



Value life's benefits

2003-2004

Duval County Public Schools

Attention DCPS Employees!

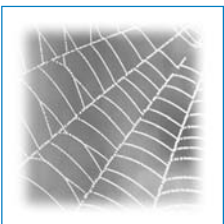
New this year...

Open Enrollment, August 11 – 29, 2003, is an educational opportunity for all employees to learn more about the District's Flexible Benefit's plan, review current benefit elections and to make changes to existing benefits. This year's enrollment is a "changes only" enrollment. Employees who do not complete the enrollment process will keep their current benefits at the new, increased premium rates for the 2003/2004 plan year. Employees who wish to review, or make changes to their current benefits must meet with an enrollment counselor to confirm new plan year elections. All employees who meet with an enrollment counselor will participate in a chance to win special Enrollarama prizes.

Payroll deductions for the new plan year will begin in August 2003 and will reflect some rates revisions for the 2003-2004 Plan Year.

Renewal rate increases will be made for medical, dental and short-term disability plans. Please review the appropriate sections of this book to determine what new rates may affect your August paycheck. Take time to revise your FSA contribution(s) to ensure they meet your changing needs for the next plan year.

All employees are encouraged to meet with an Enrollment Counselor during the scheduled visit to your worksite location. This is your opportunity to confirm your 2003-2004 benefits.



Employee Benefits Resource Directory

EMPLOYER DEPARTMENT HOURS PHONE ADDRESS

Duval County Public Schools Risk Management M - F 7:30 a.m. - 5:00 p.m. 1-904-390-2353
www.educationcentral.org

PROVIDER COMPANIES DEPARTMENT HOURS PHONE ADDRESS

AETNA Customer Service M - F 8 a.m. - 6 p.m. 1-877-791-6470
(Medical Plan) Aetna Navigator www.aetna.com
Primary Care Physician network listing www.aetna.com/docfind
Rx Mail Order (Aetna RxHome Delivery) 1-866-612-3862
Magellan Behavioral Services Customer Service & Refills 24-hours a day
Customer Service 1-800-424-5679

American Family Life Assurance Company (AFLAC) Customer Service M - F 8 a.m. - 8 p.m. 1-800-992-3522
(Personal Cancer Expense, Hospital Intensive Care) www.aflac.com

Allstate Workplace Division, American Heritage Life Insurance Company Claims (AWD) M - F 9 a.m. - 5 p.m. 1-800-348-4489
(Hospital Indemnity Insurance) www.ahlcorp.com

Delta Dental Customer Service M - F 8 a.m. - 9 p.m. 1-800-422-4234
(DeltaCare Dental HMO) M - F 7:15 a.m. - 7:30 p.m. 1-800-521-2651
(Delta Dental DPO) www.deltadentalins.com

Fringe Benefits Management Co. FBMC Customer Service M - F 7 a.m. - 10 p.m. 1-800-342-8017
(Flexible Spending Accounts) Interactive Benefits 24-hours a day 1-800-865-3262
www.fbmc-benefits.com

Trustmark Insurance Company Customer Service M - Th. 8 a.m. - 7 p.m. 1-800-918-8877
(Universal Life, Cancer Protector) F 8 a.m. - 6 p.m. www.trustmarkins.com

UNUM Life Insurance Company Customer Service M - F 8 a.m. - 8 p.m. 1-800-858-6843
(Short-Term and Long-Term Disability) 1-800-227-4165
(Long-Term Care) www.unumprovident.com

VisionCare Plan (VCP) Customer Service M - F 8 a.m. - 6 p.m. 1-800-865-3676
(Vision)-Benefit Forms www.visioncare.com

Work & Family Benefits, Inc. M - F 8 a.m. - 9 p.m. 1-800-328-4071
(Dependent Care, Consultation and Referral Legal & Credit Counseling) www.wfbenefits.com

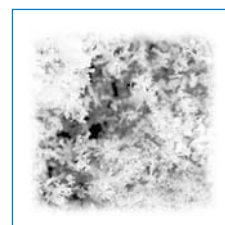




Table of Contents

Benefit Tips

All employees are encouraged to meet with an Enrollment Counselor to learn about changes in the benefit plan.

It's That Time Again...	5
Meeting Your Changing Needs	6
Access Your Benefits	7
Understanding "Flex Dollars"	8
Eligibility Requirements	9
Dependent Certification Requirements	10
Changing Your Coverage	11
Basic Life and AD&D	14
Your Medical Plan	15
Work & Family Benefits	16
Dental Care	17
Vision Care	30
Hospital Indemnity Insurance	34
Disability Income Protection Plans	36
Flexible Spending Accounts	39
EZ REIMBURSE® MasterCard® Card	41
EZ REIMBURSE® MasterCard® Card Fax Cover Sheet	42
Medical Expense FSA	43
Dependent Care FSA	45
Flexible Spending Accounts Worksheets	47
Long-Term Care Protection	48
PremierSelectSM Critical Illness Plan	50
Universal Life	52
Personal Cancer Protector Plan	55
Hospital Intensive Care Insurance	63
COBRA and Retiree Q&A	65
Beyond Your Benefits	67



It's That Time Again...

Important Dates to Remember

**Your Open Enrollment dates are:
August 11, 2003 through August 29,
2003**

**Your Period of Coverage dates are:
October 1, 2003 through September
30, 2004**

Open Enrollment is Here!

One to One consultations with a Flexible Benefits Enrollment Counselor will be available from August 11, 2003 through August 29, 2003. See your Enrollment Schedule 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

- **How do I enroll?** Your Enrollment Counselor will complete an Enrollment Form with you during Open Enrollment.
- **What happens if I do not re-enroll?** If you do not re-enroll, your flexible benefits will remain in force as enrolled in the previous years enrollment. **Please note that if you enrolled in a FSA, this amount will continue for the 2003-2004 Plan Year unless a new enrollment form is completed.**
- On your August 15, 2003 paycheck your Medical, Dental, and Short Term Disability will be deducted at current 02-03 plan rates. Adjustments for new plan rates and any changes in coverage levels will begin August 29, 2003 and run concurrent throughout the year.

How to Call About Your Benefits

There are three ways to receive benefit information:

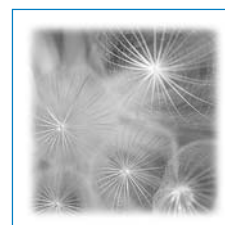
1. You may contact the customer service department about the specific plan for which you are inquiring (refer to the Employee Benefits Resource Directory on Page 3).
2. For personal assistance, you may call FBMC Customer Service at **1-800-342-8017** Monday through Friday, 7 a.m. - 10 p.m. ET.
3. You may contact the FBMC Customer Service 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 Customer Service 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. The system is designed to provide *information*; to make changes you must first contact FBMC's Customer Service.

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 2003-2004 Plan Year.**



Meeting Your Changing Needs

Duval County Public Schools recognize 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:

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.

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 10 for required documentation.

Who is Fringe Benefits Management Company?

Fringe Benefits Management Company (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 Tips

Reviewing enrollment materials is a must before your enrollment meeting.

It is imperative that you retain your confirmation notice for future reference.



Access Your Benefits *On the web and over the phone*

FBMC Web Site

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

Enter **www.fbmc-benefits.com** into your Internet browser. This will bring you to FBMC's new homepage. Navigational tabs to customer links are located along the top portion of the page. By simply clicking on one of these tabs and entering your employee number and password, you'll be able to access the information you need. The following Web site customer links are available to meet your benefit needs:

Account Information

If you select the 'Account Information' tab, you'll be prompted to enter your Social Security Number and password. Enter your PIN (last 4 digits of your Social Security Number) and follow the prompts to access your FSA details.

You'll notice a navigational menu on the left panel of the Web page. These menu items allow you to check the history of your FSA transactions, balance, and claims you submitted. You may also view your list of dependents and change in status requests from the menu.

Downloading Forms

If you select the 'Download Forms' tab, a choice of forms including a FSA Reimbursement Claim form, Medical Necessity, Direct Deposit, or Debit Card Receipt Transmittal Form are posted for your convenience. You'll need Acrobat Reader to view and print these forms. A link to download the Acrobat Reader application is located at the bottom of the Web page.

Frequently Asked Questions

The 'Frequently Asked Questions' tab will provide 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 allows you to access your benefits any time to check on a claim, verify the status of a Flexible Spending Account, request a form and more! Getting connected to your benefits is easy. Call the Information Line at: **1-800-865-FBMC (3262)**.

A Word About Your PIN

To access both the FBMC Web site and the Interactive Voice Response system, all you need is your Social Security Number (SSN). The last four digits of your SSN will be your first Personal Identification Number (PIN). Then:

On the Web

The site will ask you to select your own confidential four-digit PIN for future use. This 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 by clicking on the link at the upper left hand corner of the page. A representative will respond via e-mail with further instructions. Once you've selected your new PIN, you may access information about your benefits.

Over the Phone

The system will ask you to select your own confidential four-digit PIN for future use. This new PIN cannot be the last four digits of your SSN, as it was previously. If you forget your PIN, you may press '0' at any time to speak with a Customer Service Representative. Once you've selected your new PIN, the system will give you the following list of options from which to choose.

Please keep your PIN in a safe place. The PIN you select will give you access to both the Interactive Voice Response (IVR) system and the FBMC Web site.

PHONE LINE MAIN MENU OPTIONS:

- Press 1** Flexible Spending Accounts
- Press 2** Form requests
- Press 3** Current Benefits
- Press 4** Change PIN
- Press 5** Verify address

Other Options:

- Press 0** Customer Service Representative
- Press 9** Main Menu
- Press *** Repeat the menu
- Press #** Exit Information Line



Understanding “Flex Dollars”

Duval County Public Schools strives to provide competitive benefits for its full-time employees. As part of this effort, the Duval County School Board provides you with \$250 per year in “Flex Dollars” to help you pay for the benefits you need.

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 (M-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.

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:

DeltaCare Dental Employee and Family	\$ 27.44
Vision Employee and Family	\$ 9.58
Total before Flex Money	\$ 37.02
Less Flex Dollars	- 12.50
Total Payroll Deduction	\$ 24.52



Eligibility Requirements

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 2003-2004 Plan Year begins October 1, 2003. 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.

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.

Benefit Tips -- 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. See "COBRA and Retiree Q&A" for more details.

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*.

Deductible Year

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

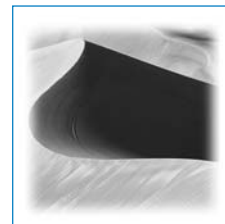
Mid-plan Year Election Change to Duval's Medical Plans.

As a Duval County Public Schools employee, the Board pays all your medical coverage. You remain covered for the entire plan year even if you, your spouse or your dependent experience a valid mid-plan year election change. Upon approval of an election change request, you may remain in your current medical plan.

Benefit Tips

To Make Changes: Within 30 days of an event, which is consistent with one of the event categories on pages 12-13, 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.



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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Benefit Tips

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



Changing Your Coverage

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

Under some circumstances your employer's plans and the IRS may permit you to make a mid-year election change or vary a salary reduction amount depending on the type of pre-tax coverage and the triggering event.

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, 2003 through September 30, 2004. 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.



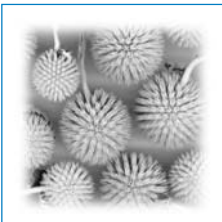
Changing Your Coverage

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 elect to decrease or cancel the accident or health insurance coverage only for the individual(s) involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
2. *Gain of Coverage Eligibility Under Another Employer's Plan.* For a change in which 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 elect to cease or decrease coverage only for that individual if coverage for that individual becomes effective or is increased under the other employer's plan.
3. *Dependent Care Expenses.* For dependent care expenses, you may change or terminate your Dependent Care FSA (DFSA) election only if: (i) such change or termination is made on account of and corresponds with a Change in Status (CIS) that affects eligibility for coverage under your employer's or other employer's plan; or (ii) the election change is on account of and corresponds with a CIS that affects 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 including marriage, death of a spouse, divorce or annulment (legal separation is not recognized by Florida law).
Change in Number of Tax Dependents	A change in number of dependents, including the following: birth, death, adoption, and placement for adoption. Existing dependents can also be added whenever a dependent gains eligibility as a result of a valid CIS event. IRS special consistency rules 1 and 4 may apply as noted at left.
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; such as 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 such as: due to attainment of legal age; student status; marital status; employment 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; such as moving out of an HMO service area (except for Medical Expense FSAs).



Changing Your Coverage *Continued*

Some Other Permitted Changes:

<p>Coverage and Cost Changes</p>	<p>Your employer's plans may permit election changes due to cost or coverage changes that affect other pre-tax benefits, excluding a Medical Expense FSA. Contact your employer. 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.</p>
<p>Open Enrollment Under Other Employer's Plan</p>	<p>You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if*:</p> <ul style="list-style-type: none"> • their employer's plan year is different from your employer's cafeteria plan, • they participate in their employer's plan, and • their employer's plan permits mid-plan year election changes under this event. <p>*Does not apply to a Medical Expense FSA.</p>
<p>Judgement/Decree/Order</p>	<p>If a judgement, decree, or order from a divorce, legal separation (if recognized by state law), annulment, or change in legal custody requires that you provide <i>accident or health coverage</i> 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) cover the dependent child and provide coverage under that individual's plan, you may change your election to <i>revoke</i> coverage only for that dependent <i>child and only if the other individual actually provides the coverage</i>.</p> <p>*Does not apply to Dependent Care FSA.</p>
<p>Medicare/Medicaid</p>	<p>Gain or loss of Medicare/Medicaid eligibility and enrollment may trigger a permitted election change.</p>
<p>Family and Medical Leave Act (FMLA) Leave of Absence</p>	<p>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.</p>
<p>HIPAA</p>	<p>Your employer's group health plan(s) are subject to HIPAA's special enrollment provision. if you enroll your new dependent within 30 days of one of the following CIS events: <i>birth, adoption, or placement for adoption</i>, you may cover your new dependent on a pre-tax basis, retroactive to the date of that event. Election may also extend to previously eligible (but not yet enrolled) dependents.</p>

Basic Life and AD&D

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.

Additional Purchasing Options

You can purchase additional term life coverage equal to one, two, or three times your salary. 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 for a separate application or contact the Risk Management Department, Duval County Public Schools, at 904-390-2114.

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.

Benefit Tips

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

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, 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.



Your AETNA, Inc. Medical Plan

Our goal is simple - to provide you with access to quality health care 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 2003-2004 Plan Year, Aetna will offer only 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.

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

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

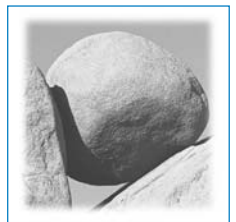
For questions or additional information regarding your Open Enrollment Medical Health Plan options through Aetna, you may contact Aetna Member Services Monday - Friday 8:00 A.M. to 6:00 P.M. at **1-877-791-6470**.

YOUR RATES*

AETNA POINT OF SERVICE PLAN

COVERAGE	20 Pay	24 Pay
Employee Only	— BOARD PAID —	—
Employee & Child(ren)	\$96.47	\$80.39
Employee & Spouse	\$129.95	\$108.30
Employee & Family	\$244.19	\$203.49

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



Work & Family Benefits

FREE SOLUTIONS FOR BUSY PEOPLE

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 Profiles*SM 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 Search*SM allows you to enter any location in the country and instantly receive a mapped list of the twenty child or elder care providers nearest to that location.
- *WFB FitFind*SM gives a complete list of health clubs, fitness centers and gyms nearest to you.
- *WFB Notes*SM and guidebooks on a broad range of dependent care topics.
- WFB's Adoption Resources
- *WFB's PetCares*SM to locate and map nearby veterinarians, pet sitters, boarders, groomers and trainers.
- WFB's College Planning provides resources for college search and the College Aid Calculator® for financial planning.
- Links to health and wellness resources.

Plan Provider

Work & Family Benefits, Inc. provides this plan. Call 1-800-328-4071 for all 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

Dental Care Benefit Options

Delta Dental Insurance Company offers two choices for dental coverage:

- DeltaCare Option (HMO) and
- Delta Dental Preferred Option (DPO).

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 20.

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 20 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 23-29 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 44 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	\$11.15	\$9.29
Employee + one	\$18.64	\$15.54
Employee + family	\$27.44	\$22.87

DELTA DENTAL (DPO)	20 Pay	24 Pay
Employee	\$23.70	\$19.75
Employee + one	\$47.18	\$39.32
Employee + family	\$61.49	\$51.24

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

For the 2003-2004 Plan Year (October 1, 2003 through September 30, 2004), all rates are shown for 20 or 24 payroll deduction cycles.

Benefit Tips

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.**



Dental Care *Continued...*

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
(Calendar Year is Jan. 1 - Dec. 31)

None

Calendar Year Maximum

None

Claim Forms

None

Procedures

You Pay

Office visit
Routine exams
Prophylaxis (cleaning) - basic
Emergency treatment
X-ray and complete series including bitewings**
Fluoride application

no cost
no cost
no cost (one per six months)
\$10 (regular office hours)
no cost
(one series per six months)
no charge to age 19
(one per six months)

Basic/restorative procedures

Simple extractions
Amalgam fillings - 1 surface perm
Resin based fillings - posteriors
Root canal - anterior***
Root canal - molar***

\$6
no cost
\$15 - \$35
\$75
\$180

Major procedures

Crowns - porcelain, base metal
Crowns - porcelain, high noble metal
Dentures - upper/lower
Bridges - porcelain, base metal
Bridges - resin, high noble metal

\$195
\$295
\$225
\$195
\$295

Periodontics

Scaling and root planning

\$45 per quadrant

Orthodontics

Start up fee
Routine 24 month fully banded case
Adult
Child

\$350
\$2,000
\$1,800

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**

** 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

- PMI 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).

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

Limitations

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

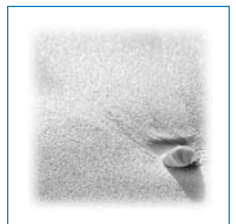
- while the enrollee was covered under the DeltaCare program or
- while the enrollee was covered under another DeltaCare program, and if the benefits for the expenses incurred would have been paid if the enrollee had remained covered under that program.

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 PMI's Customer Relations department at 1-800-422-4234.



DeltaCare Plan A30 Panel List and General Providers

FERNANDINA

#951801
W D RODEFFER, DDS
1010 SOUTH 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 AVENUE
(904) 384-5700 P/T 1

#003451
LEROY R POLITE, DDS
1680 DUNN AVENUE STE 31
(904) 696-6767 F/T 1

#005795
OPTIMUN DENTAL CARE
CENTER
8011-2 MERRILL ROAD
(904) 726-8000 P/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
SMILECARE/HEATH
3704 HEATH RD
(904) 743-6380 F/T 4

#831801
SMILECARE/MERRILL
9119 MERRILL RD STE 29
(904) 744-7202 F/T 4

#831901
SMILECARE/BAY
9109 BAYMEADOWS RD
(904) 731-4343 F/T 1

#832001
SMILECARE/NS
1403-10 DUNN AVE
(904) 751-3444 F/T 4 P/T 1

#832101
SMILECARE/JAMMES
5218 JAMMES RD STE 4
(904) 778-0990 F/T 2 P/T 1

#832201
SMILECARE/NORMANDY
7909 NORMANDY BLVD
(904) 786-1309 F/T 2 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 W EDGEWOOD AVE 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
5111 BAYMEADOWS RD STE 8
(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 DAVIS ST
(904) 355-1423 F/T 1 (SP)

#943101
DENTAL HEALTH GROUP
751 OAK STREET STE 601
(904) 354-4031 F/T 4 P/T 3

#944101
PRIME CARE DENTAL CENTER PA
9208 ARLINGTON EXPRESS WAY
(904) 721-1601 F/T 1 (SP)

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

#951301
BAKER DENTAL CENTER
1147 S EDGEWOOD AVE
(904) 388-1421 F/T 1

#959101
JACK ROSNER, DDS
7332 LEM TURNER ROAD
(904) 764-2422 F/T 1

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

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

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

#964101
SMILECARE
3733 SOUTHSIDE BLVD
(904) 996-0111 F/T 2 P/T 1

#964201
SMILECARE
3706 BLANDING BLVD
(904) 777-1477 F/T 2 P/T 2

#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 N 3RD ST
(904) 241-0880 F/T 3 P/T 1

ORANGE PARK

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

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

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

ST AUGUSTINE

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

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

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

#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 E UNION ST
(904) 358-3827 F/T 1

#961801
BAHRI DENTAL GROUP PA
8131 BAYMEADOWS CIR W 101
(904) 448-9669 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 #101
(904) 805-8823 P/T 1 (SP)

ORANGE PARK

#84100
SMILECARE DENTAL ASSOC
1950 MILLER ST STE 4
(904) 269-3488 F/T 1 P/T 1

PONTE VEDRA BEACH

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

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 Relations 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 website: www.deltadentalca.org/pmi

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*
(Calendar Year is January 1 - December 31)

\$75 per year, individual
\$150 per year, per family

Calendar Year Maximum

\$1,500 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

Scaling and root planning 50% (1 per 24 months)

Orthodontics

50% up to \$1,000 lifetime maximum after 1 year waiting period (dependent children only)

Waiting Period Applies to new participants (orthodontics only)

DPO Dentist Benefits

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

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

**DeltaPreferred Dentists are limited to the PPO fee.

DeltaPremier 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.

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.

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.



Delta Preferred Provider Directory - DPO providers and 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 2003, 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

ATLANTIC BCH

General Dentists

DUKES, MW
100 ROYAL PALMS DR
(904) 241-5342

Pedodontists

PEREZ, R
645 MAYPORT RD #2
(904) 242-0010

GAINESVILLE

General Dentists

BANFIELD, GW
5347 SW 91ST TER #B
(352) 375-6116

COAST DENTAL
5021 NW 34TH ST #A
(352) 371-7766

COSBY, EA
635 NW 6TH ST
(352) 372-2030

DAVIDSON, RM
4000 W NEWBERRY RD
(352) 372-4557

DAVILA-RIVERA, JL
4001 W NEWBERRY RD #B4
(352) 377-8678

DAY, RC
1410 NW 13TH ST #8
(352) 376-8207

DECKER, BC
1204 NW 69TH TER #C
(352) 331-4626

DELL III, JM
2516 NW 43RD ST
(352) 376-2409

GODET, Y
150 NW 75TH DR #B
(352) 333-9898

GOH, H
4436 NW 23RD AVE
(352) 376-3216

GOTTS, AW
4965 NE 8TH AVE #B
(352) 375-1966

HARRIETT, WE
1230 NW 9TH AVE
(352) 376-5661

HESS, RT
4436 NW 23RD AVE
(352) 376-3216

HUGHES, BJ
316 SW 16TH AVE
(352) 378-3323

KASSABIAN, KN
5021 NW 34TH ST #A
(352) 371-7766

KU-TORRES, AM
7733 W NEWBERRY RD #B3
(352) 331-4700

NEW, SL
4909 NW 27TH CT #A
(352) 373-3178

PALADINO, JC
1204 NW 69TH TERRACE #E
(352) 331-9992

PASTORA, Y
3601 SW 2ND AVE #C
(352) 335-3003

POMERANZ, AW
5021 NW 34TH ST #A
(352) 371-7766

THOMAS, PA
4040 W NEWBERRY RD #1400
(352) 378-0111

TRAN, LT
1014 NW 23RD AVE
(352) 373-1884

TRAN-SON-TAY, DB
7733 W NEWBERRY RD #B3
(352) 331-4700

WEBER, TJ
2845 NW 41ST ST
(352) 384-0050

WEITZEL, KC
7109 NW 11TH PL #F
(352) 331-8683

WITT, WM
5622 NW 43RD ST
(352) 378-3139

Oral Surgeons

STOROE, WC
3500 SW 2ND AVE #2
(352) 371-4111

Endodontists

GOLDFADEN, SL
1905 NW 13TH ST
(352) 375-7776

Orthodontists

COHEN, DA
1010 NW 76TH BLVD
(352) 332-7911

PAPPAS, JN
320 NW 75TH DR #B
(352) 332-7466

TAPLEY, PM
320 NW 76TH DR
(352) 332-7466

GREEN CV SPGS

General Dentists

MCCABE, JB
407 WALNUT ST
(904) 284-0773

SMALL, LJ
708 SPRING ST
(904) 284-6688

HAWTHORNE

General Dentists

GARLITZ, JH
6605 SE 221ST ST
(352) 481-2741

KING, SD
6605 SE 221ST ST
(352) 481-2741

HIGH SPGS

General Dentists

COX JR, CG
1025 N MAIN ST #1
(386) 454-2665

DOWDY, JH
60 S MAIN ST #1
(386) 454-1412

MARKHAM, S
1025 N MAIN ST #1
(386) 454-2665

WATSON, JB
1025 N MAIN ST #1
(386) 454-2665

JACKSONVILLE

General Dentists

ABID, JJ
1185 S LANE AVE #6
(904) 783-1422

ABOOD, MP
9307 SAN JOSE BLVD #9
(904) 733-1900

ABOOD, PJ
9309 SAN JOSE BLVD
(904) 733-3391

ABOOD, TB
9307 SAN JOSE BLVD #9
(904) 733-1900

AGARWAL, SK
7408 103RD ST
(904) 778-0366

AIKENS, CA
305 E UNION ST
(904) 358-3827

AKEL, FA
7724 LEM TURNER DR
(904) 765-5573

ALNITI, DP
12276 SAN JOSE BLVD #101
(904) 805-8823

ALNITI, DP
9208 ARLINGTON EXPWY
(904) 721-1601

ALON-ALON, MR
5652 TIMUQUANA RD
(904) 777-5444

ALTON, HL
3434 ATLANTIC BLVD #6
(904) 396-2747

ANAND, S
1420 SAN MARCO BLVD
(904) 399-3632

BAHRI, S
8131 BAYMEADOWS CIR
#102
(904) 744-2111

BARD, BJ
50 W 8TH ST
(904) 356-8077

BARIUAN, NR
6144 GAZEBO PK PL #210
(904) 262-9466

BARKET, TA
3965 CONFEDERATE PT RD
(904) 772-0508

BASCO, M
2771 MONUMENT RD #21
(904) 641-3732

BAXTER, WD
1566 DUNN AVE #3
(904) 751-4958

BIBB, J
2166 CASSAT AVE
(904) 384-5700

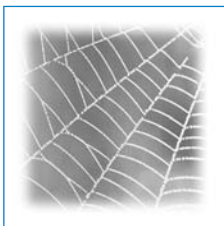
BIBB, J
6001 ARGYLE FOREST BLVD
(904) 771-6838

BILOTTI, JS
11518 SAN JOSE BLVD
(904) 268-5600

BLISS, RQ
2700 RIVERSIDE AVE #12
(904) 387-0469

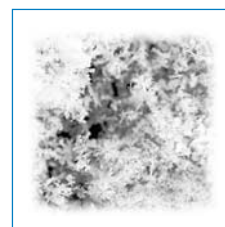
Delta Preferred Provider Directory - DPO providers and premier providers

BOALES, OJ 10920 BAYMEADOWS RD #5 (904) 363-3559	CIRIC, S 3504 CARDINAL POINT DR (904) 730-2266	DPO	DEAN, AT 945 S LANE AVE (904) 781-4011	FARNHAM, SB 11528 SAN JOSE BLVD (904) 262-2551	GREENBURG, MM 6820 ST AUGUSTINE RD (904) 733-3110
BOULTER, JR 8823 GOODBYS EXEC DR (904) 731-0432	CLARK, BC 3539 UNIVERSITY BLVD N (904) 745-0243	DPO	DEASON, BW 765 MILL CREEK RD (904) 724-6321	FETNER, DL 8255 BAYBERRY RD (904) 636-0000	GRIER, CN 8383 BAYMEADOWS WAY (904) 731-8765
BREITMOSER, HG 1716 UNIVERSITY BLVD S (904) 724-1055	CLARK, BC 5475 SOUDEL DR (904) 764-4576	DPO	DELUCIA, JW 14185 BEACH BLVD #2 (904) 223-9999	FETNER, HA 5566 TIMUQUANA RD (904) 778-1455	GULLY, JR 41 SARA DR (904) 757-1555
BRODY, R 11571 SAN JOSE BLVD (904) 354-4031	CLARK, LP 3539 UNIVERSITY BLVD N (904) 745-0243	DPO	DELUCIA, JW 2204 ROGERO RD (904) 744-2000	FORD-EDWARDS, RT 137 W ADAMS ST (904) 353-3303	GUPTON, F 7301 MERRILL RD (904) 743-3114
BRODY, R 751 OAK ST #601 (904) 354-4031	CLARK, LP 5475 SOUDEL DR (904) 764-4576	DPO	DEPAUL, BM 10490 BALMORAL CIR #E (904) 751-6733	FOSS, DF 3245 SOUTHSIDE BLVD (904) 565-1800	HANNA, SK 2135 BLANDING BLVD (904) 384-5571
BRODY, R 800 LOMAX ST #114 (904) 354-4031	CLARK, PL 10950 SAN JOSE BLVD #64 (904) 260-4244	DPO	DEPETRIS, ER 1125 N 3RD ST (904) 241-0880	FRANKLIN, AJ 6344 103RD ST (904) 778-4748	HASTINGS, AG 1147 S EDGEWOOD AVE (904) 268-0904
BROTMAN, SG 3647 HENDRICKS AVE (904) 396-4091	CLARK, SA 9141 CYPRESS GREEN DR #4 (904) 737-1232	DPO	DESAI, BD 1440 DUNN AVE #1 (904) 757-2500	FRENCHMAN, SM 3676 CROWN POINT CT (904) 268-2011	HASTINGS, G 5218 JAMMES RD #D (904) 573-8884
BRYAN, L 7301 MERRILL RD (904) 743-3114	CLEMENT, WJ 4006 BLANDING BLVD (904) 771-0367	DPO	DRAPER, SW 7410 MERRILL RD (904) 745-5115	FULLER III, JW 3706 BLANDING BLVD (904) 777-1477	HERRERA, EL 2292 MAYPORT RD #17 (904) 249-1302
BUNYI, DP 9208 ARLINGTON EXPWY (904) 726-8000	COAST DENTAL 10950 SAN JOSE BLVD #64 (904) 260-4244	DPO	EBER, HR 3667 CROWN POINT RD (904) 268-4904	FULLER III, JW 2078 ROGERO RD (904) 743-9222	HINDER, PR 9119 MERRILL RD #29/30 (904) 744-8462
BURNSIDE, LD 301 W BAY ST (904) 634-0460	COAST DENTAL 25 UNIVERSITY BLVD N (904) 722-0104	DPO	EDWARDS JR, CM 8354 BAYMEADOWS RD (904) 737-7436	GARNER, D 2363 DUNN AVE (904) 751-6030	HIREZI, FD 1301 MONUMENT RD #26 (904) 733-9191
BURNSIDE, LD 12708 SAN JOSE BLVD (904) 268-0904	CROUCH, EC 6073 SAN JOSE BLVD W (904) 737-2111	DPO	EDWARDS JR, CM 774 N EDGEWOOD AVE (904) 388-9038	GATLING, RS 1413 DUNN AVE (904) 751-4556	HIREZI, FD 4495 BAYMEADOWS RD (904) 733-9191
CAKMIS, W 1151 CASSAT AVE (904) 384-5543	DANG, MT 751 OAK ST #601 (904) 354-4031	DPO	ELGEZIRY, SA 3837 SOUTHSIDE BLVD #5 (904) 642-2010	GELMAN, ES 4521 ATLANTIC BLVD (904) 398-0200	HIREZI, NJ 4495 BAYMEADOWS RD (904) 733-9191
CAVENDISH, M 137 W ADAMS ST (904) 353-3303	DAVID, JA 10991 SAN JOSE BLVD #20 (904) 268-0606	DPO	ELINOFF, R 9776 SAN JOSE BLVD #7 (904) 268-6751	GERRY, CY 7505 ARLINGTON EXPWY (904) 731-8745	HIREZI, NJ 1301 MONUMENT RD #26 (904) 733-9191
CIRIC, R 3504 CARDINAL POINT DR (904) 730-2266	DAVIS, LC 8727 OLD KINGS RD S (904) 731-5000	DPO	ELROD, K 14286 BEACH BLVD#23 (904) 821-9555	GIRARDEAU, AE 3505 SOUTHSIDE BLVD #5 (904) 564-1888	HOANG, TT 1329 LANE AVE #1 (904) 786-5850
	DAVIS, RB 4402 SALISBURY RD (904) 296-7757	DPO	ELROD, K 9119 MERRILL RD #29 (904) 744-8462	GLOSTER, KR 5255 DUNN AVE NE (904) 751-6211	
	DAWLEY, ME 1125 N 3RD ST (904) 241-0880	DPO	FARNHAM, JG 11528 SAN JOSE BLVD (904) 262-2551	GOCH, MJ 7909 NORMANDY BLVD (904) 786-1309	



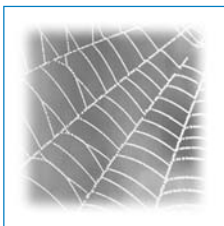
Delta Preferred Provider Directory - DPO providers and premier providers

HOMAYOUNI, S 25 UNIVERSITY BLVD N (904) 722-0104	DPO	KELLEY, JR 9109 BAYMEADOWS RD #1 (904) 731-4343	DPO	MARCHAN, SL 701 MAYPORT CROSSING #7 (904) 246-2603	OLITSKY, JS 9109 BAYMEADOWS RD #1 (904) 731-4343	DPO	ROMEU, E 10415 OLD ST AUGUSTINE (904) 262-9464
HULFELD, JR 7451 103RD ST #18 (904) 777-4622	DPO	KELLY, JC 3675 HENDRICKS AVE (904) 398-1549		MARMUR, FT 14286 BEACH BLVD #23 (904) 821-9555	DPO	ORTIZ, JA 10302 SOUTHSIDE BLVD (904) 363-3366	ROSNER, JH 7332 LEM TURNER RD (904) 764-2422
JONES, DW 6514 SAN JUAN AVE (904) 786-5221		KILCOYNE, JM 9109 BAYMEADOWS RD #2 (904) 731-0311	DPO	MARSHALL, BT 10302 SOUTHSIDE BLVD (904) 363-3366		OSSI, EJ 4244 UNIVERSITY BLVD S (904) 733-2213	SABOL, CM 9119 MERRILL RD #29 (904) 744-8462
JOSEPH JR, B 3704 HEATH RD (904) 744-8462	DPO	KOKAL JR, A 1540 MONUMENT RD #1 (904) 646-0671	DPO	MCKINNEY, JJ 7410 MERRILL RD (904) 745-5115		PARK, YS 12220 ATLANTIC BLVD #128 (904) 221-8221	SABOL, CM 9109 BAYMEADOWS RD #1 (904) 731-4343
KAROL, RE 200 W FORSYTH ST #1550 (904) 356-1010		KROMBACH, MA 520 JACKSONVILLE DR (904) 249-3696		MILLER, TR 9501 ARLINGTON EXPWY (904) 725-4433		PATCH, GR 10609 ST AUGUSTINE RD #3 (904) 268-1331	SABROSKE, RP 7451 103RD ST #18 (904) 777-4622
KATIBAH, EW 943 CESERY BLVD (904) 744-6244	DPO	KROMBACH, MA 1774 UNIVERSITY BLVD S (904) 725-7085	DPO	MOORE, MR 5607 UNIVERSITY BLVD W (904) 733-5533		PATEL, JA 5310 TIMUQUANA RD (904) 771-0933	SALEM, RB 6237 MERRILL RD (904) 744-2111
KELLEY, JR 7909 NORMANDY BLVD (904) 786-1309	DPO	KUROSKO, WA 1550 FOURAKER RD (904) 783-0917		MORRISON, WS 5425 VERNA BLVD (904) 783-1633		PATEL, TC 2262 DUNN AVE #1 (904) 757-7940	SARGI, EM 2700 RIVERSIDE AVE #10 (904) 384-0383
KELLEY, JR 1403 DUNN AVE #10 (904) 751-3444	DPO	LEE, YH 11250 ST AUGUSTINE RD (904) 262-1737		MUMFORD, KA 25 UNIVERSITY BLVD N (904) 722-0104	DPO	PERRIN, JH 4765 HODGES BLVD #5 (904) 992-9396	SAYAF, K 1147 S EDGEWOOD AVE (904) 307-0767
KELLEY, JR 9119 MERRILL RD #29 (904) 744-8462		LEIBOWITZ, RB 301 W BAY ST (904) 634-0460		MURRAY JR, EP 3704 HEATH RD (904) 573-8884	DPO	PHILIPS, BA 2166 CASSAT AVE (904) 384-5700	SAYRE, LM 2301 PARK ST (904) 387-3333
KELLEY, JR 3733 SOUTHSIDE BLVD #5/6 (904) 996-0111	DPO	LEONARD, JW 563 UNIVERSITY BLVD N (904) 724-7190		NARDUCCI, NA 10302 SOUTHSIDE BLVD (904) 363-3366		PHILLIPS, GL 3665 HENDRICKS AVE (904) 396-2929	SCALES, KI 4116 BLANDING BLVD (904) 771-1630
KELLEY, JR 3704 HEATH RD (904) 743-6380	DPO	LEVIN, HR 8255 BAYBERRY RD (904) 636-0000		NEMETZ, MM 9501 ARLINGTON EXPWY (904) 725-4433		POLITE, LR 1680 DUNN AVE #31 (904) 696-6767	SCARLETT, GT 10302 SOUTHSIDE BLVD (904) 363-3366
KELLEY, JR 14286 BEACH BLVD #23 (904) 821-9555	DPO	LEWIS JR, JW 1646 DAVIS ST (904) 355-1423	DPO	NEMETZ, RJ 3733 SOUTHSIDE BLVD #5/6 (904) 996-0111	DPO	PULIDO, PL 6444 BEACH BLVD #201 (904) 727-6006	SCHLOTH, P 10490 BALMORAL CIR #E (904) 751-6733
KELLEY, JR 5218 JAMMES RD #D (904) 573-8884	DPO	LOTT, EG 10028 SAN JOSE BLVD (904) 268-1498		NEWTON, F 1190 W EDGEWOOD AVE #C (904) 765-4406	DPO	RAJ, RR 9343 LEM TURNER RD (904) 764-3844	SCHNEIDER, T 6476 FT CAROLINE RD (904) 743-0900
KELLEY, JR 3706 BLANDING BLVD (904) 777-1477	DPO	MAGOS, M 1151 CASSAT AVE (904) 384-5543		NGUYEN, DD 6491 103RD ST (904) 779-9999	DPO	RILEY, CK 13170 ATLANTIC BLVD #60 (904) 221-0120	SCHULTZ, JB 8789 SAN JOSE BLVD #107 (904) 737-8081
		MAHJOORY, A 3733 SOUTHSIDE BLVD #5/6 (904) 996-0111	DPO	OAKES-LOTTRIDGE, D 3706 BLANDING BLVD (904) 777-1477	DPO	RITTENBERG, HL 5417 ORTEGA BLVD (904) 384-4391	
		MALOWITZ, GH 4124 UNIVERSITY BLVD S (904) 733-3763	DPO	OLINZOCK, DR 12620 BEACH BLVD #18 (904) 620-0404		RODEFFER, SH 2363 DUNN AVE (904) 751-6030	



Delta Preferred Provider Directory - DPO providers and premier providers

SCHUMACHER, JL 4201 ROOSEVELT BLVD (904) 388-3559	STRICKLAND, PD DPO 4001 CONFEDERATE PT RD (904) 772-8060	WALO, R 9041 SOUTHSIDE BLVD #176 (904) 363-2121	ZIMMERMAN, R 3676 CROWN POINT CT (904) 268-2011	O'BRIEN, DA DPO 9550 REGENCY SQ BLVD (904) 724-5020
SCHUTT, CE 2801 ST JOHNS BLUFF RD S (904) 641-3777	TABA, FP DPO 12420 SAN JOSE BLVD (904) 268-3002	WITTEN, AL DPO 223 W ADAMS ST (904) 356-0072	Oral Surgeons	O'BRIEN, DA DPO 4131 UNIVERSITY BLVD S (904) 737-6733
SHAEFFER, LB DPO 2711 ST JOHNS BLUFF RD S (904) 642-1139	TANNEN, MK 3810 WILLIAMSBURG PK #5 (904) 733-3360	WITTEN, PJ DPO 223 W ADAMS ST (904) 356-0072	CHERRY, JE DPO 4100 SOUTHPOINT DR E #5 (904) 281-2225	PARKER, TJ DPO 8259 BAYBERRY RD #1 (904) 737-3263
SHAH, BR DPO 3000 DUNN AVE #38 (904) 768-3790	TAPNIO, LO 10909 ATLANTIC BLVD #15 (904) 641-0944	WOHLGEMUTH, PE DPO 751 OAK ST #601 (904) 354-4031	GESEK, DJ DPO 2047 PARK ST (904) 388-7665	ROTHSTEIN, JP DPO 943 CESERY BLVD (904) 743-5604
SHARP, AN 3557 HENDRICKS AVE (904) 396-1023	THOMAS JR, HF 3325 HENDRICK AVE #2 (904) 398-6444	WOODWARD, WR DPO 3704 HEATH RD (904) 743-6380	GROSHAN, GJ DPO 3007 HARTLEY RD (904) 886-4558	STRENTA, VR DPO 5218 JAMMES RD #B (904) 573-9560
SHIVASHANKAR, N DPO 12421 SAN JOSE BLVD (904) 268-7552	TITUS, WD DPO 14286 BEACH BLVD #23 (904) 821-9555	WOODWARD, WR DPO 7909 NORMANDY BLVD (904) 786-1309	GROSHAN, GJ DPO 4131 UNIVERSITY BLVD S (904) 737-6733	TAYAPONGSAK, P DPO 7101 NORMANDY BLVD (904) 786-9200
SMITH, AL DPO 1190 W EDGEWOOD AVE #B (904) 764-4549	TITUS, WD DPO 1403 DUNN AVE #10 (904) 751-3444	WOODWARD, WR DPO 3733 SOUTHSIDE BLVD #5/6 (904) 996-0111	GROSHAN, GJ DPO 9550 REGENCY SQ BLVD (904) 725-5020	WOODS, DD DPO 9550 REGENCY SQ BLVD (904) 724-5020
SMITH, DE DPO 1190 W EDGEWOOD AVE #B (904) 764-4549	TRAN, VH DPO 6491 103RD ST (904) 779-9999	WOODWARD, WR DPO 14286 BEACH BLVD #23 (904) 821-9555	HADDAD, RD DPO 10302 SOUTHSIDE BLVD (904) 363-3366	WOODS, DD DPO 4131 UNIVERSITY BLVD S (904) 737-6733
SMITH, IJ DPO 1190 W EDGEWOOD AVE #B (904) 764-4549	TROTTER, LA 2532 OAK ST (904) 389-3451	WOODWARD, WR DPO 1403 DUNN AVE #10 (904) 751-3444	HARTLEY, GW DPO 9550 REGENCY SQ BLVD (904) 724-5020	WOODS, DD DPO 3007 HARTLEY RD (904) 886-4558
SOLIMAN, A 9501 ARLINGTON EXPWY (904) 725-4433	UNDERKOFER, SJ DPO 1746 UNIVERSITY BLVD S (904) 724-3023	WOODWARD, WR DPO 3706 BLANDING BLVD (904) 777-1477	HARTLEY, GW DPO 3007 HARTLEY RD (904) 886-4558	Endodontists
SPENCER, MD 800 LOMAX ST #109 (904) 355-5531	VANOVER, MD DPO 14286 BEACH BLVD #23 (904) 821-9555	WOODWARD, WR DPO 9109 BAYMEADOWS RD #1 (904) 731-4343	HARTLEY, GW DPO 4131 UNIVERSITY BLVD S (904) 737-6733	BOWDEN, JW DPO 5218 JAMMES RD #C (904) 777-5878
SPURLING, JE 2500 MONUMENT RD #102 (904) 641-0651	VERA, K DPO 3245 SOUTHSIDE BLVD (904) 565-1800	WOODWARD, WR DPO 9119 MERRILL RD #29 (904) 744-8462	IMRAY, S DPO 2047 PARK ST (904) 388-7665	DIETZ, JA DPO 3706 BLANDING BLVD (904) 777-1477
STEVENSON, RA 6851 BELFORT OAKS PL (904) 281-2566	VERRETTE, RM DPO 456 UNIVERSITY BLVD N (904) 721-1400	WOODWARD, WR DPO 5218 JAMMES RD #D (904) 573-8884	KHAN, ZU DPO 14286 BEACH BLVD #23 (904) 821-9555	JONES, HL DPO 9501 ARLINGTON EXPWY (904) 725-4433
STRICKLAND JR, JA DPO 4001 CONFEDERATE PT RD (904) 772-8060	WAGNER JR, RF 3434 ATLANTIC BLVD (904) 396-2747	WYCALL, BT DPO 8131 BAYMEADOWS CIR #102 (904) 744-2111	KHAN, ZU DPO 3706 BLANDING BLVD (904) 777-1445	JONES, HL DPO 7301 MERRILL RD (904) 743-3114
	WAGNER, WS 14333 BEACH BLVD #6 (904) 223-5644	YORKO, SE 10490 BALMORAL CIR #E (904) 751-6733	MIDDLEBROOKS, ML DPO 4232 BAYMEADOWS RD (904) 739-0690	O'CONNELL, TP DPO 5218 JAMMES RD #C (904) 777-5878
	WALLACE, RC 445 SR 13 #22 (904) 287-0033	YOUNG, LC 4487 BAYMEADOWS RD (904) 731-9833	O'BRIEN, DA DPO 3007 HARTLEY RD (904) 724-5020	



Delta Preferred Provider Directory - DPO providers and premier providers

SMITH, MR
5218 JAMMES RD #C
(904) 777-5878

DPO

LEVINE, MR
8355 BAYBERRY RD
(904) 733-7254

SWINDLE, RB
4337 PABLO OAKS CT
(904) 744-2766

DPO

LEVINE, MR
3600 CARDINAL POINT DR
(904) 737-4626

TOPCIK, PL
8810 GOODBYS EXEC DR #B
(904) 739-2422

DPO

MITCHELL, OD
1190 W EDGEWOOD AVE #A
(904) 766-6000

YANG, SC
7301 MERRILL RD
(904) 743-3114

DPO

NG, KT
4131 UNIVERSITY BLVD S
(904) 731-0521

YOUNG, AR
4211 SOUTHPOINT PKWY #A
(904) 296-8884

DPO

WEAVER, PM
5218 JAMMES RD #A
(904) 880-9866

Orthodontists

BAHRI, G
6237 MERRILL RD
(904) 744-2111

DPO

WEAVER, PM
11571 SAN JOSE BLVD #1
(904) 268-1285

BAHRI, G
1185 S LANE AVE #6
(904) 783-1422

DPO

Pedodontists

COCHRAN, S
8355 BAYBERRY RD
(904) 733-7254

BAHRI, G
765 MILL CREEK RD
(904) 724-6321

DPO

MCLELLAN, MA
9501 ARLINGTON EXPWY
(904) 725-4433

BAHRI, G
8131 BAYMEADOWS CIR
#102
(904) 448-9669

DPO

PEREZ, R
2771 MONUMENT RD #23
(904) 645-9555

BURNS, AS
8259 BAYBERRY RD
(904) 731-4002

DPO

SCHNEIDER, HS
1871 UNIVERSITY BLVD S
(904) 721-2565

BURNS, AS
4612 SAN JUAN AVE
(904) 387-3300

DPO

SETZER, B
8355 BAYBERRY RD
(904) 733-7254

CARDEN, DR
3540 S 3RD ST
(904) 241-2471

DPO

SUGGS, S
10302 SOUTHSIDE BLVD
(904) 363-3366

HAYES JR, RJ
13170 ATLANTIC BLVD #55
(904) 221-6446

DPO

SWITKES, MD
9857 OLD ST AUGUSTINE
(904) 880-5437

KAPLEY, K
9272 ARLINGTON EXPWY
(904) 725-6262

DPO

ZAHEDI, M
10601 SAN JOSE BLVD #115
(904) 880-8955

KIMMEL, S
3714 HEATH RD
(904) 743-4423

DPO

ZAHEDI, M
14444 BEACH BLVD #401
(904) 992-8900

Periodontists

BERDY, CS
1511 STOCKTON ST
(904) 389-1376

DPO

COLEMAN, JR
14286 BEACH BLVD #23
(904) 821-9555

DPO

COLEMAN, JR
3706 BLANDING BLVD
(904) 777-1477

DPO

FETNER, AE
5110 SAN JUAN AVE
(904) 389-2276

DPO

FETNER, AE
4211 SOUTHPOINT PKWY #B
(904) 296-8343

DPO

HARTIGEN, MS
4211 SOUTHPOINT PKWY #B
(904) 296-8343

DPO

HARTIGEN, MS
5110 SAN JUAN AVE
(904) 389-2276

DPO

MAKSOU, MA
9109 BAYMEADOWS RD #3
(904) 731-4347

DPO

RICE JR, GW
11560 OLD ST AUGUSTINE
(904) 262-4844

DPO

SLATER JR, CK
3434 ATLANTIC BLVD
(904) 398-1136

DPO

SLATER JR, CK
252 15TH AVE S
(904) 249-8448

DPO

Prosthodontists

AZARI-SAMANI, R
14444 BEACH BLVD #401
(904) 992-8900

AZARI-SAMANI, R
10601 SAN JOSE BLVD #115
(904) 880-8955

ELIAS, NS
9250 BAYMEADOWS RD #300
(904) 731-2120

OLSON, EM
2078 ROGERO RD
(904) 743-9222

SAYOC, AM
4940 BLANDING BLVD
(904) 777-1112

DPO

SAYOC, AM
13167 ATLANTIC BLVD
(904) 221-0054

DPO

JACKSONVILLE BCH General Dentists

HARRISON, RK
227 11TH AVE S
(904) 241-4237

DPO

JUMBER, MJ
324 3RD AVE N
(904) 246-6714

DPO

KELLEY, JR
1125 N 3RD ST
(904) 241-0880

DPO

KESSLER, MH
220 3RD AVE S
(904) 249-9069

DPO

WOODWARD, WR
1125 N 3RD ST
(904) 241-0880

DPO

Endodontists

BOWDEN, JW
233 N 3RD ST #204
(904) 777-5878

DPO

DIETZ, JA
1125 NE 3RD ST
(904) 241-0880

DPO

OCONNELL, TP
233 N 3RD ST #204
(904) 241-0030

DPO

SMITH, MR
233 N 3RD ST #204
(904) 241-0030

DPO

Pedodontists

LOVE, WL
552 JACKSONVILLE DR
(904) 247-4097

MIDDLEBURG General Dentists

HUAMAN, KA
4075 CR 218 W
(904) 282-9371

MATE, SM

4075 CR 218 W
(904) 282-9371

NEPTUNE BCH General Dentists

RAS, EM
201 1ST ST
(904) 246-6431

NEWBERRY General Dentists

RICHTER, HM
12 SW 250TH ST
(352) 472-4444

ORANGE PARK General Dentists

ALON-ALON, MR
1101 BLANDING BLVD #106
(904) 777-5444

ALON-ALON, MR
1543 KINGSLEY AVE #19
(904) 269-1973

ARCHAMBAULT, GA
1414 KINGSLEY AVE #3
(904) 269-3842

ARIAS, MA
473 BLANDING BLVD
(904) 272-7170

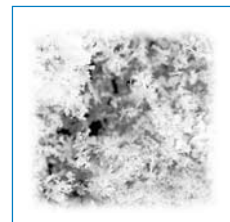
BUNYI, DP
1543 KINGSLEY AVE #19
(904) 269-1973

CIOFFI, GA
767 BLANDING BLVD #109
(904) 272-6244

COAST DENTAL
5000 US HWY 17 S #4
(904) 215-7855

COAST DENTAL
410 BLANDING BLVD #6
(904) 276-5950

CROVATTO, RC
105 FOXRIDGE DR
(904) 272-0800



Delta Preferred Provider Directory - DPO providers and premier providers

CROVATTO, SE
752 BLANDING BLVD #108
(904) 272-0800

MCRAE, TE
637 BLANDING BLVD
(904) 272-1564

SKAGGS, DE
3168 HWY 17 S #A
(904) 278-7308

FIELDS, R **DPO**
421 KINGSLEY AVE #301
(904) 269-2022

OLSON, EJ
1 FLORIDA PARK DR #224
(386) 446-5141

FEDERICO, RA **DPO**
1409 KINGSLEY AVE #9F
(904) 264-5806

MURRAY JR, EP **DPO**
1605 DOCTORS INLET DR
(904) 797-4108

STANDISH, CM
1700 WELLS RD #17
(904) 269-6558

LAZARRA, G
1910 WELLS RD
(904) 269-2002

WATSON, DA
1 FLORIDA PARK DR #224
(386) 446-5141

HUDGINS, CH
767 BLANDING BLVD #109
(904) 276-0000

NERIKAR, VV
1910 WELLS RD
(904) 269-7004

WALL, T
1910 WELLS RD
(904) 269-7004

PEDEN, JP
1406 KINGSLEY AVE
(904) 264-4510

Oral Surgeons

JOHNS-STOUTAMIRE, LC
1543 KINGSLEY AVE #10
(904) 264-7516

PATEL, BB **DPO**
1580 WELLS RD #20
(904) 278-9011

WOODWARD, WR **DPO**
1605 DOCTORS INLET DR
(904) 215-3533

PRIETO, JS
1950 MILLER ST #3/4
(904) 269-3488
DPO

AKERS, JO **DPO**
9 PINE CONE DR
(386) 252-6438

FLEUCHAUS, PT **DPO**
9 PINE CONE DR
(386) 252-6438

KELLER, PJ
2301 PARK AVE #201
(904) 269-1048

PATEL, RR
168 BLANDING BLVD #4
(904) 276-5143

WOODWARD, WR **DPO**
1950 MILLER ST #3/4
(904) 269-3488

Pedodontists

FRASER, MS **DPO**
1584 KINGSLEY AVE #1
(904) 264-5437

GAINES, RT **DPO**
9 PINE CONE DR
(386) 252-6438

KELLEY, JR **DPO**
1950 MILLER ST #3/4
(904) 269-3488

PEARSON, ML
38 BLANDING BLVD #A
(904) 272-9440

Oral Surgeons

CAPUTA JR, LA **DPO**
1409 KINGSLEY AVE #5
(904) 264-7383

STRATTON, MW **DPO**
1584 KINGSLEY AVE #1
(904) 264-5437

JOHNSON, DL **DPO**
9 PINE CONE DR
(386) 252-6438

KELLEY, JR **DPO**
1605 DOCTORS INLET DR
(904) 797-4108

PEARSON, RA **DPO**
38 BLANDING BLVD #A
(904) 272-9440

GROSHAN, GJ **DPO**
2141 LOCH RANE BLVD #122
(904) 276-0200

SUGGS, S **DPO**
1910 WELLS RD
(904) 269-9299

SCHALIT, CJ **DPO**
9 PINE CONE DR
(386) 252-6438

KLEMENT, BD
2140 KINGSLEY AVE #4
(904) 272-7277

RAMSEY, TJ **DPO**
410 BLANDING BLVD #6
(904) 276-5950

HADDAD, RD **DPO**
1910 WELLS RD
(904) 269-9299

WEAVER, GK **DPO**
1584 KINGSLEY AVE #1
(904) 264-5437

Orthodontists

LE, LT **DPO**
868 BLANDING BLVD #128
(904) 276-9402

ROESSLER, RK
1910 WELLS RD
(904) 269-7004

HARTLEY, GW **DPO**
2141 LOCH RANE BLVD #122
(904) 276-0200

Periodontists

SALLOUM, L **DPO**
1542 KINGSLEY AVE #135
(904) 272-3908

FAUNCE, RA
1 FLORIDA PARK DR #201
(386) 446-9312

LINDER, JL
784 BLANDING BLVD #110
(904) 272-2438

ROSENBERG, SR
1725 VILLAGE WAY
(904) 264-6500

O'BRIEN, DA **DPO**
2141 LOCH RANE BLVD #122
(904) 276-0200

PALM COAST

General Dentists

COAST DENTAL **DPO**
114 PALM COAST PKWY
(386) 446-5595

Pedodontists

MCLELLAN, BA **DPO**
3 CYPRESS BRANCH WAY
(386) 447-8728

LINDHARDT, V
1406 KINGSLEY AVE #A
(904) 269-2185

ROSENBLUM, RL
390 JEFFERSON AVE
(904) 272-1588

SEVETZ, EB **DPO**
2140 KINGSLEY AVE #7
(904) 272-8484

GORDON, VL **DPO**
114 PALM COAST PKWY
(386) 446-5595

MCLELLAN, MA **DPO**
3 CYPRESS BRANCH WAY
(386) 447-8728

MACLEOD, PJ
1406 KINGSLEY AVE
(904) 264-9911

SANTIAGO, C **DPO**
1409 KINGSLEY AVE #7A
(904) 269-1419

WOODS, DD **DPO**
2141 LOCH RANE BLVD #122
(904) 276-0200

LACY, BW
1 FLORIDA PARK DR #224
(386) 446-5141

PONTE VEDRA BCH

General Dentists

DELLA PORTA, JM **DPO**
135 PROFESSIONAL DR #107
(904) 280-4151

MARCHESE, W
4609 HWY 17 S #2
(904) 278-7567

SCALES, DK
4609 HWY 17 S #2
(904) 278-7567

Endodontists

JONES, HL **DPO**
1910 WELLS RD
(904) 269-9299

NAZ, O
7 OLD KINGS RD #10
(386) 445-0977

FIELD, CM
200 SOLANA RD
(904) 285-1990

MARSHALL, BT
1910 WELLS RD
(904) 269-7004

SEARS, BD **DPO**
5000 US HWY 17 S #4
(904) 215-7855

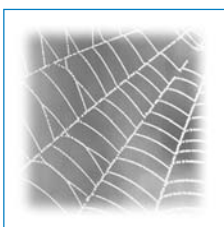
Orthodontists

BROWN, AB
2217 KINGSLEY AVE
(904) 272-1165

HINDER, PR
100 PROFESSIONAL DR
(904) 285-5748

SHERMAN, MA **DPO**
2233 PARK AVE #401
(904) 269-5520

SINGLE, JA
1910 WELLS RD
(904) 269-7004



Delta Preferred Provider Directory - DPO providers and premier providers

KAROL, RE
2103 SAWGRASS PARK PL
(904) 285-8807

KELLEY, JR **DPO**
238 SOLANA RD
(904) 280-1717

NEAL, KL
100 PROFESSIONAL DR
(904) 285-5748

PLATOCK, LG
100 PROFESSIONAL DR
(904) 285-5748

SANTOS, RJ **DPO**
238 SOLANA RD
(904) 280-1717

SCHWEIM, B **DPO**
7000 SAWGRASS VLG CIR
(904) 273-5111

SEARS, DT
35 EXECUTIVE WAY #100
(904) 285-3128

SKAFF, PJ
200 SOLANA RD
(904) 285-1990

VAIL, D
5000 SAWGRASS VLG CIR
(904) 273-4766

WEEKS, PL
200 SOLANA RD
(904) 285-1990

WINTER, MC
100 PROFESSIONAL DR
(904) 285-9173

WOODWARD, WR **DPO**
238 SOLANA RD
(904) 280-1717

Oral Surgeons

KESSLER, MW **DPO**
115 PROFESSIONAL DR #105
(904) 280-4006

Orthodontists

HAYES JR, RJ
3109 SAWGRASS VLG CIR
(904) 273-9115

ST AUGUSTINE General Dentists

BAILEY, MS
75 SAN MARCO AVE
(904) 810-1002

DAVID, A
1971 OLD MOULTRIE RD
(904) 829-5111

DOMINGOES, MW
3534 A1A S
(904) 461-5788

GOSSELIN, PF **DPO**
9 ST JOHNS MED PK DR
(904) 797-4108

KELLEY, JR **DPO**
9 ST JOHNS MED PK DR
(904) 797-4108

MORSE, D
2199 A1A S
(904) 471-3300

MORSE, WJ
2199 A1A S
(904) 471-3300

NEMECEK, M
2199 A1A S
(904) 471-3300

PAINTER, RB
10 DOLPHIN DR
(904) 824-8652

POULOS, S **DPO**
804 16TH ST
(904) 471-3344

SANTIAGO, R
5 ARRENDONDO AVE #A
(904) 824-0990

SINDAD, J
72 VALENCIA ST
(904) 829-2032

VALDEZ-DOMINGOES, M
3534 A1A S
(904) 461-5788

WOODWARD, WR **DPO**
9 ST JOHNS MED PK DR
(904) 797-4108

Orthodontists

GLENOS, WJ
22 ST JOHNS MED PK DR
(904) 797-6453

WEAVER, PM **DPO**
150 S PARK BLVD #201
(904) 823-8822

Pedodontists

MCLELLAN, BA **DPO**
1100 S PONCE DE LEON #2A
(904) 829-6321

MCLELLAN, MA **DPO**
1100 S PONCE DE LEON #2A
(904) 829-6321

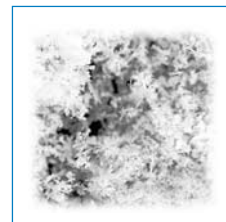
Prosthodontists

ELIAS, NS
150 SOUTHPARK BLVD #203
(904) 826-0307

YULEE General Dentists

POTTER, S **DPO**
1561 E SR 200
(904) 225-0607

SLAVKOVSKY, JR
520 US HWY 17 S #F
(904) 225-4999



Vision Plan

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 deductible, 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, subject to the applicable deductible, up to the amounts in the following reimbursement schedule on Page 31.

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.

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 \$30 reimbursement.
- **Elective Contact Lenses** - The plan limits benefits to \$80 reimbursement for elective contacts.
- **Medically Necessary Contacts** - Paid in full under the Preferred Panel option; non-network option will pay up to \$150.

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

Benefit Tips

You must first call VCP at 1-800-865-FORM (3676) to obtain a benefit form before you make an appointment.

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

30



Vision Plan *Continued...*

Plan Comparison - Reimbursement Schedule

	VCP Network Doctor (Plan Pays)	Non-network Doctor (Plan Pays)
VISION EXAMINATION* (minus \$12 co-payment for network and non-network examination)	Covered in full	up to \$30
MATERIALS (minus \$15 co-payment for network and non-network 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 \$30
CONTACT LENSES* (in lieu of all other materials and services)		
Medically Necessary	Covered in full	\$150
Elective (co-payment does not apply)\$80		\$80

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

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

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

How do I use this benefit?

Call VisionCare Plan at 1-800-865-FORM (3676) to request an approved benefit form, or complete and mail your "Request for VisionCare Plan Benefits" card (mailed to you in your Benefit Certification Kit). You may also visit our web site at www.visioncare.com and fill out a VisionCare Plan Benefit form. Your eligibility will be verified and an approved benefit form, valid for 60 days, will be sent to you along with a current list of panel doctors in your area. **Do not make an appointment for vision care services until you obtain an approved benefit form.**

If you visit a network doctor as a private patient without obtaining a benefit form in advance, the doctor is not obligated to accept the VCP allowances as a full payment. The doctor may charge the usual and customary fees. You will be responsible for any additional charges for services.

YOUR RATES*

	20 Pays	24 Pay
Employee	\$3.51	\$2.93
Employee + Family	\$9.58	\$7.98

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

For the 2003-2004 Plan Year (October 1, 2003 through September 30, 2004), all rates are shown for 20 or 24 payroll deduction cycles.



The following VisionCare Plan doctors are available to you:

BAKER COUNTY

MacClenny

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

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

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

Robert L. Phillips, OD.
1183 S. 6th Street
MacClenny, FL 32063-4620
(904) 259-6797

CLAY COUNTY

Keystone Heights

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

Orange Park

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

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

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

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

David A. Green, OD
2023 Professional Ctr. Dr.
Orange Park, FL 32073-4461
(904) 272-2020

David A. Green, OD
1615 County Rd. 220 Ste. 140
Orange Park, FL 32073
(904) 272-2020

Clarence M. Harris, MD
2023 Professional Ctr. Dr.
Orange Park, FL 32073-4461
(904) 272-2020

Clarence M. Harris, MD
1615 County Rd. 220 Ste. 140
Orange Park, FL 32073
(904) 272-2020

James R. Hoffman, OD
905 Park Ave., Ste. 100
Orange Park, FL 32073-4110
(904) 264-1206

James R. Hoffman, OD
784 Blanding Blvd., Ste. 100
Orange Park, FL 32065-7724
(904) 272-3937

Melanie C. Javier, OD
2023 Professional Ctr. Dr.
Orange Park, FL 32073-4461
(904) 272-2020

Melanie C. Javier, OD
1615 County Rd. 220 Ste. 140
Orange Park, FL 32073
(904) 272-2020

Dana M. White-Nolan, OD
905 Park Ave., Ste. 100
Orange Park, FL 32073-4110
(904) 264-1206

Dana M. White-Nolan, OD
784 Blanding Blvd., Ste. 100
Orange Park, FL 32065-7724
(904) 272-3937

John D. Wilcox, MD
2023 Professional Ctr. Dr.
Orange Park, FL 32073-4461
(904) 272-2020

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

DUVAL COUNTY

Jacksonville

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

Gary M. Akel, OD
953 Lane Ave. S.
Jacksonville, FL 32205-4706
(904) 786-4442

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

Norman S. Bateh, OD
5162 Norwood Ave.
Jacksonville, FL 32208-5003
(904) 764-2591

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

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) 768-9196

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

Lynn D. Johnson, OD
8626 Baymeadows Rd.
Jacksonville, FL 32256-7424
(904) 739-2050

James C. Lanier, Jr, OD
1500 Riverside Ave
Jacksonville, FL 32204-4125
(904) 356-7101

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

Peter D. Liane, OD
100 W. Bay St.
Jacksonville, FL 32202-3838
(904) 356-9431

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

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

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

David E. 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

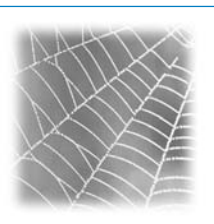
Robert L. Phillips, OD
1580 Blanding Blvd.
Jacksonville, FL 32210-1834
(904) 387-0025

Michael A Powers, OD
1060 Arlington Rd N
Jacksonville, FL 32211-5811
(904)725-9090

Alan I. Rauchwarger, OD
9397-2 San Jose Blvd.
Jacksonville, FL 32257
(904) 730-2299

Alan I. Rauchwarger, OD
9400 Atlantic Blvd., Ste. 62
Jacksonville, FL 32225-824
(904) 721-7700

Patrick L. Reardon, OD
961 Cesery Blvd.
Jacksonville, FL 32211-5607
(904) 743-9955



The following VisionCare Plan doctors are available to you:

Joanne F. Reed, OD
8626 Baymeadows Rd.
Jacksonville, FL 32256-7424
(904) 739-2050

B. W. Roberts, OD
8102 Blanding Blvd.
Jacksonville, FL 32244-7500
(904) 777-3937

Ellen L. Rogers, OD
1500 Riverside Ave.
Jacksonville, FL 32204-4125
(904) 356-7101

Roy H. Schnauss, MD
804 Margaret St
Jacksonville, FL 32204
(904)359-2020

Jeffrey D. Shearer, OD
9978-3 Baymeadows Rd.
Jacksonville, FL 32256
(904) 641-3937

Donna D. Sherrill, OD
11808 San Jose Blvd., Ste. 1
Jacksonville, FL 32223-1862
(904) 262-2249

Robert L Spurling, OD
9119 Merrill Rd., Ste. 13
Jacksonville, FL 32225-4307
(904) 743-6410

Anthony L. Stubits, OD
8626 Baymeadows Rd.
Jacksonville, FL 32256-7424
(904) 739-2050

Bryan A. Stam, OD
100 W Bay St.
Jacksonville, FL 32202-3838
(904)356-9431

Stephen D. Stubits, OD
8626 Baymeadows Rd.
Jacksonville, FL 32256-7424
(904) 739-2050

James W. Watts, OD
11808 San Jose Blvd., Ste. 1
Jacksonville, FL 32223-1862
(904) 262-2249

Jerome Weitzen, OD
213 N. Laura St.
Jacksonville, FL 32202-3501
(904) 353-3163

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Jacksonville, FL 32219-3492
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Jacksonville, FL 32204-4125
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Alan I Rauchwarger, OD
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Fernandina Beach, FL
32034-3212
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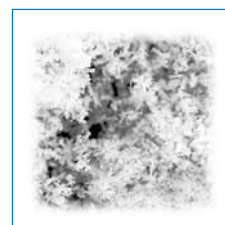
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Hospital Indemnity Insurance

Policy CHCFL with SAR1FL rider

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) 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.

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.

Benefit Tips

To apply, have your Enrollment Counselor fill out the Hospital Indemnity Insurance application.

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

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 apply to the rider.

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.



Hospital Indemnity Insurance *continued*

Policy CHCFL with SAR1FL rider

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 this policy. 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 rider SAR1FL.

Your Rates

\$75 HOSPITAL CONFINEMENT COVERAGE

1 UNIT CHCFL AND 1 UNIT SAR1FL 20 PAY PERIODS

Issue Age	Employee	Employee & Child(ren)	Employee & Spouse	Employee & Family
18-35	\$ 3.90	\$ 6.54	\$ 7.80	\$ 10.44
36-49	\$ 4.50	\$ 7.20	\$ 9.00	\$ 11.70
50-59	\$ 5.64	\$ 7.38	\$ 11.28	\$ 13.02
60-64	\$ 7.50	\$ 7.86	\$ 15.00	\$ 15.36

\$75 HOSPITAL CONFINEMENT COVERAGE

1 UNIT CHCFL AND 1 UNIT SAR1FL 24 PAY PERIODS

Issue Age	Employee	Employee & Child(ren)	Employee & Spouse	Employee & Family
18-35	\$ 3.25	\$ 5.45	\$ 6.50	\$ 8.70
36-49	\$ 3.75	\$ 6.00	\$ 7.50	\$ 9.75
50-59	\$ 4.70	\$ 6.15	\$ 9.40	\$ 10.85
60-64	\$ 6.25	\$ 6.55	\$ 12.50	\$ 12.80

\$150 HOSPITAL CONFINEMENT COVERAGE

2 UNITS CHCFL AND 1 UNIT SAR1FL 20 PAY PERIODS

Issue Age	Employee	Employee & Child(ren)	Employee & Spouse	Employee & Family
18-35	\$ 7.08	\$ 11.94	\$ 14.16	\$ 19.02
36-49	\$ 8.10	\$ 13.08	\$ 16.20	\$ 21.18
50-59	\$ 10.26	\$ 13.38	\$ 20.52	\$ 23.64
60-64	\$ 13.80	\$ 14.28	\$ 27.60	\$ 28.08

\$150 HOSPITAL CONFINEMENT COVERAGE

2 UNITS CHCFL AND 1 UNIT SAR1FL 24 PAY PERIODS

Issue Age	Employee	Employee & Child(ren)	Employee & Spouse	Employee & Family
18-35	\$ 5.90	\$ 9.95	\$ 11.80	\$ 15.85
36-49	\$ 6.75	\$ 10.90	\$ 13.50	\$ 17.65
50-59	\$ 8.55	\$ 11.15	\$ 17.10	\$ 19.70
60-64	\$ 11.50	\$ 11.90	\$ 23.00	\$ 23.40

For the 2003-2004 Plan Year (October 1, 2003 through September 30, 2004), all rates are shown for 20 or 24 payroll deduction cycles.

Benefit descriptions and rates are for policies issued in Florida.



Disability Income Protection Plans

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 Tips

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:

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.



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.

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.

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.

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		Benefit Amount	You are eligible for a monthly accident and sickness disability benefit of:	Rate Per 24 Pay Periods	
Short-Term (14th day)	Long-Term (180th day)			Short-Term (14th day)	Long-Term (180th day)
\$ 4.50	\$3.55	If your gross annual is at least: \$ 7,200	\$ 400	\$ 3.75	\$2.96
\$ 6.75	\$ 5.35	\$10,800	\$ 600	\$ 5.63	\$ 4.46
\$ 8.99	\$ 7.12	\$14,400	\$ 800	\$ 7.50	\$ 5.93
\$ 11.24	\$ 8.91	\$18,000	\$1,000	\$ 9.37	\$ 7.43
\$13.49	\$ 10.70	\$21,600	\$1,200	\$11.25	\$ 8.92
\$16.88	\$13.37	\$27,000	\$1,500	\$14.07	\$11.14
\$20.24	\$16.05	\$32,400	\$1,800	\$16.87	\$13.38
\$27.01	\$21.40	\$43,200	\$2,400	\$22.51	\$17.83



Flexible Spending Accounts

What is a Flexible Spending Account?

A Flexible Spending Account (FSA) is an IRS-approved, tax-free account that saves you money on eligible medical and dependent care expenses. You authorize per-pay-period deposits to your FSA from your before-tax salary. Then, as you incur eligible expenses, you request tax-free withdrawals from your account to reimburse yourself. There are two kinds of FSAs: a Medical Expense FSA and a Dependent Care FSA. If you incur both types of expenses, you can establish both accounts.

Why would I enroll in a FSA? To Save Money!

Over a year's time you will probably spend a part of your salary on health or dependent care. You can save money by putting that amount directly into a Flexible Spending Account.

Get the facts about FSAs

If you have questions, call Fringe Benefits Customer Service (Monday-Friday, 7 a.m.-10 p.m.) at 1-800-342-8017. You may also e-mail Customer Service at webcustomerservice@fbmc-benefits.com.

Direct Deposit

Enroll in Direct Deposit to ensure that your FSA reimbursement checks are automatically deposited into your checking or savings account. There is no fee for this service, and 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 application form available from your **Enrollment Counselor**, or by calling FBMC Customer Service at 1-800-342-8017. Please note that processing your Direct Deposit application may take between four to six weeks.

Receiving Reimbursement

You should receive your reimbursement within 5-10 days from the time you mail your properly completed reimbursement request. To avoid delays, follow instructions for submitting your requests in the FSA sections to follow.

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA.
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, 2004) at the end of the plan year for reimbursement of eligible FSA expenses incurred during your period of coverage within the 2003-2004 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 2003-2004 Plan Year. IRS regulations mandate that any unused funds which remain in an FSA account 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.

Your FSA Contributions:

Termination or Leave

MEDICAL EXPENSE FSAs

If you experience an event permitting a mid-plan year FSA election change such as termination of employment or unpaid leave, you can continue to contribute to your Medical Expense FSA on an after-tax basis by calling FBMC Customer Service at 1-800-342-8017 within 30 days of the event. You may also e-mail FBMC Customer Service at webcustomerservice@fbmc-benefits.com.

As long as you make full after-tax contributions to your Medical Expense FSA, you can receive reimbursements on eligible healthcare expenses incurred during your period of coverage.

You have a 90-day grace period after the plan year ends to submit claims for reimbursement of eligible FSA expenses which you incurred during the plan year. Your Medical Expense FSA coverage will not be continued beyond the plan year in which the COBRA qualifying event occurred.

The Family and Medical Leave Act (FMLA) may affect your rights to continue coverage when on leave. Please consult with Human Resources at 904-390-2065 for more information.

Without an FSA: (Example)*

\$50.00	monthly budget for a medical expense
- 11.33	taxes on that \$50 taken from your paycheck
<hr/>	
\$38.67	amount you have left for medical expense

With an FSA: (Example)

\$50.00	monthly FSA deposit for a medical expense
- 0.00	no taxes (no taxes on FSA deposits)
<hr/>	
\$50.00	amount you have left for medical expense

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

Because the money you deposit in your Medical and Dependent Care FSA is deducted before taxes, the income you use for these expenses is ALWAYS TAX FREE.

Flexible Spending Accounts *Continued*

DEPENDENT CARE FSAS

You cannot continue contributing to your Dependent Care FSA. You can, however, continue to request reimbursement for eligible expenses incurred while employed until you exhaust your account balance or the plan year ends.

Is mileage for doctor visits reimbursable?

Yes, it is reimbursable, as long as a receipt, statement or bill is sent along with your request that validates your visit.

Expenses incurred for transportation are not considered a dependent day care expense.

How do you submit mileage for reimbursement?

Calculate the mileage on the actual bill/receipt detailing the following: roundtrip mileage multiplied by \$.12 (which is the IRS current amount per mile reimbursable) along with the name of the provider visited.

Example: If your office visit with Dr. Jay on 1/1/04 resulted in a total of 80 miles roundtrip, your note should read:

1/1/04—80 miles x .12= \$9.60 for Dr. Jay

On your claim form indicate "Mileage" under Provider of services with the dates of travel and \$9.60 as your amount requested for reimbursement. In addition, attach your statement, bill or receipt along with your request that validates your visit. Please note the \$.12 per mile rate is subject to change each tax year.

Are parking fees and tolls to the doctor's office reimbursable?

Yes, in addition to mileage reimbursement at \$.12 per mile, you may seek reimbursement for parking fees and tolls to your medical appointment. To substantiate the claim you will need to provide a receipt for the toll and/or parking fee in addition to a bill or receipt from your healthcare provider.

Is mileage reimbursable for visits to and from my local pharmacy for my prescription(s)?

Yes, a visit to your pharmacy will be treated as a visit to your local healthcare provider.

Are expenses incurred for out-of-town healthcare services reimbursable, i.e., airline fare, hotel room and rental car?

You may include the medical expense amounts you pay for transportation to another city if the trip is primarily for, and essential to, receiving medical services. You cannot include in medical expenses a trip or vacation taken merely for a change in environment, improvement of morale, or a general improvement of health, even if you make a trip on the advice of a doctor.

(IRS Publication 502).

Are the lodging expenses I incur during my dependent's out-of-town hospitalization reimbursable?

Yes. You may be able to include in medical expenses the cost of lodging not provided in a hospital or similar institution. The amount you include in medical expenses for lodging cannot be more than \$50 per night for each person. Lodging is included for a person for whom transportation expenses are a medical expense because that person is traveling with the dependent receiving medical care. For example, if a parent is traveling with a sick child, up to \$100 per night can be included as a medical expense for lodging. Meals are not included.

(IRS Publication 502).

Benefit Tips

NEW THIS YEAR! Because you do not have to complete an enrollment form, please check your FSA contributions to ensure they will meet your changing needs.

Failure to review this benefit could result in a loss of your hard-earned money.



EZ REIMBURSE[®] MasterCard[®] Card

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 debit or 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 a 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 benefit eligible employees participating in the Duval County Public Schools medical plan will receive their own EZ REIMBURSE[®] Card. Additional cards for dependents are 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, 2003.

Co-payments for wellness visits and prescription drugs do not count toward the annual plan deductible.

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 a 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 Flexible Spending Account. 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.

When do I use paper claim forms?

- 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. Therefore, whenever you use your card, **a copy of all itemized receipts must be provided to FBMC using the fax transmittal cover sheet** (see the following page) or mail directly to FBMC. You may also access this form on the FBMC Web site at www.fbmc-benefits.com.
- 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.
- To reduce the processing time, you can apply for direct deposit and speed up your reimbursement.
- If you are paying for dependent care services, you would need to 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.

EZ REIMBURSE[®] Advantages:

- Faster reimbursements – cash-free transactions!
- You save taxes by participating in an MFSA account
- No Annual Fees charged to you
- Use the card to cover your medical deductible and co-payment costs throughout the year and send in your receipts

***Please see the *Beyond your Benefits* section, Page 69, of this book for information about debit card reimbursement and proper procedure.**

**EZ REIMBURSE® MasterCard® Card
RECEIPT TRANSMITTAL COVER SHEET**

- Only use this cover sheet if you are mailing or faxing EZ REIMBURSE® MasterCard® receipts! You do not need a cover sheet to fax your paper claim form and receipts.
- FBMC will receive your FAX and secure the content according to the HIPAA Privacy requirements. Be sure that you or others working on your behalf secure your data at the point of origination.
- Attach copies of your receipts with this cover sheet.
- Make sure to keep copies of your original receipts.

Note: The customer is responsible for misrepresentation regarding requests for reimbursement. If you have any further questions please call 1-800-342-8017.

Fax to: FBMC, 850-425-4608

**Mail to: Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, Florida 32302-1800**

I certify that I am a person authorized to use the MasterCard® Card issued on behalf of the participant indicated below and that by signing and using my debit card I agree to all terms and conditions. I understand that any transactions initiated by my use of an authorized Card are subject to the terms and conditions of the Cardholder Agreement, and the Funds Transfer Disclosure Statement received with the Card. I certify that the qualified healthcare expenditures presented with this transmittal have been received by an eligible individual and are true and accurate. I further certify I have not and will not seek reimbursement through any other source, and will exhaust all other sources of reimbursement, including those provided under my Employer's plan(s), before seeking reimbursement from my FSA. I will collect and maintain sufficient documentation to validate my reimbursed FSA expenses. I will not claim any reimbursed FSA expense for any federal income tax deduction or credit.

Employee's Full Name

Employee Signature

Employee's Social Security Number

Total Amount of Attached Receipts

Employee's Work Phone Number

Employee's E-mail Address

Card Number (Last 10 digits)

Privacy & Confidentiality of Information Notice:

This communication contains Personal Health Information (PHI) intended for the sole use of the designated recipient(s).

If you are not the intended recipient, or have received this communication in error, please notify the sender immediately by reply e-mail or by telephone, and delete all copies of this communication, including attachments, without reading them or saving them to disk.

If you are the intended recipient, you must secure the contents in accordance with all applicable state or federal requirements related to the privacy and confidentiality of information, including the HIPAA Privacy guidelines.



Medical Expense FSA

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

Who is eligible?

Under the Medical Expense FSA, you may be reimbursed for eligible expenses incurred by the following:

- yourself
- your spouse and
- your dependents. To qualify as a dependent, an individual must meet the following criteria:
 - a) the individual must be your relative or live with you for at least one calendar year
 - b) he or she must be a U.S. citizen or a resident of the U.S., Mexico or Canada and
 - c) you must have provided the individual with at least half of their total support and/or expenses during the past calendar year.

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

Availability

Once you sign up for a Medical Expense FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible medical expenses will be available throughout your period of coverage, provided the request does not exceed your annualized contribution.

It's like a cash advance because you don't have to wait for the cash to accumulate in your account before you can use it to pay for your uninsured, eligible medical expenses. Your money is tax-free and interest free!

FSA vs. Claiming Expenses on IRS Form 1040

Unless your itemized medical expenses exceed 7.5 percent of your adjusted gross income, you can't get a break by claiming them on your IRS Form 1040.* But you can save taxes by paying for your uninsured, out-of-pocket medical expenses through a tax-free Medical Expense FSA.

For instance, if your adjusted gross income is \$45,000, the IRS would only allow you to deduct itemized expenses that exceed \$3,375 or 7.5 percent of your adjusted gross income. But, if you have \$2,000 in eligible medical expenses, the FSA saves you \$653 on your medical expenses in federal income (25 percent) and Social Security taxes (7.65 percent).

With a Medical Expense FSA, the money you set aside for medical expenses is deducted from your salary before taxes. So, it is ALWAYS tax free, regardless of the amount. By enrolling in a Medical Expense FSA, you guarantee your savings.

***Note:** Both you and your spouse's incomes must be included for the purposes of determining adjusted gross income.

Ineligible Expenses

- Insurance premiums
- Vision warranties and service contracts
- Most over-the-counter drugs and medical supplies (even if prescribed by your healthcare provider)
- Health or fitness club membership fees
- Cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition

Setting Aside Funds

Written Confirmation From a Healthcare Provider is Recommended. Before setting aside money in a Medical Expense FSA for any surgical procedure (i.e. corrective laser eye surgery) to treat, cure or mitigate a specific medical condition, it is recommended that you complete all testing procedures and secure written approval as required by the healthcare provider performing your surgery. This must be obtained from your surgical healthcare provider prior to the commencement of the plan year in which the procedure is scheduled and performed. A change in your health circumstances that makes you an unsuitable candidate for a surgical procedure after the 2003-2004 Plan Year commences will not permit you to reduce or cancel your Medical Expense FSA.

Benefit Tips

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.

(Non-Cosmetic) Medical Treatments, Including Orthodontia

Orthodontia treatment designed primarily to improve one's appearance is **not** reimbursable. Orthodontia treatment designed to treat a specific medical condition, such as malocclusion, is reimbursable if the following documentation is attached to the initial Flexible Spending Account Form each plan year:

1. A written statement (e.g., bill) from the treating dentist /orthodontist showing the date the service was rendered, the identity of the individual receiving the service, and the cost for the service.
2. A Letter of Medical Need from the treating dentist /orthodontist. Visit the FBMC Web site at www.fbmc-benefits.com, or call FBMC Customer Service at 1-800-342-8017 to obtain this letter.
3. A copy of the patient's contract with the dentist /orthodontist for the orthodontia treatment.

If the initial service (banding) takes place under a contract for orthodontia treatment, then the amount shown on a submitted Flexible Spending Account Form is reimbursable if it has been paid and is:

- for the initial down payment.
- for the entire contract amount paid up-front.
- for a contract amount spread out under a payment plan crossing plan years.
- monthly payment coupons submitted at the first of each applicable month.

Weight-loss Programs and the IRS

It is significant to note that the IRS officially recognizes obesity as a disease and out of pocket medical expenses for doctor prescribed treatment of obesity as reimbursable under your Medical Expense FSA. This includes treatment in weight-loss programs and/or meetings; it excludes diet foods that are substitutes for normal nutritional requirements.

How to Request Reimbursement†

To request reimbursement from your Medical Expense FSA, you must mail or fax a correctly completed FSA Reimbursement Request Form along with the following:

- a receipt, invoice or bill from your healthcare provider listing the date you received the service, the cost of the service, the type of service and the person for whom the service was provided
- an Explanation of Benefits (EOB) from your health insurance provider that shows the 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 healthcare provider that the service was medically necessary if those services *could* be deemed cosmetic in nature.

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

Fax to: 850-425-4608

Eligible Expenses

Acupuncture
Ambulance service
Birth control pills
Chiropractic care
Contact lenses (corrective)*
Dental fees*
Diagnostic tests-health screening
Doctors' fees
Drug addiction/ alcoholism treatment
Drugs (prescription only**)
Experimental medical treatment
Eyeglasses***
Guide dogs
Hearing aids & exams
Injections and Vaccinations
In vitro fertilization
Nursing services*
Optometrist fees
Orthodontic treatment*
Prescription drugs to alleviate nicotine withdrawal symptoms
Reconstructive surgery after mastectomy****
Smoking cessation programs/treatments
Surgery****
Transportation for local medical care
Weight Loss*
Wheelchairs
X-rays

* To be eligible for reimbursement, some treatments, prescription drugs or services deemed cosmetic in nature require written proof of medical necessity from your healthcare provider.

** Not all drugs requiring a prescription are approved by the IRS as eligible for reimbursement.

*** The effective date for glasses and prosthetic devices is the day the item is available to be picked up, not the date ordered.

**** Unused funds designated for Medical FSAs cannot be refunded to you. Please verify with your healthcare provider (prior to the commencement of the upcoming plan year) that you are a suitable candidate for any surgical procedure before committing the money to your FSA.

† Please see the *Beyond your Benefits* section, Page 69, of this book for more information about debit card reimbursement.



Dependent Care FSA

Minimum Annual Deposit: \$250
Maximum Annual Deposit: The maximum contribution depends on your tax filing status as the list indicates.

Tax Filing Status:

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

How the Dependent Care Flexible Spending Account Could Work for You:

A Dependent Care FSA can help recover some of the money you spend to ensure your dependents (child, adult or elder) are taken care of while you're working.

Who is Eligible?

Under the Dependent Care FSA, you may be reimbursed for eligible care expenses incurred by the following:

- Children 12 years or younger who reside in your household
- Adults/children mentally or physically incapable of self-care who spend at least eight hours a day in your household

FSA vs. Child Care Tax Credit

Generally a FSA saves you more in taxes than the Child Care Tax Credit, but it depends on your income. If you expect your adjusted gross family income to exceed \$39,000 and you are not in the 15 percent tax bracket, the Dependent Care FSA will probably benefit you more.

You can use the Dependent Care FSA and file for a tax credit as long as the total for both (the amount you have placed in your FSA plus the amount you have paid for out-of-pocket dependent care expenses) does not exceed the tax credit limits: \$3,000 for one dependent and \$6,000 for two or more dependents. You cannot use the tax credit if you are married and filing separately, and you cannot take a credit for expenses that have been reimbursed through your FSA. Call FBMC Customer Service at 1-800-342-8017 for assistance in determining the best choice for you. You may also e-mail FBMC Customer Service at webcustomerservice@fbmc-benefits.com.

Eligible Expenses

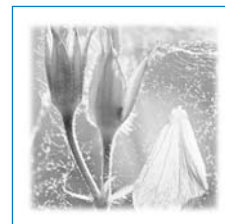
Generally, child, adult and elder care costs that allow you and your spouse to work or actively look for work are eligible for reimbursement. If you are married, your spouse must work, be a full-time student or be mentally or physically incapable of self-care. Payments for dependent care services provided by your dependent, your spouse's dependent, or your child who is under age 19 are not eligible for reimbursement.

Examples:

- Day care facility fees for qualified dependents
- Local day camp fees for qualified dependents
- Baby-sitting fees for at-home care of qualified dependents while you and your spouse are working (care cannot be provided by you, your spouse, or other dependent)

Ineligible Expenses:

- Child support payments or child care if you are a non-custodial parent
- Payments for dependent care services provided by your dependent, your spouse's dependent, or your child who is under age 19
- Healthcare costs or educational tuition
- Overnight care for your dependents (unless it allows you and your spouse to work during that time)
- Nursing home fees
- Diaper services
- Books and supplies
- Activity fees
- Kindergarten expenses



Dependent Care FSA *Continued*

How to Request Reimbursement:

Each Dependent Care FSA reimbursement request sent by mail or fax must include a properly completed FSA Reimbursement Request Form, including receipts showing the following:

- the date your dependent received the care (for example, October 13, 2003 through October 17, 2003) not the date you paid for the service
- the name, address and tax identification number of the facility or
- the name, address, Social Security number and signature of the individual providing the dependent care service.

Be certain you can obtain the above information before you enroll in a Dependent Care FSA. This information is required with each request for reimbursement.

Mail to: Contract Administrator
Fringe Benefits Management Co.
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 Child Care Tax Credit, you must attach IRS Form 2441, which reflects the above information, to your 1040 income tax return. Failure to do this could result in the IRS not allowing your pre-tax exclusion.

Benefit Tips

Be certain you can obtain the information needed to request reimbursement before you enroll in a Dependent Care FSA.

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

When to Request Reimbursement

You can request reimbursement as often as you like; however, **your request cannot be approved for payment unless the last date of service for which you are requesting reimbursement has passed.**

For example, if you pay your dependent care provider on October 1 for the entire month of October, you can submit your reimbursement request for all of October only after the last day of care for that month has been received.

If your dependent care provider requires you to pay in advance for a period of time not to exceed one month in advance (e.g., at the beginning of the month for care throughout the month), FBMC will authorize your request for reimbursement as often as you want to submit it—weekly, biweekly or monthly.

Make sure that your FSA Reimbursement Request Form identifies the dates for which service has already been received and the amount you are requesting reimbursed. Make several copies of your original receipt, so that photocopies of it can be attached to each request.

For timely processing of your reimbursement, your payroll contributions must be current.

Availability

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depends on the actual amount in your account. Unlike a Medical Expense FSA, the entire maximum annual amount is not available at the beginning of the plan year.



FSA Worksheets

Deciding How Much to Deposit

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

TAX-FREE MEDICAL EXPENSE WORKSHEET

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year, which is October 1, 2003 through September 30, 2004.

YOUR UNINSURED MEDICAL, DENTAL AND VISION EXPENSES

_____ \$ _____
 _____ \$ _____
 _____ \$ _____
 _____ \$ _____
 _____ \$ _____

SUBTOTAL

Estimated eligible uninsured medical expenses for your period of coverage during the plan year.
 Amount cannot exceed \$4,250 = \$ _____

SUBTRACT

Less the \$500 or \$1,000 school board contribution.
 Less any remaining Flex Dollars - \$ _____

DIVIDE

by the number of pay periods during the plan year (20 or 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.

TAX-FREE DEPENDENT CARE WORKSHEET

Estimate your eligible, uninsured out-of-pocket dependent care expenses for the plan year, which is October 1, 2003 through September 30, 2004.

NUMBER OF WEEKS

you will have dependent (child, adult or elder) care expenses from October 1, 2003 through September 30, 2004. *Remember to subtract holidays, vacations and other times you may not be paying for eligible child, adult or elder care.* = _____

MULTIPLY

by the amount of money you expect to spend each week X \$ _____

SUBTOTAL

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

DIVIDE

by the number of pay periods during the plan year (20 or 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.

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



Long-Term Care Protection

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

Long-Term Care Protection *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 Tips

Medicare only pays for the first 100 days of hospitalization.

Plan ahead now.

PremierSelectSM Critical Illness Plan - *New!*

If your family history suggests you are at risk for cancer, 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)
 - Thermopgraphy

50



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 (birth 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

PremierSelectSM Critical Illness Plan *Continued*

The following is a comparison chart of the new 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



Voluntary Universal Life Insurance Plan

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
- Those employed by Duval County Public Schools for at least three months prior to the coverage 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



Voluntary Universal Life Insurance Plan *Continued*

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

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?

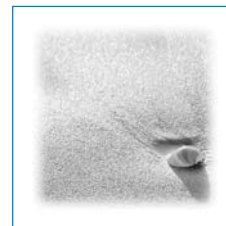
You can have your premiums waived in case of total disability prior to age 60 with the optional Waiver of Premium rider.

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.

Benefit Tips

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.



Voluntary Universal Life Insurance Plan *Continued*

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.

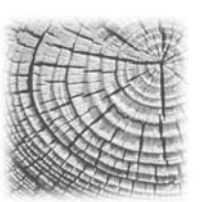
Plan Provider

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



AFLAC Personal Cancer Protector Plan

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 Tips

To apply, ask your 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 x 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)
6/03

MMC-01-240

AFLAC Cancer Expense Insurance Policy

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.**



AFLAC Cancer Expense Insurance Policy *Continued*

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

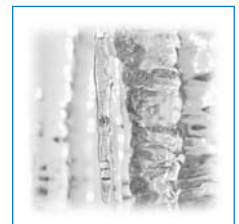
AFLAC will pay the charges incurred up to \$250 to any covered person for a second surgical opinion concerning cancer surgery for a diagnosed cancer by a licensed physician not related to the covered person. This benefit is not payable the same day the NCI Evaluation/Consultation Benefit is payable. **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.



AFLAC Cancer Expense Insurance Policy *Continued*

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.



AFLAC Cancer Expense Insurance Policy *Continued*

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 preventative 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/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.



AFLAC Cancer Expense Insurance Policy *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

Cancer Coverage A-59200

Employee Only	\$13.68
One-Parent Family	\$17.10
Employee + Family	\$22.74

Cancer Coverage A-59300

Employee Only	\$15.54
One-Parent Family	\$20.10
Employee + Family	\$27.30

24 Pay Periods

Cancer Coverage A-59200

Employee Only	\$11.40
One-Parent Family	\$14.25
Employee + Family	\$18.95

Cancer Coverage A-59300

Employee Only	\$12.95
One-Parent Family	\$16.75
Employee + Family	\$22.75

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

For the 2003–2004 Plan Year (10/1/2003–9/30/2004), all rates are shown for 20 or 24 payroll deduction cycles.



AFLAC Benefit Riders

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.

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.

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

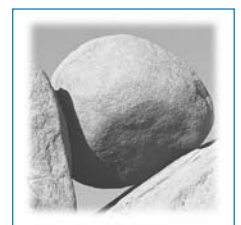
The effective date of this rider is the effective date of the policy to which it is attached or the effective date of this rider, as stated on the Policy Schedule, if later.

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

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.



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

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 are deducted from your salary.

For the 2003–2004 Plan Year (10/1/2003–9/30/2004), all rates are shown for 20 or 24 payroll deduction cycles.

AFLAC Hospital Intensive Care Insurance Policy

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

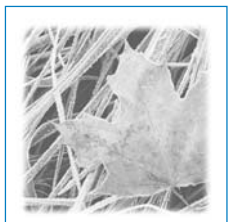
Benefits will be paid for the actual charges incurred for ground ambulance transportation of a covered person to and from a hospital where the covered person is confined in a hospital intensive care unit or sub-acute intensive care unit. This benefit pays up to \$250.

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.



Continuation of Coverage Benefit (Continued)

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.

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

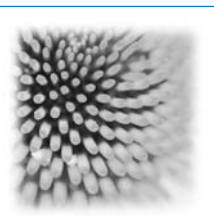
Employee Only	\$4.35
Employee + Family	\$8.32

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

For the 2003–2004 Plan Year (10/1/2003–9/30/2004), 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.



COBRA and Retiree Q&A

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, your spouse and dependents are each entitled to continue the group health plans (including Medical Expense FSA coverage) that were in effect at the time of the 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 *Consolidated Omnibus Reconciliation Act of 1985* (COBRA) qualifying event.

What are COBRA Qualifying Events?

As a general rule, there is a COBRA “qualifying event” if:

- a covered employee's termination of employment occurs other than due to gross misconduct.
- there is a reduction in a covered employee's hours of employment
- a covered employee dies
- a covered employee becomes entitled to Medicare
- a covered employee experiences a divorce or legal separation
- a child ceases to qualify as a dependent under the terms of the plan.

How does HIPAA affect COBRA?

HIPAA gives a person already on COBRA specific enrollment provisions to add dependents only if such a person:

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

Spouse or dependents who are 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.

How are COBRA Qualified Beneficiaries affected?

Except for your employer's Medical Expense FSA Plan, the same open enrollment rights are extended to COBRA qualified beneficiaries as are available to active employees.

How long is the COBRA coverage period?

A qualified beneficiary's maximum coverage period is determined by the qualifying COBRA event.

How does COBRA affect my Medical Expense FSA Plan?

In accordance with COBRA, your employer's plan offers limited COBRA continuation rights to qualified beneficiaries who have under spent their M-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.

Who are Qualified Beneficiaries?

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

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. Under COBRA, your premium must be paid by check or by money order. Administration fees may apply.

COBRA laws allow 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 day of the month for which the full premium payment is due.

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.

When is my initial premium payment due?

A COBRA participant's initial payment including all back premiums is due 45 days after COBRA continuation election.



What if I fail to make subsequent required payments?

A COBRA premium payment (other than the initial premium payment) will be considered timely if made within 30 days after the premium's due date. A qualified beneficiary's COBRA coverage will terminate (without any ability to reinstate it) for failure to pay the required subsequent COBRA monthly payments on time.

What should I do when I retire?

During the 90 days prior to your anticipated retirement date, contact your 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 Other 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 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 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.

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 leaves the umbrella of District group coverage for medical/optional programs (dental, vision, etc.), he/she cannot be enrolled in those plans again.



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, 2004).

In order to continue your benefits coverage after the end of your month of termination, you will need to contact the following sources for the benefit programs outlined below:

Risk Management: 1-904-390-2353

- Health Insurance
- Group Life Insurance
- Voluntary AD&D

Fringe Benefits Management Company: 1-800-342-8017

- Dental
- Vision
- Medical Expense Account — Your participation in your employer's Medical Expense FSA Plan is subject to COBRA. Refer to the *COBRA and Retiree Q&A* section for further details.
- Disability Income Protection and Dependent Care FSA are not continuable upon termination of employment.

OTHER PROGRAMS:

UNUM Life Insurance Co.

- Long-Term Care Insurance 1-800-227-4165

American Heritage Life Insurance Company

- Hospital Indemnity Insurance 1-800-348-4489

AFLAC

- Hospital Intensive Care Protection 1-800-992-3522
- Personal Cancer Expense Protection 1-800-992-3522

Trustmark

- Premier Select Critical Illness Plan 1-800-918-8877
- Cancer Protector Plan 1-800-918-8877
- Universal Life Insurance 1-800-918-8877

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 Resources 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.

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.

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. An Enrollment Representative can approximate any Social Security reduction during a Personal Enrollment Session or you can call FBMC Customer Service at 1-800-342-8017 for an approximation.



How Does the Flexible Benefits Plan Affect Other Benefits? Your Retirement 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.

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.



Processing Claims for Debit Card Transactions

All claims for eligible Flexible Spending Account expenses require supporting documentation in the form of itemized receipts (with date and type of service)--including debit card transactions. If you are using your debit card, you have 30 days from the time you swipe your card to submit your supporting documentation or receipts. If you do not send in your receipts within 30 days, FBMC will notify you in writing that a transaction is outstanding and you must send the receipt(s) in order for that claim to be qualified and processed.

You have 20 days from the date you receive the first letter to comply with the request for outstanding receipts. If you do not submit a receipt within 20 days, your debit card will be suspended and you cannot use your card. After receipts for outstanding transactions are adjudicated by FBMC, your card will be automatically reactivated within one business day.

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. After receiving and processing approved debit card receipts, a payment will be sent to John which represents the difference between the approved paper claim (\$120.00) and the outstanding debit card transactions (\$30.00).

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:

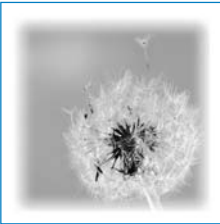
1. FBMC has been authorized by your employer to provide administrative services for your employer's insurance plans offered herein. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits offered herein to provide certain services, including (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.

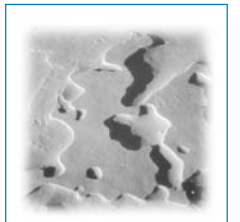


Notes

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Notes





EMPLOYEE NAME: Clarissa Johnson		DUVAL COUNTY PUBLIC SCHOOLS		CHECK NUMBER: 00649	
SSN: 123-45-6789		PA: 1380		PAY PERIOD: 04/19/03-5/2/03	
EMPLOYEE NUMBER: 5150		PSA: TEAC		CHECK DATE: 5/9/03	
		EG: T		ESG:97	
SUMMARY OF EARNINGS			MISCELLANEOUS DEDUCTIONS		
Regular wages 150,160		1,595.90	/BP5	Credit plan credit (FLEX)	31.26
			3303	GRP LIFE PRETX	-6.68
			3387	MED FSA PRETX	-31.26
			3653	VANGUARD TSA	-165.00
			4097	ECCU Credit Union	-170.00
			4203	GRP LIFE PSTX	-1.67
			4285	STD PSTX-\$1800/M0 PSTTX C	-16.87
			4286	LTD PSTX-\$1800/M0 PSTTX C	-13.38
Total gross wages and other compensation		1,595.90	TOTAL		-372.80
TAX AND YEAR TO DATE GROSS INFORMATION			LEAVE INFORMATION IN HOURS		
	THIS CHECK		CYTD		
	Taxes	Wages	Taxes	Wages	
TX Withholding Tax	198.34	1,424.22	1,858.40	14,242.20	Sick leave used
TX EE Social Security Tax	98.54	1,589.22	985.32	15,892.20	Annual leave used
TX EE Medicare Tax	23.05	1,589.22	230.44	15,892.20	Personal leave used
					TDE used
					OJI used
					Military used
					Jury/Court used
					Sick pool used
TOTAL TAXES	319.93				LEAVE BALANCES
FISCAL YEAR TO DATE WAGES					Personal leave used YTD
CALENDAR YEAR TO DATE WAGES		15,959.00			Sick leave balance
					Annual leave balance
					Sick pool balance
EMPLOYER CONTRIBUTIONS			NET PAY		
	THIS CHECK		YTD Contributions		
Total gross	91.92		919.20		Total gross
Total EE tax	98.54		985.32		Total EE tax
EE Deductions	23.05		230.44		EE Deductions
Bank transfer	500.00		1,333.50		Bank transfer
CHECK MESSAGE					

Benefit deduction amounts appear here. Check to verify their accuracy each pay period

REMOVE DOCUMENT ALONG THIS PERFORATION

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	DUVAL COUNTY PUBLIC SCHOOLS Jacksonville, FL	Date 05/09/03 THIS IS A DIRECT DEPOSIT
	DO NOT CASH THIS IS NOT A CHECK	
DEPOSIT TO THE ORDER OF: Clarissa Johnson 321 Your Street Jacksonville, FL		DEPOSIT TO BANK - Duval County Credit Union ROUTING NUMBER - 123456 ACCOUNT NUMBER - 1234567890 AMOUNT DEPOSITED - \$903.20
NationsBank, N.A. Jacksonville, FL		

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.



FBMC