(s) were received, the cost of the service(s) incurred, and the name of the IRS eligible person(s) for whom the services(s) were provided.
- Some provided medical treatments and services, including those that could be deemed personal or cosmetic, require a Letter of Medical Need from the treating healthcare provider.
- Supporting documentation must be legible.
- The date a service was provided defines its eligibility regardless of when it was paid. You cannot prepay with the EZ REIMBURSE® Card or use it for service dates out side your period of coverage.
- Refer to your employer's current plan year enrollment materials for information on participation rules, expense eligibility, type of supporting documentation required and other information.

Important things to remember about using the EZ REIMBURSE® Card

- Over-the-counter drugs cannot be purchased with the EZ REIMBURSE® Card. You must submit an FSA paper claim as outlined in your employer's current plan year enrollment materials. The IRS requires the complete name of all over-the-counter drugs be obtained and documented on pharmacy receipts.
- Present the card as any other credit card at a merchant or service provider, authorized by your employer who accepts MasterCard® and is properly coded as an eligible healthcare provider.
- A successful transaction or acceptance of the card by a merchant or service provider that is approved by your employer and properly coded as an eligible health care provider, does not constitute and/or validate the eligibility of a health care expense.
- If medical coverage is not provided through an HMO, and a transaction requires after-the-fact substantiation, you must attach an Explanation of Benefits (EOB) from the health insurance provider, showing the date service(s) were received, the cost of the service(s), the type of medically necessary service(s) received, the name of the IRS-eligible person(s) for whom the service(s) were provided, and any uninsured portion of the cost.

Long-Term Care (LTC) should be a part of everyone's retirement planning.

Are you saving for retirement? If you do not have Long-Term Care protection, you could be risking the following assets:

- 403(b) / 457 plans
- equity in your home
- savings accounts.

People who require LTC services and have no insurance must pay out of pocket.

Eligibility Requirements

Long-Term Care is available to:

- active employees and/or their spouses
- parents
- natural, adoptive or step-parents
- grandparents of an active employee or spouse.

Plan Description

You may choose one of the following plans based on your needs:

- Base Plan - Includes each of the following coverages:
 - a) Facility Care - provides a monthly benefit which will be paid if you receive care in a nursing facility, or 60 percent of the nursing facility benefit for care in an assisted living facility.
 - b) Professional Home Care - provides a benefit if you receive care at home from a licensed professional (through a Home Health Care Agency).

Optional Benefits

- Total Home Care - This pays you a flat 50 percent (per month) of the nursing facility benefit you selected for the Base Plan when you receive care at home. Care does not have to be provided by a licensed health care worker. Subject to the lifetime maximum, benefits may be payable up to six years.
- Inflation Protection - This option helps protect your Long-Term Care benefit from the impact of inflation. You may purchase an additional five percent of your original monthly benefit which will adjust your benefit for 20 years.

Ask your Enrollment Counselor for details on how to purchase these options.

Your Long-Term Care (LTC) insurance plan is listed below.

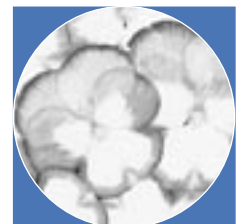
Elimination Period: 60 days

Guarantee Issue: Your plan is offered on a Guarantee Issue basis and does not require completion of UNUM's Long-Term Care Application (medical questionnaire) if you apply within 30 days of your date of eligibility. All family members must complete UNUM's Long-Term Care Application.

Lifetime Maximum: The Lifetime Maximum is the maximum benefit dollar amount UNUM will pay over the life of your coverage. This dollar amount is based on the Facility Benefit Amount and Benefit Duration.

Insurance Age: Insurance Age is used to determine the cost of your coverage. Insurance Age is your age on the effective date if you enroll for coverage prior to the plan effective date. If you enroll for coverage after the plan effective date, Insurance Age is your age on the date you sign the application for coverage.

Facility Benefit Amount	\$1,000	\$3,000
Benefit Duration	3 years	3 years
Assisted Living Facility Percent	60%	60%
Lifetime Maximum	\$36,000	\$108,000
Professional Home Care	50%	50%
Total Home Care - optional	50%	50%
Inflation Protection - optional	simple capped	simple capped



CONTINUED

Your Coverage Levels

- Base Plan - Select either \$1,000 or \$3,000 monthly facility benefit, payable up to three years. The Base Plan provides the monthly benefit you select when you are in a nursing facility, or 60 percent of the facility benefit when you are in an assisted living facility. For Professional Home Care you receive up to 50 percent of the facility benefit you selected (1/30th of that amount for each day of care).

Plan Features

- You may receive benefits after 60 consecutive days of continuous loss of functional capacity.
- This benefit is portable — If you leave the School Board, you may take it with you at the same group rate.
- You are not required to pay premiums while receiving Long-Term Care benefits.
- If you enroll during your initial Open Enrollment period, you are guaranteed coverage without having to prove good health. To obtain coverage after that period will require proof of good health. Spouses, parents, parents-in-law, grandparents and grandparents-in-law will always require proof of good health.

Note: You must complete a separate enrollment application to enroll in this benefit.

What's Not Covered

This plan will not pay benefits for:

- a disability caused by any act of declared or undeclared war
- a disability caused by self-destruction or attempted suicide (while sane or insane)
- a disability caused by or resulting from the commission or attempted commission of a felony
- disabilities or confinements during which you are outside the United States, its territories or possessions for longer than 30 days
- a disability caused by alcoholism or alcohol abuse
- a disability caused by voluntary use of any controlled substance (as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments) unless the controlled substance is prescribed for you by a doctor
- a period in which you are confined in a hospital other than if you are confined in a nursing facility that is a distinctly separate part of a hospital (this exclusion does not apply to those periods covered under the Bed Reservation Benefit)
- a disability caused by psychological, psychiatric or mental conditions, regardless of cause, which include depression, generalized anxiety disorders, personality disorders, schizophrenia, manic depressive disorders, adjustment disorders, and other conditions using psychotherapy or psychotropic drugs for treatment or
- a disability caused by pre-existing conditions.

Pre-existing Conditions

Pre-existing conditions are those for which an employee received medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines during the six months before coverage began.

Where a pre-existing condition exists and disability due to that condition begins before the employee has been insured for six months, such disability will NOT be covered.

Note: If you do not have to complete an Evidence of Insurability form for Long-Term Care Insurance, a pre-existing condition exclusion may apply to you.

Loss of Functional Capacity Defined

After the effective date of this coverage, benefits are payable upon loss of two or more Activities of Daily Living (ADLs) or if you suffer a Cognitive Impairment (i.e. Alzheimer's). The six ADLs are: bathing, dressing, transferring, toileting, continence, and eating.

Rates

Rates are based on your age at the time of purchase and do not increase with age. Ask your Enrollment Counselor for specific rate information.

Plan Provider

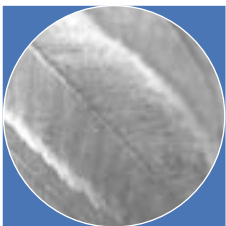
UNUM Life Insurance Company of America underwrites this plan. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates UNUM "A-" Excellent.

For use with Policy series TQB.LTC

Benefit Tip

Medicare only pays for the first 100 days of hospitalization.

Plan ahead now.



The Trustmark PremierSelectSM Critical Illness Plan can provide a benefit ranging from \$5,000 - \$100,000.* This plan gives you the flexibility of using the money at your own discretion.

*Benefit is 50 percent in first year

The plan provides an immediate pre-selected lump sum cash benefit upon first diagnosis of a critical illness or cancer after the plan's effective date. Your benefit is paid in full regardless of whether you have started treatment and allows you to decide how to use your benefit money.

Plan Features

- The PremierSelectSM Critical Illness Plan includes cancer coverage. However, the plan can be separated for "cancer-only" or "critical illness-only" coverage. See your enrollment counselor for further details.
- You may add the EZ Value Plan Option to this plan, which automatically increases your coverage annually on each of the first five policy anniversaries. The increase is equal to the amount of protection an additional \$1 per week of deduction would purchase.

Optional Health Screening Benefit

Pays the cost of one screening test per calendar year (up to \$50 or \$100 benefit maximum). Eligible tests include:

- Low Dose Mammography
- Pap Smear (women over age 18)
- Hemocult Stool Specimen
- Prostate Specific Antigen
- Colonoscopy
- Flexible Sigmoidoscopy
- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine levels of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Serum Protein Electrophoresis (blood test for myeloma)
- Thermography

Who is eligible?

All eligible employees may purchase the PremierSelectSM Critical Illness Plan.

- Employees who have NOT previously purchased cancer coverage through Trustmark (Cancer Protector[®]) may apply for up to \$100,000 of coverage.
- Employees who have previously purchased cancer coverage through Trustmark (Cancer Protector[®]) may apply for an increase up to a total of \$100,000 of coverage. The \$100,000 is a combination of current cancer coverage (including the EZ Value Plan) and new PremierSelectSM coverage.
- Employees with existing cancer coverage through Trustmark (Cancer Protector[®]) may continue their current plans. No new Cancer Protector[®] policies will be issued.

Issue Ages

- Employees (18 through 70)
- Spouse (18 through 70)
- Children (15 days through 23)

What payroll deduction premiums will I pay for this plan?

You select the coverage and premium that best fits your budget and family needs. As a Duval County Public Schools employee, your group purchasing power ensures you receive a high insurance value at an affordable cost. Speak with your Enrollment Counselor for more information.

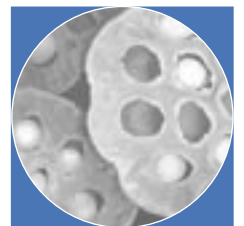
Can I continue my coverage if I terminate employment or retire?

Yes. This plan is portable after the first payroll deduction. You can continue with the full amount of insurance coverage and arrange for premiums to be billed directly to you.

What if I have questions about my certificate?

After you enroll, you can get answers about your certificate by calling Trustmark Customer Service at 1-800-918-8877.

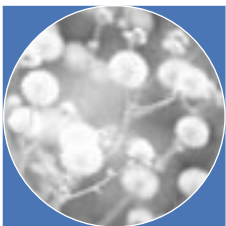
Policy Form CACI-82001



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The following is a comparison chart of the PremierSelectSM Critical Illness Plan and the Cancer Protector[®] Plan previously available. Employees who currently have a Cancer Protector[®] may continue their coverage. No new Cancer Protector[®] plans will be issued this year.

	New Plan			Previous Plan	
Product	PremierSelect SM Cancer	PremierSelect SM Critical Illness	PremierSelect SM Critical Illness with Cancer (Combo)	Cancer Protector [®] (No Critical Illness)	Cancer Protector [®] with Critical Illness Rider
Covered Cancer	Invasive Cancer (including Hodgkin's Disease and Leukemia) 25% Benefit: Carcinoma in Situ		Invasive Cancer (including Hodgkin's Disease and Leukemia) 25% Benefit: Carcinoma in Situ	Internal Cancer (including Hodgkin's Disease and Leukemia)	Internal Cancer (including Hodgkin's Disease and Leukemia)
Covered Critical Illness		Major Organ Transplant Kidney Failure Heart Attack Stroke ALS Blindness Paralysis of two or more limbs 25% Benefit: Coronary Artery Bypass Surgery	Major Organ Transplant Kidney Failure Heart Attack Stroke ALS Blindness Paralysis of two or more limbs 25% Benefit: Coronary Artery Bypass Surgery		Major Organ Transplant Kidney Failure Heart Attack Life-threatening Stroke ALS
Maximum Benefit	\$100,000 and EZ Value	\$100,000 and EZ Value	\$100,000 and EZ Value	\$50,000 and EZ Value	\$50,000 and EZ Value



Wouldn't you like to know that your loved ones will be taken care of should something happen to you? The Voluntary Universal Life Plan features progressive coverage for your peace of mind.

Wouldn't you like to have life insurance you can take with you if you leave the school system . . . a plan that features portable coverage and cash values that can increase during your lifetime?

Thanks to Duval County Public Schools and FBMC, you have the opportunity. It's easy! By answering just two health questions you can apply for this plan without a medical examination.

Who is eligible?

- Full-time or regular part-time employees who work an average of 20 hours per week
- Employees between the ages of 18 and 70
- Employees actively working at the time of application and on the first payroll deduction date
- New employees may enroll at the next Open Enrollment if they do not meet the above requirements.

Can I apply for my dependents?

Your spouse, children, or grandchildren may also qualify for coverage. You don't have to get coverage for yourself to cover family members. There may be additional eligibility requirements to include your grandchildren. If you have any questions, please speak with your Enrollment Counselor.

What does the plan offer?

Voluntary Universal Life Insurance offers you and your family the following flexible benefits:

Accelerated Death Benefit—If a physician determines that you have 24 months or less to live, an advance death benefit pays up to 75 percent of the base certificate death benefit (up to \$187,500).

*The Accelerated Death Benefit is subject to review by the insurer and is subtracted from the final death benefit.

Home Health and Long-Term Care—If you are confined in a qualified long-term care facility or require medically necessary Home Health or Adult Day Care, this pays you a monthly benefit of two percent of your policy (up to \$5,000 a month) for up to 50 months. Your monthly deductions are waived while you are confined.*

* This benefit is subtracted from the final death benefit.

Interest-earning Cash Value—Interest is credited to your plan. Current tax law allows the cash value in this life insurance plan to accumulate on a tax-deferred basis (within guidelines).

Certificate Loans— You can borrow cash value at a favorable interest rate for any purpose after your certificate is at least one year old. You may also make partial withdrawals from your plan (within certificate limits) after one year, which reduces your face amount and is subject to a withdrawal charge.

EZ Value Plan Option—This Plan also offers the EZ Value Plan Option, an inflation-fighting option which automatically increases coverage annually on each of the first five or 10 policy anniversaries. For employees and their spouses under 60, the amount of the Death Benefit increase is equal to the amount of protection for an additional \$1 per week deduction (or \$2 per week for employees only) would purchase for the first five anniversaries. An increase of \$1 per week on each of the first 10 anniversaries is granted to employees only up to age 55.*

* Existing EZ Value participants may extend to the 10-year options (with restrictions) if they choose to do so.

Death Benefit Restoration Rider—Automatically increases the Death Benefit to restore the advanced death benefits for home healthcare, adult day care or long-term care confinement in a nursing home.

Example: An insured party has a \$50,000 death benefit with the Home Health and Long-Term Care rider and dies after 10 months of long-term care confinement.

	With Rider	Without Rider
Total Benefits Paid	\$70,000	\$50,000
Death Benefit	\$50,000	\$30,000
Living LTC Benefits	\$20,000	\$20,000

Extension of Home Health and Long-Term Care Benefits Rider

—Doubles the benefit period when medically necessary long-term care services extend beyond the 50 months provided by the HHC rider. Extended benefits are payable when 100 percent of the original death benefit has been paid out during the initial qualified period. Extended benefits are paid in the same amount and frequency and for the same duration as under the Home Health and Long-Term Care rider. Benefits under the extension may or may not be taxable depending on how the IRS interprets applicable portions of the tax code.

Example: \$100,000 death benefit

Type of Confinement	Monthly Benefit	Extended Benefit Period	Additional Living Benefit
Nursing Home	\$4,000	25 months	\$100,000
Home Healthcare	\$2,000	50 months	\$100,000
Adult Day Care	\$2,000	50 months	\$100,000

CONTINUED

How do I apply?

Have your Enrollment Counselor complete the Universal Life Insurance plan application.

Streamlined Issue Coverage for New Employees Only: you may receive the amount of coverage \$12 per week will purchase up to \$150,000; spouses may receive the amount \$4 per week will purchase; and up to \$10,000 for a child term rider or a \$2 or \$3 per week child certificate may be purchased for children. Applicants must answer limited health questions before qualifying for coverage.

Current Participants: may apply for an additional \$3 per week of coverage up to a total benefit of \$150,000.

Non-Participants: may apply for \$8 per week of coverage to a maximum of \$75,000. Spouses may apply for \$3 per week of coverage and eligible children may be covered with a \$2 or \$3 per week child certificate or \$5,000 child term rider.

For amounts of insurance over \$150,000 and up to the plan maximum of \$250,000, you must answer a few additional questions concerning your health history, and have a blood sample taken.

Can I continue my Universal Life coverage if I terminate employment or retire?

Yes. This plan is portable after the first payroll deduction. You can continue with the full amount of insurance coverage and arrange for premiums to be billed directly to you. Your coverage and premiums stay the same.

What about the group term life policy I already have with the school system?

This Universal Life Insurance plan complements any group term life insurance you may have and enables you to vary your premiums, coverage and cash value accumulation as your needs change. You can adjust the death benefit and premium upward and downward throughout your lifetime, subject to certificate limits.

What if I become disabled or die accidentally?

You can have your premiums waived in case of total disability prior to age 60 with the optional Waiver of Premium rider.

An Optional Accidental Death Benefit rider is also available to cover accidental death occurring prior to age 70. Your Counselor can provide you with the features and costs for these additional riders.

What payroll deduction premiums will I pay?

You select the coverage and premium that best fit your budget and family needs. As a Duval County Public Schools employee, your group purchasing power ensures you receive a high insurance value at an affordable cost. Speak with your Enrollment Counselor for more information.

Remember, this contract is offered in addition to any employer coverage and is paid solely by employee post-tax contributions.

What if I have questions about my certificate?

After you enroll, you can get answers about your certificate by calling Trustmark Customer Service at 1-800-918-8877.

Plan Provider

Trustmark Insurance Company, Lake Forest, Illinois, underwrites this plan. The A.M. Best Company, an organization that compares and rates the financial strength and performance of insurance companies, rates Trustmark "A-" Excellent. This information is being provided to employees by Duval County Public Schools in advance of more complete information from the insurer.

Universal Life Insurance is available on a post-tax basis, and a separate application is required.

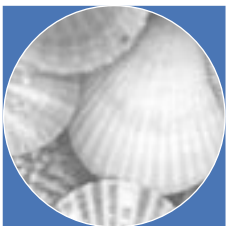
Note: If you need to make any changes throughout the year or would like answers about your certificate, you must contact Trustmark Customer Service at 1-800-918-8877.

Policy Form GUL-899

Benefit Tip

To apply have your Enrollment Counselor fill out the Universal Life Insurance Plan application.

After you enroll, you can get answers about your certificate by calling Trustmark Customer Service at 1-800-918-8877.



Plan Provider

Thanks to modern medical technology, surviving cancer is possible. Unfortunately, these innovations can come with a high price tag. The Personal Cancer Expense Insurance policy from American Family Life Assurance Company of Columbus (AFLAC) provides you with additional benefits to offset the cost of cancer treatment.

Cancer Protector is available on a pre-tax basis. A separate application is required.

Benefit Tip

To apply, ask your licensed enrollment counselor for a Cancer Protector application.

Personal Cancer Expense Insurance Policy Benefits Description

FIRST-OCCURRENCE **\$2,000 (A-59200) and \$5,000 (A-59300)**

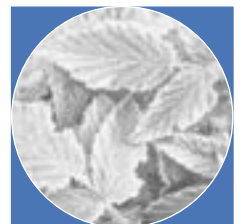
Policy Series A-59200 and Policy Series A-59300

HOSPITAL CONFINEMENT	\$300 1–30 days \$600 31+ days
ANTI-NAUSEA	Incurred charges up to \$100 per calendar month
RADIATION & CHEMOTHERAPY	Up to \$300 per day
NURSING SERVICES	Up to \$100 per day for RN, LPN, or LVN
SURGICAL	\$100 to \$5,000 per operation
ANESTHESIA	25% of Surgical Benefit
SKIN CANCER SURGERY	\$100–\$600, depending on procedure performed
PROSTHESIS	Up to \$3,000 (surgical); up to \$200 (nonsurgical)
IN-HOSPITAL BLOOD & PLASMA	Up to but not exceeding \$100 times the number of days confined
OUTPATIENT BLOOD	Up to \$250 per day
WELLNESS	\$75 per year
SECOND SURGICAL OPINION	Up to \$250
NCI EVALUATION/ CONSULTATION BENEFIT	\$500 for evaluation/consultation \$250 for transportation/lodging
AMBULANCE	Incurred charges (limit two trips per confinement)
TRANSPORTATION	Actual charges for commercial or 50 cents per mile (limited to \$1,500 per round trip)
FAMILY LODGING	Actual charges up to \$60 per night (one adult family member; must be over 100 miles)
HOME HEALTH CARE	Up to \$50 per day (10 per hospital confinement, 30 per year)
EXTENDED-CARE FACILITY	\$100 per day
HOSPICE	\$100 per day for 60 days \$50 over 60 days to \$12,000 lifetime maximum
WAIVER OF PREMIUM	Yes
NEWBORN TRANSPORTATION	Up to \$1,000
BONE MARROW TRANSPLANTATION	Incurred charges up to: \$10,000 inpatient \$5,000 outpatient \$1,000 donor indemnity
STEM CELL TRANSPLANTATION	Up to \$2,500
EXPERIMENTAL TREATMENT	Up to \$300 per day

American Family Life Assurance Company of Columbus (AFLAC)

6/04

MMC-01-240



Policy Series A-59000

- Policy Series A-59200
\$2,000 FIRST-OCCURRENCE BENEFIT
- Policy Series A-59300
\$5,000 FIRST-OCCURRENCE BENEFIT

AFLAC will pay the FIRST-OCCURRENCE BENEFIT selected above to any covered person when diagnosed as having internal cancer. This benefit is payable only once for each covered person and will be paid in addition to any other benefit in this policy. Internal cancer includes melanomas classified as Clark's Level III and higher. When the hospitalization is based on tentative diagnosis, benefits are payable from the date of tentative diagnosis, at the time and date that a positive diagnosis is obtained. In addition to the pathological or clinical diagnosis required by the policy, AFLAC may require additional information from the attending physician and hospital. Any covered person who has had a previously diagnosed cancer will not be eligible for a First-Occurrence Benefit under this policy for a recurrence, extension, or metastatic spread of that same cancer.

The benefits listed below are payable for either the A-59200 Policy Series or the A-59300 Policy Series.

Hospital Confinement Benefit

(This includes confinement in a U.S. government hospital.) AFLAC will pay \$300 for each day any covered person is hospitalized and charged as an inpatient for the first 30 days for cancer treatment. Benefits increase to \$600 per day beginning with the 31st day of continuous confinement. The wording "for each day any covered person is charged as an inpatient" does not apply to confinements in U.S. government hospitals. No lifetime maximum.

For treatment of cancer: Radiation and Chemotherapy, Experimental Treatment, Anti-nausea, Nursing Services, Surgical/Anesthesia, Skin Cancer Surgery, Prosthesis, and In-hospital Blood and Plasma Benefits are not payable when a covered person is confined in a U.S. government hospital unless the covered person is actually charged and is legally required to pay for such services.

Radiation and Chemotherapy Benefit

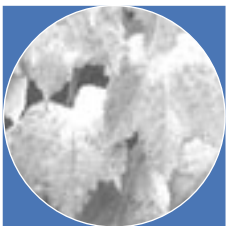
AFLAC will pay the charges incurred up to \$300 per day when any covered person receives one or more of the following cancer treatments for the purpose of modification or destruction of abnormal tissue: (1) cytotoxic chemical substances and their administration in the treatment of cancer—administration by medical personnel in a doctor's office, clinic, or hospital; self-injected medications or medications dispensed by a pump will be limited to the actual cost of the drugs up to \$300 per prescription; oral chemotherapy, regardless of where administered, will be limited to the actual cost of the drugs up to \$300 per prescription (monthly maximum of \$1,200); (2) radiation therapy; or (3) the insertion of interstitial or intracavitary application of radium or radioisotopes in sealed or nonsealed sources. (The Surgical/Anesthesia Benefit provides additional amounts payable for insertion and removal. Benefits will not be paid for each day the radium or radioisotope remains in the body.) This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, simulation, dosimetry, treatment planning, or other procedures related to these therapy treatments. This benefit is not payable on the same day that the Experimental Treatment Benefit is paid and is limited to \$300 per day. No lifetime maximum.

Experimental Treatment Benefit

AFLAC will pay the charges incurred up to \$300 per day for a covered person who receives experimental cancer treatment for the purpose of modification or destruction of abnormal tissue. The treatments must be consistent with one or more National Cancer Institute-sponsored protocols. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, and therapeutic devices or other procedures related to these therapy treatments. This benefit is not payable on the same day that the Radiation and Chemotherapy Benefit is paid. No lifetime maximum.

Anti-nausea Benefit

AFLAC will pay the charges incurred up to \$100 per calendar month when a covered person receives anti-nausea drugs that are prescribed while receiving radiation or chemotherapy treatments. No lifetime maximum.



Policy Series A-59000**Nursing Services Benefit**

AFLAC will pay the charges incurred up to \$100 per 24-hour day to a covered person while confined to a hospital for full-time private care by RNs, LPNs, or LVNs other than those regularly furnished by the hospital. Services must be required and authorized by the attending physician. This benefit is not payable for private nurses related to any covered person. This benefit is payable for only the number of days the Hospital Confinement Benefit is payable. No lifetime maximum.

Surgical/Anesthesia Benefit

AFLAC will pay \$100 to \$5,000 of the indemnity listed when a surgical operation is performed on a covered person for a diagnosed internal cancer (depending on type of surgery performed). Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid for the most expensive procedure. If any operation for the treatment of cancer is performed other than those listed, AFLAC will pay an amount comparable to the amount shown in the Schedule of Operations for the operation most nearly similar in severity and gravity (surgery for skin cancer will be payable under the Skin Cancer Surgery Benefit). AFLAC will pay an indemnity benefit equal to 25% of the amount shown on the Schedule of Operations for the administration of anesthesia during a covered surgical operation. The combined benefits payable in the Surgical/Anesthesia Benefit for any one operation shall not exceed \$6,250. No lifetime maximum on number of operations. See Schedule of Operations.

Skin Cancer Surgery Benefit

AFLAC will pay \$100 to \$600 of the indemnity listed (depending on the procedure performed) for surgery (with or without anesthesia) to any covered person when a surgical operation is performed for a diagnosed skin cancer. No lifetime maximum on number of operations.

Prosthesis Benefit

(1) AFLAC will pay the charges incurred up to \$3,000 to any covered person for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for cancer treatment. Lifetime maximum of \$3,000 per covered person. (2) AFLAC will pay up to \$200 to any covered person for the charges incurred per person for nonsurgically implanted prosthetic devices that are prescribed as a direct result of cancer treatment. Examples of these include voice boxes, hair pieces, and removable breast prosthetics. Lifetime maximum of \$200 per covered person.

In-hospital Blood and Plasma Benefit

AFLAC will pay the charges incurred up to but not exceeding \$100 times the number of days of covered hospital confinement if a covered person receives blood/plasma, blood processing, blood administration, crossmatching, and transfusion fees during a hospital confinement. This benefit does not pay for immunoglobulins, immunotherapy, or colony-stimulating factors. No lifetime maximum.

Outpatient Blood and Plasma Benefit

AFLAC will pay the charges incurred up to \$250 for blood/plasma, processing, blood administration, crossmatching, and transfusion fees for each day a covered person receives blood transfusions for the treatment of cancer as an outpatient in a doctor's office, clinic, hospital, or ambulatory surgical center. This benefit does not pay for immunoglobulins, immunotherapy, or colony-stimulating factors. No lifetime maximum.

Second Surgical Opinion Benefit

AFLAC will pay the charges incurred up to \$250 to any covered person for a second surgical opinion concerning cancer surgery for a diagnosed cancer by a licensed physician not related to the covered person. This benefit is not payable the same day the NCI Evaluation/Consultation Benefit is payable. No lifetime maximum.

National Cancer Institute (NCI) Evaluation/Consultation Benefit

AFLAC will pay \$500 when a covered person seeks evaluation or consultation at an NCI-sponsored cancer center as a result of receiving a prior diagnosis of internal cancer. The purpose of the evaluation/consultation must be to determine the appropriate course of cancer treatment. AFLAC will also pay \$250 for the transportation and lodging of the person receiving the evaluation/consultation if the cancer center is more than 100 miles from the covered person's residence. This benefit is not payable the same day the Second Surgical Opinion Benefit is payable. This benefit is payable once per covered person. NCI-sponsored cancer centers include but are not limited to:

- M.D. Anderson Cancer Center
- Norris Comprehensive Cancer Center at USC
- Mayo Cancer Center
- Johns Hopkins Oncology Center
- Memorial Sloan-Kettering Cancer Center
- St. Jude Children's Research Hospital

Refer to policy and riders for complete details, limitations, and exclusions. This brochure is for illustration purposes only.



Policy Series A-59000

This is a partial listing of NCI-designated cancer centers, and AFLAC does not endorse any center over another. Please see insert Form A-59276 for a complete listing of the current facilities and their locations.

This benefit is also payable at the AFLAC Cancer Center at Children's Healthcare of Atlanta.

Ambulance Benefit

AFLAC will pay you or any covered person the charges incurred for transportation in a licensed ambulance to and from a hospital within 100 miles of the covered person's residence where confined overnight for cancer treatment. This benefit is limited to two trips per confinement. No lifetime maximum.

Transportation Benefit

AFLAC will pay 50 cents per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train, or bus fare) for transportation of a covered person for the round-trip distance between the hospital or medical facility and the residence of the covered person if special cancer treatment has been prescribed by the local attending physician. Reimbursement will be made only for the method of transportation actually taken. Benefits are limited to \$1,500 per round trip. This benefit will be paid for only the covered person for whom the special cancer treatment is prescribed, or if the treatment is for a dependent child and commercial travel is necessary, AFLAC will pay for up to two adults to accompany the dependent child. This benefit is not payable for transportation to any hospital located within a 100-mile radius of the residence of the covered person.

Lodging Benefit

AFLAC will pay the charges incurred up to \$60 per day for lodging for you or any one adult family member when a covered person receives special cancer treatment at a hospital or medical facility. The hospital or medical facility and lodging must be more than 100 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment nor for lodging occurring more than 24 hours following treatment. This benefit is limited to 60 days per calendar year.

Bone Marrow Transplantation Benefit

AFLAC will pay the charges incurred up to \$10,000 if a covered person receives a bone marrow transplantation for the treatment of cancer during a covered hospital confinement. It does not include the harvesting of peripheral blood cells or stem cells and subsequent reinfusion. If the bone marrow transplant is performed on an outpatient basis, AFLAC will pay the charges incurred up to \$5,000. AFLAC will pay the bone marrow donor the greater of \$1,000 or medical costs to the same extent and limitations as costs associated with the insured person for a covered bone marrow transplant. This benefit is not payable for the same procedure as the Stem Cell Transplantation Benefit. Lifetime maximum of \$10,000 per covered person.

Stem Cell Transplantation Benefit

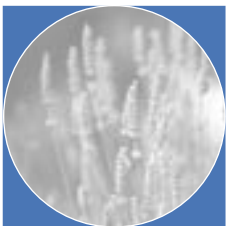
AFLAC will pay the charges incurred up to \$2,500 if a covered person receives a peripheral stem cell transplantation for the treatment of cancer. This benefit is payable once per covered person. This benefit is not payable in conjunction with the payment of the Bone Marrow Transplantation Benefit. Lifetime maximum of \$2,500 per covered person.

Extended-Care Facility Benefit

AFLAC will pay \$100 per day if a covered person is hospitalized and receives the Hospital Confinement Benefit and is later confined, within 30 days, to a section of the hospital used as an extended-care facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit, or to any bed designated as a swing bed, for such continued confinement. Benefits are limited to the same number of days that the covered person receives the Hospital Confinement Benefit. For each day this benefit is payable, benefits under the Hospital Confinement Benefit are not payable. If more than 30 days separates a stay in an extended-care facility, benefits are not payable for the second confinement unless the covered person was again confined to a hospital prior to the second such confinement. Lifetime maximum of 365 days per covered person.

Hospice Benefit

AFLAC will pay \$100 per day for the first 60 days and \$50 per day for days over 60 for care provided by a hospice organization for any covered person when medical evaluation determines that cancer treatment is no longer appropriate and the covered person's medical prognosis is one in which there is a life expectancy of six months or less as the direct result of cancer. This benefit does not cover nonterminally ill patients or organizations not qualifying as hospices. This benefit is payable once per covered person and is not payable the same day as the Home Health Care Benefit. Lifetime maximum for each covered person is \$12,000.



Policy Series A-59000

Home Health Care Benefit

AFLAC will pay the charges incurred up to \$50 per visit for home health care or health supportive services when provided on a covered person's behalf within seven days of release from the hospital for the treatment of cancer. The number of visits shall not exceed ten per hospitalization. This benefit will not be payable unless the attending physician prescribes such services to be performed in the home of the insured person and certifies that if these services were not available, the insured person would have to be hospitalized to receive the necessary care, treatment, and services. Home health care and health supportive services must be performed by or under the supervision of a person who is licensed, certified, or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a health care facility. This benefit is not payable the same day the Hospice Benefit is payable. This benefit is limited to 30 visits per calendar year for each covered person.

Cancer Screening Wellness Benefit

AFLAC's Cancer Screening Wellness Benefit is a preventive benefit. AFLAC will pay \$75 per calendar year for each covered person when a charge is incurred for one of the following: mammogram, breast ultrasound, Pap smear (lab and procedure), biopsy, flexible sigmoidoscopy, hemocult stool specimen, chest X-ray, CEA (blood test for colon cancer), CA 125 (blood test for ovarian cancer), PSA (blood test for prostate cancer), thermography, or colonoscopy. These tests must be performed to determine if cancer exists in a covered person. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.

Newborn Transportation Benefit

Under a family policy, if cancer in a newborn child requires the newborn to receive treatment to protect his or her health and safety, we will pay transportation charges as follows: actual transportation costs to and from the nearest available facility appropriately staffed and equipped to treat the condition of the newborn. The transportation must be certified by the attending physician as necessary to protect the health and safety of the newborn child. The coverage for such transportation costs shall not exceed the usual and customary charges up to \$1,000.

Waiver of Premium Benefit

If you, due to having internal cancer, are completely unable to do all of the usual and customary duties of your occupation [or, if you are not employed, are completely unable to perform two or more of the activities of daily living (ADLs) without the assistance of another person] for a period of 90 continuous days, AFLAC will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, AFLAC will require an employer's statement (if applicable) and a physician's statement of your inability to perform said duties or activities, and may each month thereafter require a physician's statement that total inability continues. AFLAC may ask for and use an independent consultant to determine whether you can perform an ADL without assistance. AFLAC will also waive from month to month any premiums falling due while you are receiving hospice benefits under the Hospice Benefit.

Continuation of Coverage Benefit

AFLAC will waive all monthly premiums due for the policy and riders for up to two months if you meet all of the following conditions: (1) Your policy was in force for at least six months. (2) We receive premiums for at least six consecutive months. (3) Your premiums were paid through payroll deduction. (4) You or your employer notifies us in writing within 30 days of the date your premium payments ceased due to your leaving employment. (5) You re-establish premium payments through your new employer's payroll deduction process or direct payment to AFLAC. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months and we have received premiums for at least six consecutive months. Payroll deduction means your premium is remitted to AFLAC for you by your employer through a payroll deduction process.

Guaranteed-Renewable

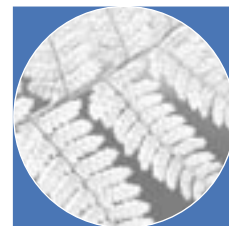
This policy is guaranteed-renewable for life subject to AFLAC's right to change applicable table of premium rates for all policies of this class.

Effective Date

The effective date of the policy will be the date shown in the Policy Schedule, not the date the application is signed. This policy is available through age 70 on payroll deduction and through age 64 on direct billing. Payroll rate may be retained after one month's premium payment on payroll deduction.

Family Coverage

Family coverage includes the insured; the insured's spouse; and dependent, unmarried children to age 25. Newborn children are automatically insured as any other family member. *One-parent family coverage* includes the insured and dependent, unmarried children to age 25.



CONTINUED

Policy Series A-59000

IMPORTANT NOTICE

When you receive your policy and application, please examine them thoroughly. If you are not satisfied, you may return the policy and application within 30 days for a full refund.

Limitations and Exclusions

AFLAC pays only for treatment of cancer, including direct extension, metastatic spread, or recurrence. Benefits are not provided for premalignant conditions; conditions with malignant potential; or complications of any other disease, sickness, or incapacity. Pathological proof of diagnosis must be submitted. Clinical diagnosis will be accepted when a pathological diagnosis cannot be made, provided medical evidence sustains the diagnosis and the covered person receives cancer treatment. This policy contains a 30-day waiting period. This means that no benefits are payable for any covered person who has cancer diagnosed before coverage has

been in force 30 days from the effective date shown in the Policy Schedule. If a covered person has cancer diagnosed during the waiting period, benefits for treatment of that cancer will apply only to treatment occurring after two years from the effective date of the policy or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium. The First-Occurrence Benefit is not payable for: (1) any internal cancer diagnosed or treated before the effective date of this policy and subsequent recurrence, extension, or metastatic spread of such internal cancer that is diagnosed or treated after the effective date of this policy (2) cancer diagnosed during this policy's 30-day waiting period (3) the diagnosis of skin cancer or melanomas classified as Clark's Levels I and II. Any covered person who has had a previous diagnosis of cancer will not be eligible for a First-Occurrence Benefit under this policy for a recurrence, extension, or metastatic spread of that same cancer. No benefits are payable for immunoglobulins or colony-stimulating factors.

Personal Cancer Expense Insurance Policy Rates

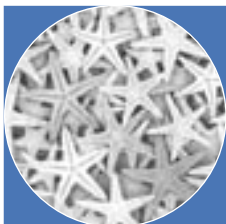
(Policy Series A-59200 and A-59300)

Your Rates*

	20 Pay Periods		24 Pay Periods
Cancer Coverage A-59200		Cancer Coverage A-59200	
Employee Only	\$13.68	Employee Only	\$11.40
One-Parent Family	\$17.10	One-Parent Family	\$14.25
Employee + Family	\$22.74	Employee + Family	\$18.95
 Cancer Coverage A-59300		 Cancer Coverage A-59300	
Employee Only	\$15.54	Employee Only	\$12.95
One-Parent Family	\$20.10	One-Parent Family	\$16.75
Employee + Family	\$27.30	Employee + Family	\$22.75

*Premiums can be paid either before or after taxes and are deducted from your salary.

For the 2004–2005 Plan Year (10/1/2004–9/30/2005), all rates are shown for 20 or 24 payroll deduction cycles.



First-Occurrence Building Benefit Rider (Optional Rider Series A-59050)

Riders become a part of the policy and are subject to all policy provisions unless otherwise stated.

First-Occurrence Building Benefit

This benefit can be purchased in units of \$100 each, up to a maximum of five units or \$500. All amounts cited in this rider are for one unit of coverage. If more than one unit has been purchased, then the amounts listed must be multiplied by the number of units in force.

The First-Occurrence Benefit will be increased by \$100 for each unit purchased on each rider anniversary date while this rider remains in force. This benefit will be paid under the same terms as the First-Occurrence Benefit. This benefit will cease to build for each covered person on the anniversary date of this rider following the covered person's 65th birthday or at the time internal cancer is diagnosed for that covered person, whichever occurs first.

Termination

This rider will terminate if the policy to which it is attached terminates or if the premiums for this rider are not paid.

Effective Date

The effective date of this rider is the effective date of the policy to which it is attached or the effective date of this rider, as stated on the Policy Schedule, if later.

Your Rates

Per \$100 Unit

	20 Pay	24 Pay
Employee Only	\$0.36	\$0.30
One-Parent Family	\$0.54	\$0.45
Employee + Family	\$0.78	\$0.65

Specified-Disease Benefit Rider (Optional Rider Series A-59052)

Riders become a part of the policy and are subject to all policy provisions unless otherwise stated.

Specified-Disease Benefits

While coverage is in force, if an insured is first diagnosed with one or more of the covered specified diseases and is hospitalized for the definitive treatment of the covered specified disease, AFLAC will pay the rates designated below:

A. Initial Hospitalization Benefit

AFLAC will pay an Initial Hospitalization Benefit of \$1,000 when a covered person is confined to a hospital for 12 or more hours as a result of receiving treatment for a specified disease. This benefit is payable only once per period of confinement and once per calendar year for each covered person.

B. Hospital Confinement Benefits

AFLAC will pay any covered person an indemnity of \$200 per day for the first 30 days when an insured person is hospitalized for a covered specified disease. Beginning with the 31st day of continuous hospital confinement, AFLAC will pay an indemnity of \$500 per day. No lifetime maximum.

Termination

This rider will terminate if the policy to which it is attached terminates or if the premiums for this rider are not paid.

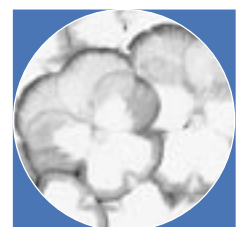
Effective Date

The effective date of this rider is the effective date of the policy to which it is attached or the effective date of this rider, as stated on the Policy Schedule, if later.

Your Rates

	20 Pay	24 Pay
Employee Only	\$0.60	\$0.50
One-Parent Family	\$0.90	\$0.75
Employee + Family	\$1.20	\$1.00

Refer to policy and riders for complete details, limitations, and exclusions. This brochure is for illustration purposes only.



CONTINUED

Definition of Covered Diseases

Specified disease used to describe this benefit means one or more of the diseases listed below:

- | | |
|---------------------------------------------------------------|--------------------------|
| A. Adrenal hypofunction (Addison's disease) | L. Muscular dystrophy |
| B. Amyotrophic lateral sclerosis (ALS) (Lou Gehrig's disease) | M. Myasthenia gravis |
| C. Cerebral palsy | N. Necrotizing fasciitis |
| D. Cystic fibrosis | O. Osteomyelitis |
| E. Diphtheria | P. Polio |
| F. Encephalitis | Q. Rabies |
| G. Huntington's chorea | R. Scleroderma |
| H. Legionnaires' disease | S. Sickle cell anemia |
| I. Malaria | T. Systemic lupus |
| J. Meningitis (bacterial) | U. Tetanus |
| K. Multiple sclerosis | V. Tuberculosis |

**American Family Life Assurance Company
of Columbus (AFLAC)
Worldwide Headquarters
Columbus, Georgia 31999**

Refer to policy and riders for complete details, limitations, and exclusions. This brochure is for illustration purposes only.

For benefits to be paid, these diseases must be first diagnosed by a legally licensed doctor of medicine after the effective date of the benefit and after the 30-day waiting period. Diagnosis must be made by and upon a tissue specimen, culture, and/or titer. If any of these diseases is diagnosed during the 30-day waiting period, benefits for that disease will be paid for loss incurred only after the benefit has been in force two years.

Your Rates*

20 Pay Periods

	Employee Only	One-Parent Family	Employee + Family
Cancer Insurance Coverage (A-59200)	\$ 13.68	\$ 17.10	\$ 22.74
\$500 First-Occurrence Building Benefit Rider	\$ 1.80	\$ 2.70	\$ 3.90
Specified-Disease Benefit Rider (A-59052)	\$.60	\$.90	\$ 1.20
Total Per Pay Deduction:	\$ 16.08	\$ 20.70	\$ 27.84
Cancer Insurance Coverage (A-59300)	\$ 15.54	\$ 20.10	\$ 27.30
\$500 First-Occurrence Building Benefit Rider	\$ 1.80	\$ 2.70	\$ 3.90
Specified-Disease Benefit Rider (A-59052)	\$.60	\$.90	\$ 1.20
Total Per Pay Deduction:	\$ 17.94	\$ 23.70	\$ 32.40

24 Pay Periods

	Employee Only	One-Parent Family	Employee + Family
Cancer Insurance Coverage (A-59200)	\$ 11.40	\$ 14.25	\$ 18.95
\$500 First-Occurrence Building Benefit Rider	\$ 1.50	\$ 2.25	\$ 3.25
Specified-Disease Benefit Rider (A-59052)	\$.50	\$.75	\$ 1.00
Total Per Pay Deduction:	\$ 13.40	\$ 17.25	\$ 23.20
Cancer Insurance Coverage (A-59300)	\$ 12.95	\$ 16.75	\$ 22.75
\$500 First-Occurrence Building Benefit Rider	\$ 1.50	\$ 2.25	\$ 3.25
Specified-Disease Benefit Rider (A-59052)	\$.50	\$.75	\$ 1.00
Total Per Pay Deduction:	\$ 14.95	\$ 19.75	\$ 27.00

*Premiums can be paid either before or after taxes and are deducted from your salary.

For the 2004–2005 Plan Year (10/1/2004–9/30/2005), all rates are shown for 20 or 24 payroll deduction cycles.

Policy Series A-18200

Daily Hospital Intensive Care Unit Benefit

Benefits will be paid if you or any covered person incurs a charge for confinement in a hospital intensive care unit (ICU). This benefit is limited to 15 days per period of confinement. No lifetime maximum.

\$600 per day (Days 1–7)

\$1,000 per day (Days 8–15)

EXCEPTION: During the first ten months the policy is in force, if a covered child is confined in a hospital intensive care unit within the first 28 days after birth, we will pay \$250 per day for hospital intensive care unit confinement of Days 1 through 15.

Daily Sub-acute Intensive Care Unit Benefit

Benefits will be paid for up to a total of 15 days when a covered person incurs a charge for the following:

1. Confinement in a sub-acute intensive care unit (step-down unit)
2. Confinement in a hospital intensive care unit (ICU) after exhaustion of benefits payable under the Daily Hospital Intensive Care Unit Benefit above. This is a \$250 per day benefit.

Benefits payable for the Daily Sub-acute Intensive Care Unit/Hospital Intensive Care Unit Benefit (combination of 1 and 2) are limited to a total of 15 days per covered period of confinement. There is no lifetime maximum.

Note: Benefits payable under the Daily Hospital Intensive Care Unit Benefit or Daily Sub-acute Intensive Care Unit/Hospital Intensive Care Unit Benefit are not payable on the same day.

If a covered person is charged for both on the same day, AFLAC will pay only the highest eligible benefit. Confinements not separated by 30 days or more from a previously covered confinement are considered a continuation of the previous period of confinement.

Human Organ Transplant Benefit

A benefit will be paid as a result of a human organ transplant procedure when a covered person is confined in a hospital and receives one or more of the following: kidney, liver, heart, heart-lung, lung, or pancreas transplant. This benefit pays \$25,000 per occurrence.

Transplant procedures involving more than one organ will be considered to be one organ transplant procedure. This benefit is not payable for transplants involving mechanical or animal organs and is limited to one procedure per 180-day period. No lifetime maximum.

Ambulance Benefit

Benefits will be paid for the actual charges incurred for ground ambulance transportation of a covered person to and from a hospital where the covered person is confined in a hospital intensive care unit or sub-acute intensive care unit. This benefit pays up to \$250.

Benefits will be paid for the actual charges incurred for air ambulance transportation of a covered person to and from a hospital where the covered person is confined in a hospital intensive care unit or sub-acute intensive care unit. This benefit pays up to \$2,000.

This benefit is limited to two trips per confinement. The ambulance service must be performed by a licensed professional or licensed volunteer ambulance company. No lifetime maximum.

Continuation of Coverage Benefit

If you are paying your premiums through payroll deduction and you leave your employer for any reason after your policy has been in force for six months and AFLAC has received premiums for six consecutive months, AFLAC will waive all monthly premiums due for the policy and riders, if any, up to the date your premium payments are re-established. You or your employer must notify us in writing within 30 days of the date your premium payments cease due to your leaving employment. For you to take advantage of this benefit, you must re-establish premium payments within two months from the date you left the employer who was remitting your premiums. You can re-establish your premium payments through your new employer's payroll deduction process or direct payment to AFLAC.

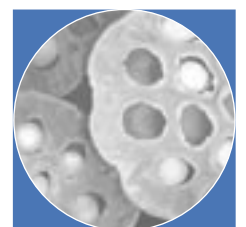
This benefit will again become available once you have re-established your premium payments through an employer's payroll deduction process for a period of six months and AFLAC has received premiums for six consecutive months. *Payroll deduction* means your premium is remitted to AFLAC for you by your employer through a payroll deduction process.

Family Coverage

Family coverage includes the insured; spouse; and all dependent, unmarried children under age 19 (age 25 if full-time or part-time students). Newborn children are automatically covered under the terms of the policy from the moment of birth. Adopted children are covered from the date of petition.

Effective Date

The effective date of the policy is the date shown in the Policy Schedule, not the date the application is signed. Payroll rate may be retained after one month's premium payment on payroll deduction.



CONTINUED

Guaranteed-Renewable for Your Lifetime with Benefits Reduced at Age 70

This policy is guaranteed-renewable for your lifetime with benefits reduced at age 70. It is subject to AFLAC's right to change the applicable table of premium rates by class upon any renewal date.

Limitations and Exclusions

All benefits payable under this policy will be reduced by one-half for losses that start on or after the policy anniversary date following the 70th birthday of a covered person. Benefits are not payable for losses that begin before the policy effective date as shown in the Policy Schedule. This policy will not cover any person who has attained age 65 prior to the effective date of the policy unless the policy is issued on a payroll deduction basis. If issued on a payroll deduction basis, this policy will not cover any person who has attained age 70 prior to the effective date of the policy.

No benefits will be payable for losses caused by or resulting from: intentionally self-inflicted bodily injury or attempted suicide; participation in or the attempt to participate in any illegal activity that is classified as a felony, whether charged or not (the term *felony* is as defined by the law of the jurisdiction in which the activity takes place); exposure to war or any act of war, declared or undeclared, or service in the armed forces; the treatment of mental or nervous disorder or disease; alcoholism or drug dependency; any loss sustained or contracted due to a covered person's being intoxicated or under the influence of alcohol, drugs or any narcotic unless administered on the advice of a physician and taken according to the physician's instructions (the term *intoxicated* refers to that condition as defined by the law of the jurisdiction in which the injury or cause of the loss occurred); or confinement in units such as: surgical recovery rooms, privately monitored rooms, observation units, labor or delivery rooms, or other facilities that do not meet the standards for a hospital intensive care unit or a sub-acute intensive care unit (step-down unit). Newborn children will not be covered for routine nursing or routine well-baby care, but we will pay the policy benefits because of their sickness or injury, including congenital anomaly.

The term *hospital* is defined as a legally licensed hospital which is accredited by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities. The term *hospital* shall include ambulatory surgical centers. Provided that medical or rehabilitative treatment for the disease covered by this policy is actually being received by an insured, we will not deny any claim for payment when the treatment is provided in any hospital meeting the above definitions. No claim will be denied because such hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of a physical disability.

Your Rates*

20 Pay Periods

Employee Only	\$5.22
Employee + Family	\$9.98

24 Pay Periods

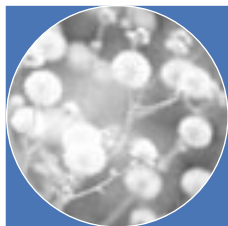
Employee Only	\$4.35
Employee + Family	\$8.32

*Premiums may be paid either before or after taxes are deducted from your salary.

For the 2004–2005 Plan Year (10/1/2004–9/30/2005), all rates are shown for 20 or 24 payroll deduction cycles.

For more information, call FBMC customer service at 1-800-342-8017.

Refer to policy and riders for complete details, limitations, and exclusions. This brochure is for illustration purposes only.



Can I continue coverage after I terminate?

If you are a covered employee who has lost group health plan coverage due to a qualifying event, you, your spouse and dependents are each entitled, under the Consolidated Omnibus Budget Reconciliation Act (COBRA), to continue the group health plans (including Medical Expense FSA coverage) that were in effect on the day prior to the qualifying event. Contact **FBMC** for continuation of your **dental** and **vision** coverage and **Risk Management** for continuation of your **health insurance** within 30 days of a qualifying event.

What are COBRA Qualifying Events?

As a general rule, there is a “COBRA-qualifying event” if eligibility for coverage is lost due to:

- a covered employee's termination of employment occurring other than due to gross misconduct.
- a reduction in a covered employee's hours of employment.
- the death of a covered employee.
- a covered employee becoming entitled to Medicare.
- the divorce or legal separation of a covered employee.
- a child ceasing to qualify as a dependent under the terms of the plan.

How does COBRA affect my Medical Expense FSA Plan?

In accordance with COBRA, your employer offers COBRA continuation rights to qualified beneficiaries who have under spent their Medical Expense FSA accounts as of the date of the COBRA-qualifying event. Unless otherwise elected, the spouse and dependents of the person electing COBRA will be covered. Only qualified beneficiaries have election rights and may elect separate COBRA coverage with:

- a separate Medical Expense FSA at the elected annual limit in effect at the time of the COBRA-qualifying event and
- a separate COBRA premium through the end of the plan year in which the COBRA-qualifying event occurs.

When must I make my initial COBRA elections?

A qualified beneficiary must elect COBRA coverage 60 days after:

- the employee's loss of group health plan coverage or
- the date the Election Notice was mailed to the qualified beneficiary.

If a qualified beneficiary fails to meet this deadline, he or she will be deemed to have declined COBRA coverage.

How do I pay for continuation of coverage?

The monthly COBRA premium for coverage is the monthly premium you were paying via salary reductions before the date of the COBRA-qualifying event, and must be received by the appropriate party by the first of the month. Your first COBRA payment must be paid within 45 days of your election and include all retroactive payments back to your COBRA effective date. Under COBRA, your premium must be paid by check or by money order. Administration fees may apply.

COBRA law allows for a 30-day grace period after the due date. If your full payments are not received by 30 days after the due date, your COBRA coverage will be cancelled retroactive to the first day of the month for which the full payment is due.

When is my initial premium payment due?

The initial COBRA premium must be paid within 45 days of your COBRA election.

What if I fail to make subsequent required payments?

Your full COBRA payments are due on the first of the month. COBRA law allows for a 30-day grace period after the due date. If your full premium payments are not received by 30 days after the due date, your COBRA coverage will be cancelled retroactive to the first of the month for which the full premium payment is due.

What are my Open Enrollment Rights?

If an employer contribution helps fund your Medical Expense FSA, as a qualified beneficiary, you may be eligible for the same Open Enrollment rights as active employees.

Who are Qualified Beneficiaries?

Qualified Beneficiaries must be:

- a covered employee, the spouse of a covered employee or the dependent of a covered employee and
- covered by a group health plan immediately before the qualifying event occurs.

How does HIPAA affect COBRA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives a person already on COBRA, specific enrollment provisions to add dependents only if:

- such a person acquires a new dependent, or
- such a person's eligible dependent declines coverage because of alternative coverage, and later loses such coverage due to certain qualifying reasons.

A spouse and/or dependent added under this paragraph do not become Qualified Beneficiaries, and their coverage will end at the same time coverage ends for the person who elected COBRA and later added them.



What should I do when I retire?

During the 90 days prior to your anticipated retirement date, contact Risk Management at 904-390-2353 to schedule an appointment for retirement and continuation of group health/life plans and flexible benefits.

How Does the Flexible Benefits Plan Affect FRS Benefits?

Your contributions to the Flexible Benefits Plan do not reduce your future Florida Retirement System (FRS) benefits or current contributions to FRS. Any salary directed to your Flexible Benefits Plan is included in the compensation reported to the Florida Retirement System.

When I retire, to whom do I send payments?

Retirees continuing their eligible group health and/or term life insurance should elect to pay their full premium payments through payroll deduction from the Florida Retirement System. Payroll deductions for health and/or term life insurance is required – provided the retirement benefit would support the deduction.

Payment arrangements for benefits other than health or term life insurance can be made directly to FBMC by the use of a coupon book if FRS payroll deduction is not desired. If a retiree selects payroll deductions through the FRS for optional benefits, FBMC requires a completed and signed FRS payroll deduction authorization form.

Until FRS deductions begin, payment by personal check or money order is required. Full premium payment(s) for health, life or optional insurance(s) must be paid by the due date specified.

Benefit Tip -- Retirement

As an FRS retiree, you may only continue the benefit programs in which you were enrolled at the time of separation from District employment.

Please plan accordingly.

If, as a retiree, I decide to withdraw from medical/optional group coverage, would I be eligible to return to the retiree group in the future?

No. Once a retiree elects to leave District group coverage for medical/optional programs (dental, vision, etc.), he/she cannot be enrolled in those plans again.

How do my benefits affect Social Security?

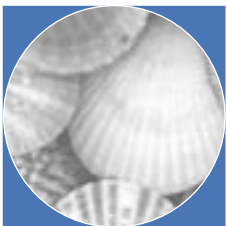
Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors', and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. As of January 2003, the maximum taxable annual wage for FICA is \$87,000. There is no maximum taxable annual wage for Medicare. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Visit www.fbmc-benefits.com for an approximation or call FBMC Customer Service at 1-800-342-8017.

Caution!

The benefit plans reflected on the preceding pages are the versions currently offered. The policy provisions in previous years may be different.

Check your policy to compare benefits. If you have any questions, call FBMC Customer Service at 1-800-342-8017.



Taxable Benefits and the IRS

Disability Income Protection – If you are paying your premiums on a pre-tax basis and you suffer a disability, any disability payments you receive under the plan will be subject to federal income tax. If you pay for your premiums on a post-tax basis and a disability entitles you to receive payments, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax advisor for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

Hospital Indemnity Insurance, Personal Cancer Expense Insurance, and Hospital Intensive Care Insurance – If you choose to pay your premiums for these plans on a before-tax basis, you will be required by the IRS to pay FICA, Medicare, and federal income taxes on your benefit payments that exceed the actual medical expenses you incur. If you have questions, consult your personal tax advisor.

Life Insurance Premiums and the IRS

According to IRS regulations, you can pay premiums on a pre-tax basis, for the first \$50,000 of life insurance. However, you must pay tax on any coverage exceeding \$50,000 (which includes your School Board-provided \$10,000) with after-tax money.

Disclaimer - Health Insurance Benefits Provided Under Health Insurance Plan(s)

Health Insurance benefits will be provided, not by your Employer's Flexible Benefits Plan, but by the Health Insurance Plan(s). The types and amounts of health insurance benefits available under the Health Insurance Plan(s), the requirements for participating in the Health Insurance Plan(s), and the other terms and conditions of coverage and benefits of the Health Insurance Plan(s) are set forth from time to time in the Health Insurance Plan(s). All claims to receive benefits under the Health Insurance Plan(s) shall be subject to and governed by the terms and conditions of the Health Insurance Plan(s) and the rules, regulations, policies, and procedures from time to time adopted.

FBMC Privacy Notice

4/14/03

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

- I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service, and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:
 - Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status, and spousal and beneficiary information.
 - Responses from you and others such as information relating to your employment and insurance coverage.
 - Information about your relationships with us, such as products and services purchased, transaction history, claims history, and premiums.
 - Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

- II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our Web site: www.fbmc-benefits.com. You have a right to a paper copy at any time. Contact FBMC Customer Service at 1-800-342-8017.

- III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies, and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.
- IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena, or to prevent fraud.

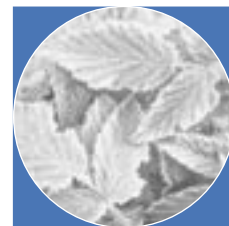
We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Notice of Administrator's Capacity

PLEASE READ: This notice advises insured persons of the identity and relationship among the contract administrator, the policyholder, and the insurer:

1. FBMC has been authorized by your employer to provide administrative services for your employer's insurance plans offered herein. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits offered herein to provide certain services, including (but not limited to) marketing, underwriting, billing and collection of premiums, processing claims payments, and other services. FBMC is not the insurance company or the policyholder.
2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.
3. The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

If FBMC is authorized to process claims for the insurance company, we will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against FBMC than would otherwise be afforded to you by law. FBMC is not an insurance company.





Contract Administrator
Fringe Benefits Management Company
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Customer Service 1-800-342-8017 • 1-800-955-8771 (TDD)
www.fbmc-benefits.com

Information contained herein does not constitute an insurance certificate or policy.
Certificates will be provided to participants following the start of the plan year, if applicable.