2005 Employee Online Benefits Notebook

Welcome to Your 2005 Plan Year!

Benefits Effective January 1, 2005 to December 31, 2005. **This is your online resource for all of your benefit information.** Get detailed information to help you choose your benefits during your Open Enrollment. You may refer to this Notebook throughout the plan year.

This is a CHANGES ONLY enrollment. If you do not make changes to your existing 2004 benefits, your current coverage will continue and any new premiums will be adjusted for the 2005 Plan Year. However, if you would like to add or make changes to your benefits or dependent coverage, you must do so by the end of your Open Enrollment Period, which is November 19, 2004.

How to Use This Publication

Click on the bookmarks on the left to link you to the information you need. Simply click on the subject and it will automatically link you to your specified page. You may highlight and print specific information or print the entire Notebook. This information will be made available online throughout the year. No printed copies will be provided.

Open Enrollment ends November 19, 2004.

Go to www.dadeschools.net and click on the 2005 Enrollment button to enroll online.

For assistance in Spanish or Creole, please contact FBMC Customer Service at 1-800-342-8017.

Para informacion en Español, por favor llame a FBMC Customer Service a 1-800-342-8017.

Pou plys enfómasyon en Kreyól, rele FBMC llan nimero sa a 1-800-342-8017.

Miami-Dade County
Public Schools
giving our students the world

It's Benefits Enrollment Time

Enrollment Overview

Open Enrollment ends November 19, 2004.

Prior to enrolling, you will need to know the following:

- The insurance benefits and levels of coverage you need
- The choice of having your premiums deducted on a pre-tax or post-tax basis
- The appropriate type of healthcare coverage, i.e., employee and spouse, etc.
- All eligibility documentation for new dependents you choose to cover, must be submitted by December 31, 2004
- Your beneficiary designations, if you select Life Insurance or Accidental Death & Dismemberment (AD&D)

If you need enrollment assistance, contact the Enrollment Help Line at (305) 995-2777.

Once you are ready to enroll, click on the 2005 Enroll Button to begin your online enrollment.

Things to Remember During Open Enrollment:

- Don't forget to print your summary page and save it. This is a copy of your benefit choices.
- Submit your enrollment elections.
- Send in proof of newly-added dependents
- To view your confirmation statement (CS), click on the CS link on the main menu of the Web site.
- Review your CS to verify the accuracy of your benefit selections. Changes cannot be made after the commencement of the plan year.

What's New

- The MetLife Dental rates have changed.
- The CompBenefits Dental Plan Schedules have been updated to reflect additional services available at scheduled co-pays.
- Long-term Disability rates have increased.
- New PIN numbers will be used to access FBMC's Web site!

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The materials contained in this notebook do not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusions of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance companies. Employees receive benefit certificates for those benefits selected.

The School Board of Miami-Dade County, Florida reserves the right to amend or to terminate the Plan described in this booklet at any time, subject to the specific restrictions, if any, in the collective bargaining agreement. In the event of any such amendment or termination, your coverage may be modified or discontinued and the School Board assumes no obligation to continue the benefits or coverages described in this booklet.

Important Phone Numbers and Hours of Operation

COMPANY	DEPARTMENT	HOURS OF OPERATION	PHONE/WEB ADDRESS
Enrollment Web Site		24-hours/7 days a week	www.dadeschools.net
Enrollment Help Line Enrollment Errors		 M - F, 7 a.m. - 10 p.m.	(305) 995-2777 1-800-342-8017
Healthcare Provider			
United Healthcare Choice Plus POS	Customer Service	M - F, 8 a.m. - 8 p.m.	1-866-365-7126
United Healthcare Choice HMO	Customer Service	M - F, 8 a.m. - 8 p.m.	www.provider.uhc.com/MDCPS
United Behavioral Health	Customer Service	M - F, 8 a.m. - 8 p.m.	1-800-582-8220
FlexPlan Providers			
CompBenefits (Dental Plan)	Member Support	M - F, 8 a.m. - 6 p.m. 24-hours a day	1-800-432-3376 www.compbenefits.com/custom/MDCPS
MetLife (Dental Plan)	Customer Service/Claims	M - Th, 8 a.m. - 8 p.m. (All Zones) F 8 a.m. - 5 p.m. (All Zones)	1-800-942-0854 www.metlife.com/dental
Optix (Vision)	Customer Service Indemnity Claims	M - F, 7 a.m. - 10 p.m. M - F, 8 a.m. - 5 p.m.	1-800-342-8017 1-800-393-2873
ARAG® (Legal Plan) (SeniorAdvocate™ Program)	Customer Service Eldercare Program	M - F, 8 a.m. - 8 p.m. M - F, 8 a.m. - 8 p.m.	1-800-247-4184 http://members.araggroup.com/mdps 1-888-718-4793 http://members.araggroup.com/mdps
UNUM (Short-Term and Long-Term Disability)	Customer Service Claims	M - F, 8 a.m. - 8 p.m. M - F, 7 a.m. - 10 p.m.	1-800-633-7479 www.unumprovident.com 1-800-342-8017
CIGNA Group Insurance (Life Insurance, Hospital Indemnity Coverage, Accidental Death and Dismemberment (AD&D))	Customer Service/Claims	M - F, 7 a.m. - 10 p.m.	1-800-342-8017
Fringe Benefits Management Company (FBMC)* (Flexible Spending Accounts)	Customer Service Automated Phone System	M - F, 7 a.m. - 10 p.m.	1-800-342-8017 1-800-865-FBMC(3262) www.fbmc-benefits.com
VISTA Management Company (401(k) Plan)	Customer Service Automated Services	M - F, 7 a.m. - 10 p.m. 24-hours a day	1-800-342-8017 1-877-204-401k e-mail: 401k@vmc.cc www.vista401k.com
Other Important Numbers			
Miami-Dade County Public Schools The Office of Risk and Benefits Management	Automated Phone System	M - F, 8 a.m. - 4:30 p.m.	(305) 995-7130 (305) 995-7190 FAX
Payroll Deduction Control	Automated Phone System	M - F, 8 a.m. - 4:30 p.m.	(305) 995-1655 (305) 995-1644 (FAX)
Fringe Benefits Management Company (FBMC)* E-mail address Enrollment Errors	Customer Service	M - F, 7 a.m. - 10 p.m.	1-800-342-8017 1-800-955-8771 (TDD) webcustomerservice@fbmc-benefits.com 1-800-342-8017

* Third Party Administrator for the M-DCPS fringe benefits program.

Before You Start Your Web Enrollment

Prior to enrolling in your benefits online, it is to your advantage to thoroughly review your enrollment materials. If you are ready to enroll, but need assistance, contact the Enrollment Help Line at (305) 995-2777 (to connect to FBMC Customer Service). Once you have the answers you need, you may begin the enrollment process.

You will need the following to enroll:

- Your 6-digit Employee Number and Password (last 4 digits of your Social Security Number)
- Your benefit choices and levels of coverage.
- The choice of having your premiums deducted on a pre-tax or post-tax basis
- Your choice of Healthcare plan
- Your type of Healthcare coverage
- To choose a FlexPlan Option, if you decline Board-Paid Healthcare coverage. See Page 36 for details.
- The Dental Facility Number, if you select a CompBenefits Dental Plan
- All eligible dependents' names and dates of birth for newly added dependents (Documentation proving dependent eligibility must be submitted prior to December 31, 2004.) See Page 14 for details.
- Your beneficiary designations, if you select Life Insurance or Accidental Death & Dismemberment (AD&D).

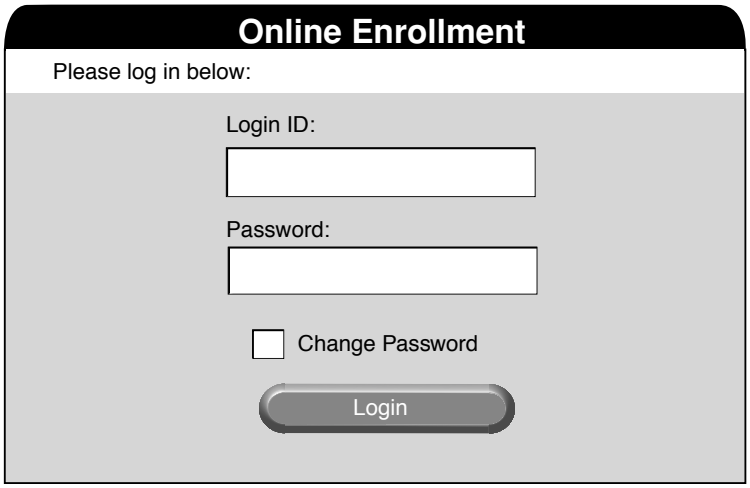
1 How to Log On

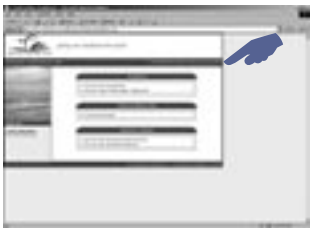
Log on to the Miami-Dade County Public Schools homepage at **www.dadeschools.net** and click on the following buttons:

- 2005 Benefits Open Enrollment button, then the
- 2005 Benefits button, then the
- 2005 Enroll button

2 Enter your Login ID and Password

NOTE: The first time you log in, enter your Employee Number and password (last four digits of your Social Security Number). You will be prompted to change the password.





3 Additional Links

There are four buttons on the menu bar across the top of all the Internet enrollment pages to provide you with additional information and help.

Links and Forms | Benefits Notebook | Enrollment Help | E-mail FBMC

Links and Forms

Links to provider listings, dental facilities listing, numbers, and forms.

Benefits Notebook

Navigate through the online Benefits Notebook to access benefits information.

Enrollment Help

Access detailed help about enrollment instructions and demographic information.

E-mail FBMC

Additional questions can be sent to webcustomerservice@fbmc-benefits.com. When sending an e-mail, please include your name and employee number.

4 Verify your Home Address (Demographic Information)

If your address is incorrect, click on the box to go to the Address Change Form and press the 'Go to Next Page' button. Once you've updated your address, click on the Submit Address Change button. This address change will be forwarded to FBMC, your Healthcare provider, and your dental plan provider. It will NOT be sent to M-DCPS. Changing your address or correcting any other information with your employer must be done through the payroll clerk at your worksite.

If you are classified as an M-DCPS "Exempt" employee, the Risk Management address is displayed instead of your home address for security reasons. If you are in Bargaining Unit 9, your displayed address is the FOP address. You will not be able to change this address.

E-Mail address: If you provide your e-mail address, you will be able to view and print your Confirmation Statement online, but you will not receive a printed Confirmation Statement. Otherwise, a paper confirmation statement will be mailed to your home address.

2005 Employee Benefits Enrollment Form

Employee Demographic Information

NOTE: To change or correct any of the highlighted information on this screen, you must contact your work location's payroll clerk.

Last Name:	Public	**First Name:**	John
Middle Initial:	Q	**Suffix:**	
Employee Number:	000001	**Gender:**	Male
Date of Birth:	08/09/1970		

☐ **Check here if the address below is incorrect.**

Address 1:	551 NW 42ND AVE #B-714	**Address 2:**	
City:	Miami	**State:**	FL
Zip Code:	33317	**Home Phone:**	954-999-9999

You will be able to view and print your Confirmation Statement online immediately after benefit selections are saved successfully. If you provide your e-mail address, you will not receive a printed Confirmation Statement in addition to the online version. Otherwise, a paper Confirmation Statement will be mailed to your home address.

E-mail Address:

I wish to continue to have my premiums deducted on a pre-tax basis. ◉ Yes ○ No

* Required

Next Page

Once your demographic information is correct, click on the "Go to Next Page" button and begin making your selections.

NOTE: If some of the following screens do not display as you enroll, and you are on a leave of absence, it is because you are not eligible to enroll in these benefits. Only the screens for benefits you are eligible to continue will display.

5 Select Your Healthcare Coverage

If you are eligible for healthcare coverage, you will see the screen at the right. Choose your healthcare plan and type of coverage, or decline medical coverage by using the drop-down arrow.

2005 Employee Benefits Enrollment Form

Healthcare Plan Selection

NOTE: If you have selected healthcare coverage for your Domestic Partner, all premiums will be deducted on a post-tax basis, with the exception of Flexible Spending Accounts. The employer funding for dependent coverage is contributed on a pre-tax basis; therefore, will be subject to Withholding and FICA taxes at the end of 2005.

Plan Selection:* United Healthcare Choice Plus POS

Type of Coverage:* Employee and Family

* Required

Previous Page | Next Page

NOTE: If you are covering the children of your Domestic Partner, you must also cover your Domestic Partner. Select `Employee and Family with Domestic Partner´ under Healthcare coverage.

6 Declination of Healthcare Coverage Affidavit

To decline School-Board provided healthcare benefits, you must select to decline healthcare coverage.

Read and agree by clicking the "I Agree" button.

If you click the "Disagree" button, you will be returned to the healthcare plan selection screen to make a new selection.

Declination of Medical Coverage Affidavit

I hereby certify that:

1. I have been given an opportunity to fully participate in the group medical plans provided through Miami-Dade County Public Schools (M-DCPS).
2. The benefits of the plans have been thoroughly explained to me, and I decline to participate.
3. I have other medical coverage currently effective January 1, 2005.
4. I understand that if I desire to apply for medical insurance at a later date, I may enroll only during an annual enrollment period determined by M-DCPS or during a "special enrollment period" (change in status) following an IRS acceptable change in status. For example, you may in the future, be able to enroll yourself or your dependents in a group medical plan through the School Board if you or your dependents lose coverage under an existing employer-provided medical plan, provided that you request enrollment within 30 days after your other group product coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption (or placement for adoption), you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the event. In case of COBRA continuation coverage, you may be eligible for a special enrollment period if the COBRA coverage is exhausted. A special enrollment period is not available if coverage under your prior plan or COBRA coverage was terminated for cause or as a result of failure to pay any contributions toward the cost of coverage on a timely basis.
   Note: Internal Revenue Service (IRS) guidelines state that the loss of insurance through an individual healthcare plan does not constitute a valid Change in Status.
5. I understand that I will not be enrolled in a Board-paid medical plan. I will receive Board-paid Standard Short-Term Disability and will be eligible to select a Board-paid FlexPlan option valued at $100 per month. (May be subject to withholdings and FICA.)

I have read, understand and agree to comply with the requirements stated above.

I Agree | Disagree

7 Board-Paid FlexPlan Options

This screen will only be displayed if you decline medical coverage. To view your FlexPlan Options, click the link to the Options page in this Enrollment Notebook.

2005 Employee Benefits Enrollment Form

Employer-Paid FlexPlan Options

FlexPlan Option Selection

Instead of Board-Paid Healthcare coverage, the board has agreed to contribute $100 per month toward a FlexPlan Option. Please use the drop down to select your option.
View the Option Contents.

FlexPlan Option:* 32

Dental Plan Selection

NOTE: If the CompBenefits High Dental Plan is included in the FlexPlan Option you select, please enter your Dental Facility # below. If you do not know or would like your Dental Facility # to be assigned by CompBenefits, enter the number '99999' in the Employee Dental Facility # field on this screen.

Select a Dental Facility

Dental Facility #:

Dental Facility Name:

Current Patient: ○ Yes ○ No

NOTE: If there is more than one provider listed within the facility you have selected, the provider name that is listed first in the database will display on this page.

* Required

Refresh Dentist Name

Previous Page Next Page

8 Short-Term Disability

Select or decline the STD upgrade.

2005 Employee Benefits Enrollment Form

Short-Term Disability Upgrade

The School Board is providing all eligible, full-time employees with Standard Short-Term Disability (STD). Would you like to upgrade to **High Short-Term Disability** for an additional premium?

◉ Yes ○ No

Previous Page Next Page

Pages 38-82 of this Summary Guide provide a summary of the FlexPlan Benefits offered to you for the 2005 Plan Year. Choose the benefits best suited for you and your family.

For more detailed information on your FlexPlan Benefits, visit www.dadeschools.net to review the full version of your 2005 Employee Benefits Notebook or click on the link located on the main menu or toolbar.

9 Flexible Spending Accounts

You may view the FSA Worksheet to help you calculate and save money on uninsured eligible medical and dependent care expenses.

2005 Employee Benefits Enrollment Form

Flexible Spending Accounts

View the FSA Worksheet.

NOTE: Expenses incurred from January through December 2004 should be included to calculate the annual contribution amount for both dependent and medical expenses. However, payroll deductions will not begin until February.

Medical Expense Flexible Spending Account

(•) Selected
( ) No Coverage

Per Pay Period Deduction $50.00

Dependent Care Flexible Spending Account

(•) Selected
( ) No Coverage

Per Pay Period Deduction $60.00

If you are enrolling in a Flexible Spending Account for the first time and were referred by an M-DCPS co-worker, please enter his or her name and employee number in the fields below. Both of your names will be entered into a drawing for a chance to win a $25 Gift Certificate to any store at a Simon Mall location.

First Name: John **Last Name:** Public

Employee Number: 12345

Previous Page Next Page

10 Select Your FlexPlan Choices

To purchase additional benefits for yourself or for you and your family, simply follow the online instructions for making other benefit selections.

If you declined Healthcare and selected a FlexPlan Option, you may select "Family Only" coverage if employee coverage is included in your option.

2005 Employee Benefits Enrollment Form

Employee-Paid FlexPlan Benefits

On this screen, you can select Employee-Paid FlexPlan benefits for yourself only, or yourself and your family, including Domestic Partners, or Domestic Partners and their children. You must cover yourself, in order to cover any dependents.

If you do not want to add additional coverage on this screen, use the drop down arrows or buttons next to each benefit listed to select "No Coverage".

You will receive warning messages for all areas not properly completed when you attempt to leave this page. You cannot continue to the next page until you correct these areas.

Dental

Plan Selection: CompBenefits High Dental Plan

Type of Coverage: Employee and Family

Click here to view a list of Facility Numbers

Facility #: 99999

Dental Provider Name: To Be Assigned

Current Patient: ( ) Yes (•) No

NOTE: If there is more than one provider listed within the facility you have selected, the provider name that is listed first in the database will display on this page.

Vision

Type of Coverage: No Coverage

Legal

Type of Coverage: No Coverage

Senior Advocate™

Type of Coverage: No Coverage

11 If you do not wish to select a benefit, use the drop down menu and click on "No Coverage".

In order to see the complete online Enrollment Form, scroll down your screen.

2005 Employee Benefits Enrollment Form

Employee-Paid FlexPlan Benefits

On this screen, you can select Employee-Paid FlexPlan benefits for yourself only, or yourself and your family, including Domestic Partners, or Domestic Partners and their children. You must cover yourself, in order to cover any dependents.

If you do not want to add additional coverage on this screen, use the drop down arrows or buttons next to each benefit listed to select "No Coverage".

You will receive warning messages for all areas not properly completed when you attempt to leave this page. You cannot continue to the next page until you correct these areas.

Dental

Plan Selection: MetLife Standard Dental Plan

Type of Coverage: Employee Only

Click here to view a list of Facility Numbers

Facility #:

Dental Provider Name:

Current Patient: ○ Yes ○ No

NOTE: If there is more than one provider listed within the facility you have selected, the provider name that is listed first in the database will display on this page.

Vision

Type of Coverage: No Coverage

Employee Only
Employee and Family
No Coverage

Legal

Type of Coverage:

Senior Advocate™

Type of Coverage: No Coverage

If a dependent is already enrolled and eligibility has been verified, that dependent's information will appear on this screen.

12 Update Your Dependent Coverage

If you have selected any dependent coverage, complete the dependent information section of the online enrollment form.

Remember that proof of eligibility must be provided for all listed dependents, if not previously submitted in 2004. If your dependent is listed, eligibility verification has been met. If you are adding a new dependent to your file, you MUST submit eligibility documentation by December 31, 2004. Otherwise, the ineligible dependent will be terminated on January 1, 2005 and claims will not be paid.

NOTE: If you are covering the children of your Domestic Partner, you must also cover your Domestic Partner. Select 'Employee and Family with Domestic Partner' coverage.

2005 Employee Benefits Enrollment Form

Eligible Dependent Information

NOTE: You will need to submit dependent eligiblity for any dependents that you are adding during your enrollment period.

Additional Information

Do you or any of your dependents have coverage under any other medical plan(s)? ○ Yes ◉ No

☐ **Remove the dependent below from my record.**

Last Name:*	Hernandez	**First Name:***	Martha
Middle Initial:	J	**Suffix:**	
Gender:*	Female	**Birthdate** (mm/dd/yyyy):*	09/18/1974
Relationship to You:*	Spouse		

☐ **Remove the dependent below from my record.**

Last Name:*	Hernandez	**First Name:***	Maria
Middle Initial:		**Suffix:**	
Gender:*	Female	**Birthdate** (mm/dd/yyyy):*	08/07/2002
Relationship to You:*	Daughter		

* Required

Add Dependent(s)

Previous Page Next Page

13 Update Your Beneficiary Information

Click the "Add" button to add beneficiaries. When done, click "Go to Next Page." This screen will only be displayed if you select Term Life Insurance or AD&D coverage.

2005 Employee Benefits Enrollment Form

Beneficiary Information

NOTE: You must indicate your beneficiaries if you select Flexplan coverage of Term Life Insurance or Accidental Death and Dismemberment.

☐ **Remove the beneficiary below from my record.**

Last Name:*	Feinstein	**First Name:***	Benjamin
Birthdate (mm/dd/yyyy):	07/14/1915	**Relationship to You:***	Father
Percentage (whole #s):*	100	**Primary/Secondary:***	Primary

Address:*	123 Main
City:*	Miami
State:*	FL
Zip Code:*	33408 -
Comments:	

* Required

Add Beneficiary(s) | Previous Page | Next Page

PRINT THIS PAGE FOR YOUR RECORDS

14 Review Your Employee Benefits Summary

After you have filled in all your enrollment information, you will need to review them at the Summary of Benefits Selection Page.

2005 Employee Benefits Enrollment Form

Summary of Benefit Selections

REMEMBER: Print a copy of this summary, then click the "Save Enrollment" button to submit your enrollment.

Employee Information

Last Name:	Public	**First Name:**	John
M.I.:	Q	**Suffix:**	
Employee Number:	999802		
Record Last Updated On:	09/01/2004 2:34:01 PM EST		
Record Last Updated By:	EMPLOYEE		
Date/Time Form Signed:	09/01/2004 12:39:00 PM EST		

Healthcare Plan

Healthcare Plan Selection:	United Healthcare Choice Plus POS		
Type of Coverage:	Employee and Family		
		Cost Per Pay:	$269.56

Employer-Paid Benefit

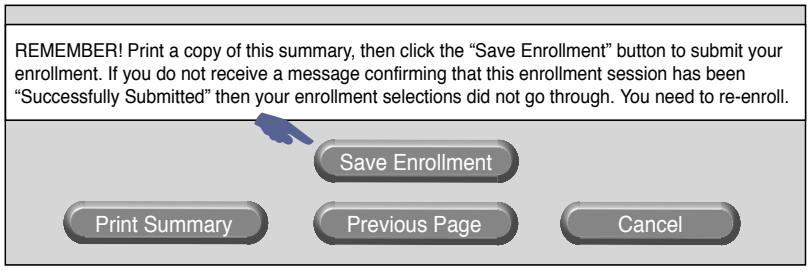
Standard Short-Term Disability

Short-Term Disability Upgrades

High Upgrade Short-Term Disability Cost:	$3.06

Flexible Spending Accounts

Medical FSA Per-Pay Deposit Amount:	Annual Amount Selected - $2,662.00		
		Cost Per Pay:	$121.00

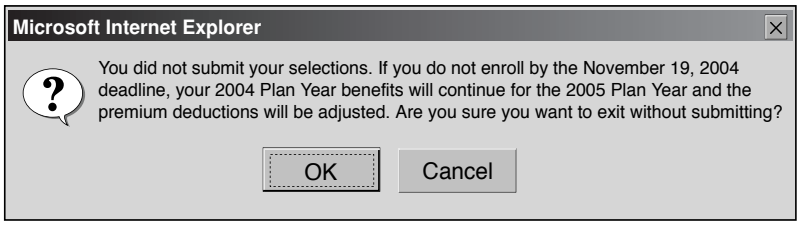


15 Saving Your Enrollment Record

Once you have reviewed your Benefits Summary and verified all information is correct, print a copy for your records. **Then click the "Save Enrollment" button.**

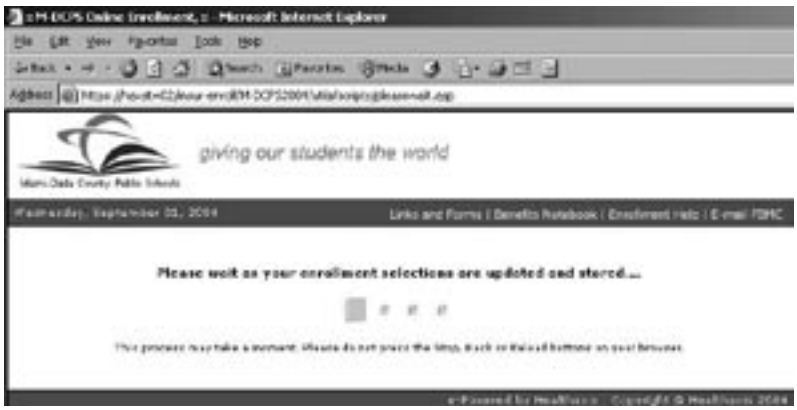
16 This is the pop up message you receive if you clicked the "Cancel" button.

If you wish to submit your selection and do not wish to exit, click "Cancel", and you will be returned to the "Benefit Summary" page, or if you click "OK" you will exit from the enrollment application and your benefit selections will not be saved.



17 Wait for your enrollment for enrollment information to be updated and stored.

Do not hit the Stop, Back or Reload button of your browser during this process or your online Enrollment Form will not be saved.



18 Submitted and Saved Successfully!

You will receive a "Submitted and Saved Successfully" message once your enrollment record has been updated.

PRINT THIS PAGE FOR YOUR RECORDS

2005 Employee Benefits Enrollment Form

Submitted and Saved Successfully

Your 2005 Miami-Dade County Public Schools Enrollment has been successfully submitted to the Online Enrollment System.

You will be able to view and print your Confirmation Statement online immediately after benefit selections are saved successfully. If you provided your e-mail address, you will not receive a printed Confirmation Statement. Otherwise, a paper Confirmation Statement will be mailed to your home address.

To view and print a copy of your Confirmation Statement, please click on the link to return to the main menu. From the main menu, click on the Confirmation Statement link. You will be able to view and print your most recent enrollment benefit selections.

Review your Confirmation Statement for accuracy. Remember, you will need to submit dependent eligibilty documentation by December 31, 2004 for any dependents that you add during the open enrollment period for healthcare, dental and vision.

Thank you for participating in the Miami-Dade County Public Schools Internet Enrollment Process.

Back to Login Page

19 Complete the Online Survey

You have the option of completing a short online survey about your online enrollment.

It is very important that we know how you rate this enrollment process. Please answer the brief survey to help us identify where we need to make improvements.

The results from this survey are used when planning next year's enrollment.

Online Survey

It is very important that we know how you rate this enrollment process. Please answer the brief survey to help us identify where we need to make improvements.

1. Did you use the How to Enroll pages in your Summary Guide to assist you in enrolling for your benefits online? ◯ Yes ◯ No
2. Did your computer or Internet Service have any problems when you were enrolling? ◯ Yes ◯ No
3. Did you use enrollment information that was provided in Spanish or Creole? ◯ Yes - Spanish ◯ Yes - Creole ◯ No
4. Did you use the Summary Guide, Online Benefits Notebook, or both for information on your benefits and other important information for Open Enrollment? ◯ Yes - Summary Guide ◯ Yes - Online Benefits Notebook ◯ Yes - both ◯ No
5. Were you able to navigate through the program easily? ◯ Yes ◯ No

Submit Survey Skip Survey

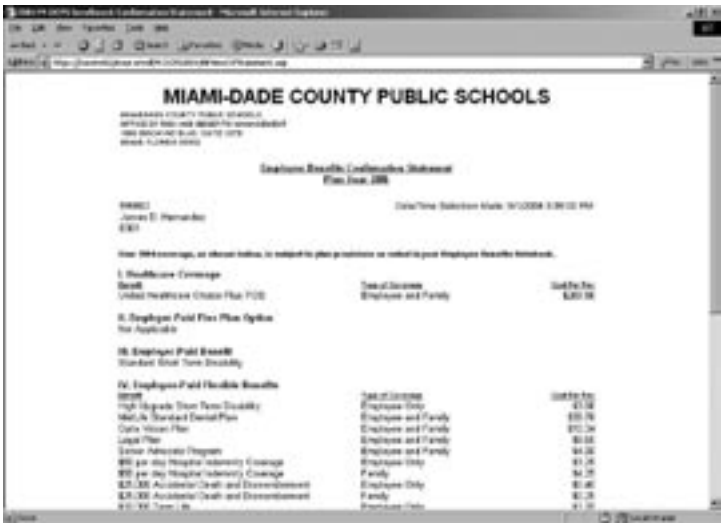
20 Review Your Confirmation Statement

You can view and print your Confirmation Statement immediately after you have saved your benefit selections. If you provided your e-mail address, you will not receive a printed Confirmation Statement. Otherwise, at the end of the Open Enrollment period, a paper Confirmation Statement will be mailed to your home address.

Sample Electronic Confirmation Statement

Upon printing your Confirmation Statement, review it carefully for accuracy. Any benefit changes during the Open Enrollment period must be made online. **After the enrollment deadline, enrollment changes will be on an appeals basis only. To appeal an enrollment selection, you must go to the Office of Risk and Benefits Management at 1500 Biscayne Blvd. #127S in person by December 15, 2004, before the beginning of the 2005 Plan Year.**

NOTE: **No faxes or phone calls are accepted**. If your Confirmation Statement does not match your enrollment selections, please contact FBMC Customer Service at 1-800-342-8017, 7 a.m. to 10 p.m. ET. Requests for all corrections, changes or appeals must be made prior to the commencement of the plan year. NO EXCEPTIONS WILL BE ALLOWED.



You may make changes to your online selections as many times as you wish until the end of Open Enrollment.

If you enroll multiple times, your enrollment selection for the 2005 Plan Year will be your last submission.

Dependent Eligibility Documentation Requirements

Dependent Relationship	Documentation Requirements	
Spouse	Marriage Certificate	
Natural Child	Birth Certificate (must list employee as a parent) NOTE: birth registration, SS card or passport is not valid proof	
Stepchild	Birth Certificate (must list employee's spouse as a parent) and Marriage Certificate.	
Adopted Child	Court Documentation of adoption	
Legal Custody or Guardianship	Court documentation defining guardianship or legal custody. NOTE: Notarized affidavit is not acceptable documentation	
Disabled Dependents Over Age 25	Social Security Disability Documentation. Disabled dependents are eligible only if covered by a School Board Healthcare plan or Flexible Benefits plan prior to the date of disability.	
Grandchildren *For specific eligibility requirements, see benefit page.*	**UNDER 18 MONTHS OLD** Birth Certificate (must list employee's child as a parent) NOTE: the parent must be a covered dependent; if not, same as Legal Custody or Guardianship	**OVER 18 MONTHS OLD** Legal Custody or Guardianship documentation

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Dependent Eligibility Documentation

Return To: School Mail: WL 9112 Suite 127S

US Mail: Office of Risk & Benefits Management 1500 Biscayne Blvd., Suite 127S Miami, FL 33132

Employee Number _____

Social Security Number _____

Employee Name _____

Important Information

- Proof of eligibility must be on file for all listed dependents.
- If proof was not submitted to FBMC previously or if you are adding new dependents, you must submit proof of eligibility by December 31 2004. Otherwise, coverage will be terminated effective January 1, 2005 for any dependent whose eligibility has not been verified. Claims incurred will not be paid and any premiums deducted will not be automatically issued. You must request a refund, if applicable, from Payroll Deduction Control.
- **(Include this form with the required documentation).**

DEPENDENT NAME (print clearly) Last Name First Name MI	**BIRTH DATE**	**RELATIONSHIP**	**GENDER**	**DOCUMENT PROOF INCLUDED** (birth certificate, marriage certificate, etc.)

Employee Signature _____ Date _____

FBMC/M-DCPS/1004

Domestic Partner Eligibility Documentation Requirements

Relationship	Documentation Requirements
Domestic Partner A copy of the Domestic Partnership Affidavit is available on the Open Enrollment Web site at www.dadeschools.net.	Affidavit of Domestic Partnership and any two of the following: • Joint mortgage or lease of residence • Joint ownership of a motor vehicle • Joint bank or investment account • Joint credit card or other financial responsibility • Will naming the partner as the beneficiary • Life Insurance policy naming the partner as the beneficiary • Assignment of durable power of attorney or healthcare proxy
Children of Domestic Partner	Birth Certificate (must list Domestic Partner as a parent) and Domestic Partner documentation as defined above. **NOTE:** Domestic Partners must be included in coverage. You must select "Employee and Domestic Partner" coverage.
Grandchildren of Domestic Partner	Birth Certificate (must list Domestic Partner's child as a parent) and children of Domestic Partner documentation as defined above. **NOTE:** Domestic Partners must be included in coverage. You must select "Employee and Domestic Partner" coverage. Legal Custody or Guardianship documentation

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Important Information

Proof of eligibility must be provided for Domestic Partner and all listed Children or Grandchildren of Domestic Partner (Include this form with the required documentation).

Employee Number _____

Employee Name _____

Social Security Number _____

RETURN BY U.S. MAIL TO:
Office of Risk & Benefits Management
1500 Biscayne Blvd., Suite 127S
Miami, FL 33132

RETURN BY SCHOOL MAIL TO:
Work Location 9112, Suite 127S

Indicate the relationship of your dependent on the form below.
DP = Domestic Partner **DC** = Child of Domestic Partner **GRC** = Grandchild of Domestic Partner

DEPENDENT NAME (print clearly) Last Name First Name MI	**BIRTH DATE**	**RELATIONSHIP**	**GENDER**	**DOCUMENT PROOF INCLUDED** (birth certificate, joint mortgage, etc.)

Employee Signature_____ Date_____

FBMC/M-DCPS/1004

Can I add or delete dependent coverage and make changes in my benefit elections during the year?

A participant is permitted to make changes to his or her elections mid-plan year only for legitimate Change in Status, meaning, "on account of and corresponding with a change in status that affects eligibility for coverage." If you experience a qualifying Change in Status (CIS), the election changes must be requested within 30 days from the qualifying event and the change must be consistent with the type of event. However, you cannot change your medical or dental plan insurance provider. You may add dependents to your existing coverage or delete your dependents. Please refer to the Change in Status events information on Page 17.

Domestic Partners and their Child(ren)

The Internal Revenue Service (IRS) Section 125 "Change In Status: Rules and Guidelines" do not apply. An employee may terminate their Domestic Partners and/or child(ren) at any time of the year, but may not reinstate their coverage until the following Open Enrollment period (effective January 1st of the following plan year) as long as all of the eligibility criteria has been met again. An employee may add their Domestic Partner if eligibility requirements are met during the plan year or due to loss of other coverage.

An employee and their Domestic Partner must sign an Affidavit of Domestic Partnership which states that the employee and domestic partner are:

- Each eighteen years of age or older and mentally competent
- Have a close and committed personal relationship, and are each other's sole domestic partner not married to or partnered with any other spouse, spouse equivalent or domestic partner
- Have provided true and accurate required documentation of their relationship, and
- Each understands and agrees that in the event any of the statements set forth on the affidavit are not true, the insurance or health care coverage for which the Affidavit is being submitted may be rescinded and/or each shall jointly and severally be liable for any expense incurred by the employer, insurer or health care entity.

For a copy of the Affidavit of Domestic Partnership, log on to www.dadeschools.net and click on 2005 Benefits Open Enrollment.

If I experience a 'Change in Status' event, how and when must I request the CIS form in order for the change to be approved?

You must call Fringe Benefits Management Company at 1-800-342-8017 within **30 days** from the date of the valid event and request a Change In Status Election Form.

Documentation supporting the change in status must be submitted with the form. **Requests made after the 30th day from the valid event date, and forms and documentation received after the due date, will not be granted. You will have to wait until the following annual Open Enrollment period to make any changes to your benefits.**

When I add dependents through a Change in Status, when do their benefits become effective?

Coverage for your dependents becomes effective on the 1st of the month following your first payroll deduction, except for newborns** and adopted dependents. Your newborn dependents are covered from their date of birth; adopted dependents are covered effective the date of placement. Valid documents are required.

****Your newborn child is not automatically enrolled by your employer or group health plan.** You must add your newborn dependent within 30 days, even if your current coverage includes employee & children, or employee & family coverage or employee and Domestic Partner and their child(ren). Don't forget to include the proper documentation when adding a dependent. See Page 14 &15 for more details.

When I delete a dependent through a Change In Status, when does their coverage terminate?

Coverage for your dependent(s) is terminated effective the last day of the month after receipt of a completed Change in Status Form and supporting documentation.

NOTE: Any 10-month employee submitting a Change in Status Form after the end of the school year will have the form processed with a benefits termination date of August 31, 2005.

If I decline School Board healthcare coverage, but I lose my other coverage, can I re-enroll under a School Board plan mid-year?

You may only enroll in a School Board healthcare plan mid-year if you have lost other **group** insurance coverage. Supporting documentation will be required.

PLEASE REFER PAGE 17 FOR CHANGE IN STATUS EVENTS.

Mid-Year Benefit Changes In Status (CIS)

Forms must be requested within 30 days from the date of the event listed below. You must contact FBMC at 1-800-342-8017 for a CIS election form. Appropriate documentation supporting the Change in Status Event is required when returning the form.

Marital Status

A change in marital status includes marriage, death, divorce or annulment (legal separation is not recognized in the State of Florida).

Change in Number of Eligible Dependents

A change in number of dependents, *includes* the following: birth, death, adoption, and placement for adoption. Existing eligible dependents can also be added whenever a dependent gains eligibility as a result of a valid CIS event.

Change in Status of Employment Affecting Coverage Eligibility

Change in employment status of the employee, or a spouse or dependent of the employee that affects the individual's eligibility under an employer's plan; 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 due to: attainment of 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 the network service area (except for Medical Expense FSAs).

Open Enrollment Under Other Employer's Plan

You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if*:

- their employer's plan year is different from your employer's plan year,
- they participate in their employer's plan, and
- their employer's plan permits mid-plan year election changes under this event.

* Does not apply to a Medical Expense FSA.

Judgement/Decree/Order

If a judgement, decree, or order from a divorce, annulment, or change in legal custody requires that you provide accident or health coverage for your dependent child (including grandchild 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 revoke coverage only for that dependent child and only if the other individual actually provides the coverage.

*Does not apply to Dependent Care FSA.

Medicare/Medicaid

Gain or loss of Medicare/Medicaid eligibility and enrollment may trigger a permitted election change.

HIPAA

If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC Sec. 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a **pre-tax** basis, effective retroactive to the date of the CIS event, **if you enroll your new dependent within 30 days** of one of the following CIS events: birth, adoption, or placement for adoption. Note that a Medical Expense FSA is **not** subject to HIPAA's special enrollment provisions if it is funded **solely** by employee contributions.

Other Election Changes

Domestic Partner and their children: The Internal Revenue Service (IRS) Section 125 "Change in Status" rules and guidelines do not apply. An employee may terminate coverage for their Domestic Partner and/or their child(ren) at any time of the year, but may not reinstate their coverage until the following Open Enrollment Period (effective January 1st of the following plan year) as long as all of the eligibility criteria has been met once again.

Open Enrollment Facts

1. What is the Open Enrollment Period? The Open Enrollment Period is a period of time, determined by the employer, during which the employee is allowed to make any changes to his/her benefits for the following plan year.

NOTICE: No changes are allowed after the commencement of a plan year. January 1, 2005. (see Page 15 for exceptions)

2. Must all eligible employees enroll for benefits effective January 1, 2005? No. If you do not make changes to your 2004 Plan Year benefits, your current benefits will continue and any new premiums will be adjusted for the 2005 Plan Year with any applicable rate changes. However, if you would like to add or make changes to your benefits or dependent coverage, you must do so by the end of your Open Enrollment period, which is November 19, 2004.

3. If I am hired during the Open Enrollment period, must I enroll for the current plan year as well as the next plan year? No. The benefits you select for Plan Year 2004 will continue for the 2005 Plan Year. However, any premiums revised will be adjusted.

4. What changes can I make during the Open Enrollment? During this period, you may purchase or discontinue benefits and delete or add dependents. Any dependent child who has reached or will reach age 25 in the year 2004 (born in1979), and is currently covered under any of your plans, must be deleted during this Open Enrollment period. If a covered dependent is disabled, proof must be submitted in order for coverage to continue beyond 25 years of age.

5. When is the last day to enroll for benefits effective January 1, 2005? You must complete your online enrollment selections by midnight on November 19, 2004.

6. What happens if I do not enroll by the enrollment deadline? Anyone that does not enroll by the deadline will continue their current benefits and family coverage for the 2005 Plan Year.

7. What if I do not have a computer or Internet access available? If you do not have access to the Internet, you may visit the Office of Risk and Benefits Management for assistance at 1500 Biscayne Boulevard, Conference Room 127. Enrollment Representatives and Internet access are available weekdays from 8:00 a.m. to 4:30 p.m., during the Open Enrollment period.

8. What if after I enroll I want to change my benefits selection? You may log on to the Internet and change your benefits selection as many times as you want throughout the Open Enrollment period, which ends November 19, 2004. Your last **saved** and **submitted** selection will be your benefits effective January 1, 2005.

9. Can I decline any of the Employer-Paid benefits? Yes. However, you may only decline healthcare coverage.

10. If I decline healthcare coverage, what happens to the Board contribution toward my benefits? In lieu of Board-paid healthcare coverage, the Board contributes $100 per month toward a FlexPlan Option. See Page 34 for a description of those options.

11. Can I select coverage for myself through one Healthcare Plan or FlexPlan benefit and another for my family? No. You and your family must be covered with the same Healthcare and FlexPlan benefit.

12. How do I view the United Healthcare or FlexPlan Provider Directory? Go to the 2005 Employee Benefits Enrollment Button and click on the Provider Directory of the company you desire.

Confirmation of Benefits

13. Will I receive a confirmation of my 2005 benefits selection? Yes. If you provide your e-mail address at the time of enrollment on the Internet, you will be able to view and print your confirmation statement online, **but you will not receive a printed confirmation statement**. Otherwise, after the end of the Open Enrollment period, the Confirmation Statement will be mailed to your **home** if you did not provide your email address. Review the statement carefully for accuracy. If you find an error before the enrollment deadline, you may log on to the Internet and re-enroll. If your Confirmation Statement does not match your enrollment selections and it is past the enrollment deadline, call FBMC Customer Service at 1-800-342-8017. Requests for all corrections, changes or appeals must be made prior to December 15, 2004. NO EXCEPTIONS WILL BE ALLOWED.

14. When will deductions begin for my 2005 benefits? Your 2005 premium deductions will begin on your paycheck of January 7, 2005.

Who Is Eligible for Coverage**

Who is an eligible dependent? An eligible dependent is defined as:

SPOUSE: Your spouse is considered your eligible dependent for as long as you are lawfully married.

DOMESTIC PARTNER: Your Domestic Partner is eligible for coverage as long as he/she:

- is of the same or opposite sex
- shares your permanent residence
- has resided with you for no less than one year
- is no less than 18 years of age and is not related to you by blood in a manner that would bar marriage under applicable state laws
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements:
- joint mortgage or lease for a residence
- joint ownership of a motor vehicle
- joint bank or investment account, joint credit card or other evidence of joint financial responsibility
- a will and/or life insurance policies which designates the other as primary beneficiary, beneficiary for retirement benefits, assignment of durable power of attorney or health care proxy.

To add a Domestic Partner, an employee must register, under applicable state or municipal laws or provide a duly sworn Affidavit of Domestic Partnership confirming the eligibility above. In addition, the definition of domestic partner will be met as long as neither partner:

- Has signed a domestic partner affidavit or declaration with any other person within 12 months before designating each other as domestic partner
- Is not legally married to another person, or
- Does not have any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

NOTE: A Domestic Partner and the child(ren) of a Domestic Partner are eligible. They do not qualify for IRS Section 125. All employee-paid benefits will be on a post-tax basis. Domestic Partners or their child(ren) who do not meet the eligibility criteria, will have benefit(s) coverage terminated effective January 1, 2005, and any claims incurred will not be paid. All other selected employee-paid benefits will continue for the remainder of the plan year on a post-tax basis. The Domestic Partner must also be included in that coverage. Domestic Partners and/or their children do not qualify as eligible dependents for FSA Reimbursement.

CHILDREN: Children can include natural born children, stepchildren, adopted children and children for whom you have been appointed legal guardian. Children of your Domestic Partner are eligible for coverage only, if the Domestic Partner is also included in the coverage.

Your unmarried children are eligible from birth until the end of the year in which the child reaches age 25, if the child is: (1) dependent on you for support; or (2) lives in your household; or (3) is enrolled full time or part time in an accredited school, college or university.

NEWBORN CHILDREN: A natural born child, adopted child, the child of your Domestic Partner, or a child for whom you have been appointed legal guardian who is born or becomes eligible while a policy is in effect will be covered from date of birth/event. However, coverage is not automatic. You must request a Change In Status Election form within 30 days of the event and add your newborn child(ren)'s information.

DISABLED CHILDREN: Coverage may be kept in force beyond the age limit for any child who becomes totally disabled while covered under any of the plans. Proof of disability (Social Security disability papers) must be provided to FBMC - 1500 Biscayne Blvd., Suite 127S, Miami, FL 33132.

GRANDCHILDREN: A newborn child of a covered dependent is eligible from birth until the end of the month in which the child reaches 18 months of age. However, if the parent becomes ineligible during the grandchild's 18 months eligibility period, coverage for both the parent and the child will terminate.

NOTE: Hospital Indemnity Coverage offered by LINA **does not** cover grandchildren.

Flexible Spending Accounts

15. Whose dependent care expense can I include in my Dependent Care FSA? Your child and dependent care expenses must be for the care of a qualifying person.

A qualifying person is:

1) Your dependent child who is 12 years of age or younger when the care was provided and for whom you can claim an exemption, 2) your spouse who was physically or mentally not able to care for himself or herself, or 3) your dependent who was physically or mentally not able to care for himself or herself and for whom you can claim an exemption. See the Dependent Care FSA section of this book for more details.

** PLEASE SEE EACH PRODUCT PAGE FOR SPECIFIC DEPENDENT ELIGIBILITY INFORMATION. ELIGIBILITY FOR HEALTHCARE, DENTAL, AND VISION WILL BE VERIFIED BY THE CONTRACT ADMINISTRATOR, FRINGE BENEFITS MANAGEMENT COMPANY. IF PROOF IS NOT SUBMITTED BY 12/31/04 THE DEPENDENT COVERAGE WILL BE TERMINATED AND CLAIMS WILL NOT BE PAID. IF DEPENDENT COVERAGE IS TERMINATED AND PREMIUMS WERE DEDUCTED, REFUNDS WILL NOT BE AUTOMATICALLY ISSUED. TO REQUEST A REFUND, IF APPLICABLE, CONTACT PAYROLL DEDUCTION CONTROL AT 305-995-1655. ALL OTHER BENEFITS WILL BE VERIFIED BY THE INDIVIDUAL INSURANCE COMPANY AT THE TIME A CLAIM IS FILED. PLEASE REFER TO PAGE 12 FOR REQUIRED DOCUMENTATION.

Flexible Spending Accounts (continued)

16. Whose medical expenses can I include in my Medical Expense FSA? You can include medical expenses you paid for your spouse or dependent. A person generally qualifies as your dependent for purposes of the medical expense deduction if:

1) That person lived with you for the entire year as a member of your household or is related to you, 2) That person was a U.S. citizen or resident, or a resident of Canada or Mexico for some part of the calendar year in which your tax year began, and 3) You provided over half of that person's total support for the calendar year. You can include the medical expenses of any person who is your dependent, even if you cannot claim an exemption for him or her on your return. Domestic Partner and their children are ineligible.

Effective Date Of Coverage

17. When are benefits for the new plan year effective and for how long? Your benefits become effective on January 1, 2005 of this plan year and continue through December 31 as long as full-time employment is continued. Should employment terminate, coverage will cease at the end of the calendar month in which employment terminates. Benefits will remain in effect through August 31 for 10-month employees who terminate employment in June, provided they work on the last day of the school year.

NOTICE: An individual who loses coverage under the plan becomes entitled to elect COBRA. The individual has the right to continue his or her medical, dental and vision coverage under COBRA law for a period of 18 months and/or medical expense FSA deposits until the end of the plan year following termination of employment.

COBRA

19. When should I drop an ineligible dependent? If your dependent child reaches age 25 in the 2004 Plan Year (born in 1979), you must drop him or her during the Open Enrollment period for coverage to terminate on December 31, 2004. Dependents that become ineligible any time during the plan year must be dropped as soon as the ineligibility (divorce, death, etc.) occurs within 30 days. Coverage for the ineligible dependent will be terminated at the end of the month after the Change in Status is processed.

Claims will not be paid nor will premiums be automatically refunded for ineligible dependents.

DISABLED CHILDREN: Coverage may be kept in force beyond the age limit for any child who becomes totally disabled while covered under any of the plans. Proof of disability must be provided to FBMC - 1500 Biscayne Blvd., Suite 127S, Miami, FL 33132.

20. How can my qualified dependent continue coverage under medical, dental, or vision plans? Within 30 days from the date of loss of eligibility, your qualified dependent must notify the COBRA Representative in the Office of Risk and Benefits Management at (305) 995-7132. A qualifying event notice and an application will be forwarded to the qualified dependent within 14 calendar days.

A Domestic Partner and their child(ren) do not qualify for COBRA.

21. How long does the qualified dependent have to make his/her COBRA elections? The qualified dependent has a 60-day period to elect whether to continue coverage. Once a qualified dependent has elected COBRA, he/she has 45 days to pay for the coverage. COBRA is retroactive if elected and paid for by the qualified dependent.

22. What are the periods of coverage for COBRA qualifying events? If the qualifying event is the employee's termination of employment, the employee, spouse, and dependent child are eligible for COBRA for up to 18 months; if the event is a divorce, or death of a covered employee, the spouse, and dependent child are eligible for coverage for up to 36 months; and if the event is loss of a "dependent child" status, the dependent child is eligible for 36 months.

You may elect to continue your Medical Expense FSA and continue to receive reimbursements through the end of the plan year.

Board-Approved Leave of Absence

23. If I take a Board-approved leave of absence, whom do I contact about my benefits? Once your leave is approved, and the Office of Risk and Benefits Management receives notification, you will be eligible for applicable benefits according to your bargaining unit and type of leave. You will be billed for any employee-paid benefits.

Miami-Dade County Public Schools implements the Family and Medical Leave Act of 1993 (FMLA) through provisions contained in the School Board Rules and collective bargaining agreement.

24. What if I am unable to pay premiums while on leave? The benefits for which you have been billed will be cancelled if payment is not received by the due date and any claims incurred will not be paid unless otherwise provided by law. Employer-paid benefits will be automatically reinstated upon your return to work. However, in order to reinstate any employee-paid benefits cancelled due to non-payment while on leave, you must request a Change in Status Election form. See the Changes in Status event information on Page 17 for further details.

Benefits at Retirement

25. If I retire, whom do I contact for benefits information? When you complete your retirement papers, the Retirement Office will notify the Office of Risk and Benefits Management and a package will be mailed to your home containing the information you need to continue your Healthcare coverage, life insurance benefits and flexible benefits plans after you retire. You will have 31 days to select your benefits. Only those dependents which were covered under your medical and flexible benefits plan at the time of your retirement will be eligible to continue coverage. You may add or drop dependents during the annual Open Enrollment for retirees. You may only continue life insurance and accidental death and dismemberment at the same level in effect at your retirement. If you retire while on a leave of absence and have no active healthcare and/or flexible benefits at retirement, you will not be eligible to enroll in any benefits not in effect.

Termination of Employment

26. Does my insurance coverage end when I terminate my employment? Benefits for you and your dependents continue to the end of the calendar month in which you terminate employment. However, benefits for 10-month employees who terminate at the end of the school year remain in effect through August 31 provided they work the last day of the school year.

27. Can I continue my own and my dependents' medical, dental and vision coverage if I terminate employment? Yes. According to federal and state law, you can continue your own and/or your dependents' coverage for a period of 18 months following a termination of employment by applying for COBRA. Upon expiration of COBRA, you can also convert the coverage to an individual plan. However, both involve a cost to you. You will be notified of these rights when you terminate; or you can call the Office of Risk and Benefits Management at (305) 995-7132 and speak to a COBRA Representative to inquire further on what benefits will be available to you.

28. Can I continue my Board Life insurance if I terminate? You may apply for a conversion policy for all or any portion of your or your dependents' life insurance in effect at termination. You must complete a conversion application, which is available from Metropolitan Life Insurance Company by calling (305) 591-9485 within 31 days of termination.

29. What happens to my FSA contributions if I terminate employment or retire? If you terminate employment or retire, your FSA contributions will stop with the pay period preceding your last day of employment. You cannot continue to submit expenses incurred after your last day of employment for reimbursement from your Medical Expense FSA unless you continue to make post-tax contributions to your account through COBRA. Eligible Dependent Care expenses incurred after termination of employment are reimbursable until funds in your account are exhausted.

Remember, you have until March 31, 2006 to submit a request for reimbursement for expenses incurred before your last day of employment. See the Flexible Spending Accounts section of this book for more details.

Claims and Claim Forms

30. What claim form must I complete for my dental and vision benefits? Claim forms for the MetLife Dental Plans and the Optix Vision Out-of-Network Plan are available at your worksite, the Office of Risk and Benefits Management or from FBMC Customer Service (1-800-342-8017, Monday through Friday, 7 a.m. -10 p.m., ET). You may also visit www.dadeschools.net to download claim forms. The CompBenefits Dental Plan and the Optix Vision Panel plan do not require claim forms.

31. Where can I obtain claim forms and assistance with my other FlexPlan benefits? Fringe Benefits Management Company Customer Service helps you determine the eligibility of a specific claim for your flexible benefits. FBMC will send you claim forms and help you to properly complete the forms. Call 1-800-342-8017 from 7 a.m. to 10 p.m., Monday through Friday for assistance. You may also visit **www.fbmc-benefits.com** to download claim forms, as well as various other forms you may need.

32. When do I request a claim form for my Short-Term and Long-Term Disability? Your claim should be submitted within 30 days after the date of your disability begins or as soon as possible. However, UNUM must receive written proof of your claim no later than 90 days after your elimination period.

How Does The Flexible Benefits Plan Affect Other Benefits?

Your Retirement Benefits

Your contributions to the FlexPlan do not reduce your future Florida Retirement System (FRS) benefits or current contributions to FRS.

Tax Sheltered Annuity

Participating in the FlexPlan does not affect your Tax Sheltered Annuity (TSA) contribution. That is, FlexPlan contributions do not reduce includable compensation* from which the maximum deferrable amount is computed under the 403(b) plan.

In 2004, if the employer or employee contributed to a 401(k) plan, $13,000 was the maximum deferrable amount under both the TSA and 401(k) plans. The maximum deferrable amount may be subject to change in 2005. Employees with questions about the specific effect of FlexPlan contributions on their TSA should contact the TSA Provider.

*Includable compensation is the gross income shown on your W-2 form.

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 2005, the maximum taxable annual wage for FICA is $87,900. 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.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call FBMC Customer Service at 1-800-342-8017 for an approximation.

Itemized Deductions

The portion of your salary set aside for benefit premiums and FSAs through the FlexPlan will not be included in the taxable salary reported to the IRS on your W-2 form. However, your contributions to your Dependent Care FSA will appear on your W-2 form for informational purposes only. You will not have to claim these payments as deductions at the end of the year. Your pre-tax FlexPlan reductions cannot be used as itemized deductions for income tax purposes at the end of the year.

Pre-tax/Post-tax

Employees who wish to have their 2005 premiums deducted POST-TAX may do so by indicating so during their enrollment. If a selection is not made, applicable deductions and employer contributions will continue on a pre-tax basis. Regardless of your selection, Flexible Spending Accounts are always PRE-TAX. Your Legal and SeniorAdvocate Plan are always POST-TAX.

When an employee elects pre-tax deductions, all employee-paid premiums will be taken prior to federal withholding tax. All benefits are subject to pre-tax deductions except those that are not exempt from taxation — Legal Coverage and the Senior Advocate Program. When an employee elects post-tax deductions, all employee-paid premiums will be taken after federal withholding tax has been taken. All benefits are subject to post-tax deductions except those that are exempt from taxation.

If you upgrade your Board-Paid Standard Short-Term Disability plan to the High Short-Term Disability plan, your premiums will be deducted on a PRE-TAX basis and you will receive a W-2 form for the calendar year in which benefits were paid. However, if your premiums were paid on a POST-TAX basis, benefits paid to you will not be taxed. The premiums paid by the School Board for the Standard Disability plan will be on a PRE-TAX basis.

Employees who elect coverage for Domestic Partners will automatically have post-tax deductions on all employee-paid benefits except those that are exempt from taxation. Should the Domestic Partner coverage be denied, all benefits will continue on a post-tax basis except those that are exempt from taxation.

UNITED HEALTHCARE CHOICE PLUS POS and UNITED HEALTHCARE CHOICE HMO

The School Board will provide employee-only healthcare coverage at no cost to all full-time employees that select a School Board sponsored healthcare plan.

The School Board is also funding a monthly percentage toward each tier of dependent coverage. The dependent healthcare premiums listed below reflect the per-payroll rates **after** the School Board contribution has been applied.

Choice Plus POS	Spouse/Domestic Partner	Child(ren)	Family / Family with Domestic Partner
A-H-W-X PAY CODES 10 MONTH 20 Deductions	$197.14	$166.34	$323.47
J PAY CODE 11 MONTH 24 Deductions	$164.29	$138.62	$269.56
C-Y-D PAY CODES 12 MONTH 26 Deductions	$151.65	$127.95	$248.82

Choice HMO	Spouse/Domestic Partner	Child(ren)	Family / Family with Domestic Partner
A-H-W-X PAY CODES 10 MONTH 20 Deductions	$123.36	$106.07	$218.48
J PAY CODE 11 MONTH 24 Deductions	$102.80	$88.40	$182.07
C-Y-D PAY CODES 12 MONTH 26 Deductions	$94.89	$81.60	$168.06

All amounts are per-pay-period deductions. Rates are effective through 12/31/05.

The School Board contribution toward each tier of dependent coverage is on a pre-tax basis. Therefore, employees selecting coverage for a domestic partner or family with a domestic partner will be subject to withholding and FICA tax on the pre-tax premium contributed by the School Board at the end of the year.

If you choose to continue your current healthcare coverage, you will NOT receive a new ID Card. A new ID Card will be sent if you change plans.

Temporary ID Card

Provided is a temporary Group Benefits Identification Card. Present an ID card to your provider or pharmacist on your next visit. Please write in the covered employee's name and social security number on the blank lines.

When you receive a permanent ID card, please destroy this temporary card and replace it with the permanent card.

This identification card is not proof of membership, nor does it guarantee coverage. Persons with coverage that remains in force are entitled to benefits under the terms and conditions of the group health benefit plan.

Cut Here

Cut Here

UnitedHealthcare®
A UnitedHealth Group Company

Group Benefits ID Card

Employer Name: Miami-Dade County Public Schools
Group Number: 702706

Employee Name: _____

Employee SSN: _____

For Member Services Call: 1-866-365-7126

Temporary ID Card

	UNITED Healthcare Choice Plus Point of Service (POS) The Point of Service, commonly known as "POS", allows you the flexibility to use either In- or Out-of-Network providers at the time you receive medical care. When using the In-Network program, you must select a provider within the Network of contracted physicians. If you elect to use the Out-of-Network program, you may use any licensed physician or hospital of your choice. When seeking Out-of-Network services, it is the member's responsibility to file the claim(s) with UHC. Payment of these claim(s) will be sent directly to the member by UHC and it is the member's responsibility to reimburse the Out-of-Network provider for the services rendered.		UNITED Healthcare Choice Health Maintenance Organization (HMO) With the HMO plan, you have the freedom to visit any network physician without the need for a referral. The majority of your routine health care services provided in the network are covered for a flat co-payment amount. This plan also includes preventative care and a Vision program for you and your covered family members. For all other services, UnitedHealthcare will pay 80% of eligible expenses after you have satisfied the Annual Deductible. You are responsible for the Annual Deductible and 20% of the eligible expenses. There is no Out-of-Network coverage in this plan.	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	
Annual Medical Expense Deductible	None	$500 per Covered Person per calendar year, not to exceed $1,000 for all Covered Persons in a family	NEW! $250 per Covered Person per calendar year, not to exceed $500 for all Covered Persons in a family	
Hospital Admission Charge	$150 co-pay per day - $450 per admission maximum	Plan pays 70% allowable after the annual deductible. You pay Balance	You pay 20% of Eligible Expenses after the annual deductible.	
Annual Out-of-Pocket Maximum Includes facility co-pays, excluding Rx, Physician co-pays and deductibles	$1,500 for individual; $3,000 for family	$3,000 for individual; $6,000 for family	NEW! $1,500 for individual; $3,000 for family	
Physicians	No referral required	No referral required	No referral required	
Hospitals	**MIAMI-DADE COUNTY** Aventura Hospital Baptist Hospital of Miami Cedars Medical Center Coral Gables Hospital Hialeah Hospital Homestead Hospital Jackson Memorial Hospital Kendall Regional Medical Center Larkin Community Hospital Mercy Hospital Miami Children's Hospital Mount Sinai Medical Center Mount Sinai Miami Heart North Shore Medical Center Palmetto General Parkway Regional South Miami Hospital University of Miami Hospital & Clinics **BROWARD COUNTY** Broward General Medical Center Cleveland Clinic Coral Springs Medical Center Florida Medical Center Hollywood Medical Center Holy Cross Hospital Imperial Point Medical Center Joe Dimaggio Children's Hospital Memorial - Pembroke Memorial Regional Memorial - West North Broward Medical Center North Ridge Medical Center Northwest Medical Center Plantation General University Hospital Westside Regional Medical Center		Any other licensed hospital	**MIAMI-DADE COUNTY** Aventura Hospital Baptist Hospital of Miami Cedars Medical Center Coral Gables Hospital Hialeah Hospital Homestead Hospital Jackson Memorial Hospital Kendall Regional Medical Center Larkin Community Hospital Mercy Hospital Miami Children's Hospital Mount Sinai Medical Center Mount Sinai Miami Heart North Shore Medical Center Palmetto General Parkway Regional South Miami Hospital University of Miami Hospital & Clinics **BROWARD COUNTY** Broward General Medical Center Cleveland Clinic Coral Springs Medical Center Florida Medical Center Hollywood Medical Center Holy Cross Hospital Imperial Point Medical Center Joe Dimaggio Children's Hospital Memorial - Pembroke Memorial Regional Memorial - West North Broward Medical Center North Ridge Medical Center Northwest Medical Center Plantation General University Hospital Westside Regional Medical Center	

$ All co-payment and co-insurance expenses are eligible for reimbursement through your Medical FSA.

OUTPATIENT SERVICES Services listed below are provided after applicable physician office co-payment and/or annual medical expense deductible.	POS IN-NETWORK YOU PAY	POS IN-NETWORK PLAN PAYS	POS OUT-OF-NETWORK YOU PAY	POS OUT-OF-NETWORK PLAN PAYS	HMO IN-NETWORK YOU PAY	HMO IN-NETWORK PLAN PAYS
Who is a Primary Care Physician (PCP)	Family Practitioners, General Practitioners, Internists, Pediatricians				Family Practitioners, General Practitioners, Internists, Pediatricians	
Physician Charges						
Physician Office Visit	$15 co-pay	100% after co-pay	Balance	70% of allowable after annual deductible	$20 co-pay	100% after co-pay
Specialist Office Visit (No Referral Required)	$30 co-pay	100% after co-pay	Balance	70% of allowable after annual deductible	$20 co-pay	100% after co-pay
Preventive Care						
• Immunizations • Hearing examination (limit 1 per year through age 16)	$15 co-pay	100% after co-pay	Balance	70% of allowable after annual deductible	$20 co-pay	100% after co-pay
• Well child care (Immunizations included) • Physical examination (limit 1 per year) • Vision Screening for children through age 18 (limit 1 per year at PCP office)	$30 co-pay Co-pay depends on whether services are performed at a PCP or Specialist's office	100% after co-pay	Balance	70% of allowable after annual deductible		
• Gynecological services (office visit, pap tests) No referral required for any Gynecological services rendered throughout the plan year	$15 co-pay for annual Wellness Exam $30 co-pay for all other visits	100% after co-pay	Balance	70% of allowable after annual deductible	$0	100% after co-pay
• Mammograms (routine)* Covered Mammograms are age based as set forth by the American Medical Association and the Insurance Plan-Baseline Mammograms between ages 35-39 = one time; between ages 40-49 = bi-annually; 49-older = annually.	$0	100%	Same as in-network		$0	100%

$ All co-payment and co-insurance expenses are eligible for reimbursement through your Medical FSA.
* Hospital based routine mammorgraphy is not subject to co-pay for in- or out-of-network.

OUTPATIENT SERVICES Services listed below are provided after applicable physician office co-payment and/or annual medical expense deductible.	POS IN-NETWORK YOU PAY	POS IN-NETWORK PLAN PAYS	POS OUT-OF-NETWORK YOU PAY	POS OUT-OF-NETWORK PLAN PAYS	HMO IN-NETWORK YOU PAY	HMO IN-NETWORK PLAN PAYS
Diagnosis and Treatment (prior notification required for specific diagnostic procedures)						
• Laboratory - Quest and LabCorp	$0	100%	Balance	70% of allowable after annual deductible	$0	100% of Eligible Expenses
• Non-Hospital Based Diagnostic imaging (CT Scans, Pet Scans, MRI, nuclear medicine, X-Ray, mammography)	$0	100%	Same as in-network		20% of Elibigle Expenses* after the annual deductible	80% of Eligible Expenses
• Hospital Based Diagnostic imaging (CT Scans, Pet Scans, MRI, nuclear medicine, X-Ray and mammograms)	$100 co-pay	100% after co-pay	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible
• Medication administered at provider location	$0	100%	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual dedcuctible	80% of Eligible Expenses* after the annual deductible
• Short-term physical and respiratory therapy • Speech therapy	$20 per visit $20 per visit	100% after co-pay (40 visits each per calendar year) (40 visits each per calendar year)	Balance	70% of allowable after annual deductible	$20 per visit 20 visits-Physical Therapy 20 visits-Pulminary Rehab. 20 visits-Speech	100% after co-pay 20 visits-Occupational Therapy 36 visits-Cardiac Rehab. per calendar year
• Therapeutic Treatments (Dialysis, intravenous, chemotherapy, radiation, or other intravenous infusion therapy)	$0	100%	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual deductible 20 visits - speech	80% of Eligible Expenses* after the annual deductible
Maternity Care • pre- and post-natal care	$30 first visit only	100% after co-pay	Balance	70% of allowable after annual deductible	$20 first visit only	100% after co-pay
• childbirth classes	Not covered	$0	Not covered	$0	Not covered	$0
• obstetrical or midwifery services	$0 (all subsequent pre- and post-natal visits are covered at 100%, only initial visit to determine the pregnancy is charged)	100%	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual deductilbe	80% of Eligible Expenses* after the annual deductible
Outpatient Surgery (prior notification required)	$100 co-pay	100% after co-pay	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible
• Performed in physician's office	$25 co-pay	100% after co-pay	Balance	70% of allowable after annual deductible	$20 co-pay	100% after co-pay

$ All co-payment and co-insurance expenses are eligible for reimbursement through your Medical FSA.
* Eligible expenses = Contracted fees between United Healthcare and the licensed physicians, hospitals and facilities.

OUTPATIENT SERVICES Services listed below are provided after applicable physician office co-payment and/or annual medical expense deductible.	POS IN-NETWORK YOU PAY	POS IN-NETWORK PLAN PAYS	POS OUT-OF-NETWORK YOU PAY	POS OUT-OF-NETWORK PLAN PAYS	HMO IN-NETWORK YOU PAY	HMO IN-NETWORK PLAN PAYS
Oral Surgery (Resulting from accident or injury ONLY) (prior notification required) • Performed in physician's office	$25 co-pay	100% after co-pay	Balance	70% of allowable after annual deductible	$20 co-pay	100% after co-pay
Emergency Care In-area: hospital emergency room	$100 co-pay (waived if admitted)	100% after co-pay	$100 co-pay for emergency visit	100% after co-pay	$100 co-pay (waived if admitted)	100% after co-pay
Out-of-area: hospital emergency room	$100 co-pay (waived if admitted)	100% after co-pay	$100 co-pay for emergency visit	100% after co-pay	$100 co-pay (waived if admitted)	100% after co-pay
Urgent Care Facility	$25 co-pay	100% after co-pay	Balance	70% of allowable after annual deductible	$50 co-pay	100% after co-pay
Definition of Emergency Care	An emergency is defined as any problem for which delay in treatment may result in loss of life, limb or permanent disability. Some examples are: Suspected heart attack, serious burns, severe stomach or chest pains, uncontrollable bleeding, or extreme difficulty in breathing. NOTE: All follow-up care for emergencies must be provided by your Primary Care Physician.					
Mental Health and Substance Abuse (prior authorization required) • Crisis intervention	**For service call United Behavioral Health at 1-800-582-8220.**					
	$20 co-pay (Limit 30 visits per year for Individual sessions)	100% after co-pay	Balance (Limit 12 visits per year for Individual sessions)	70% of allowable after annual deductible	$20 co-pay (Limit 30 visits per year for Individual sessions)	100% after co-pay
• Alcohol and drug treatment**	$20 co-pay (Limit 30 visits per year for Individual sessions)	100% after co-pay	Maximum payable benefit is $35 per visit		$20 co-pay (Limit 30 visits per year for Individual sessions)	100% after co-pay
	$10 co-pay for group sessions in any of the above categories		All treatment limits to a maximum plan payable of $2,000 per Lifetime		$15 co-pay for group sessions in any of the above categories	
IN-HOSPITAL SERVICES Services listed below are provided after applicable hospital admission co-pay and/or the annual deductible.	**POS IN-NETWORK YOU PAY**	**POS IN-NETWORK PLAN PAYS**	**POS OUT-OF-NETWORK YOU PAY**	**POS OUT-OF-NETWORK PLAN PAYS**	**HMO IN-NETWORK YOU PAY**	**HMO IN-NETWORK PLAN PAYS**
Room and Board (prior notification required) • Semi-private • Intensive Care • Maternity • Routine Nursery (well baby care) • Operating room	Hospital Admission Charge (see Page 22)	100% after Hospital Admission Charge	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible

$ All co-payment and co-insurance expenses are eligible for reimbursement through your Medical FSA.

* Eligible expenses = Contracted fees between United Healthcare and the licensed physicians, hospitals and facilities.

** Any combination of Network and Non-network benefits for outpatient substance abuse services are limited to 30 visits per calendar year.

IN-HOSPITAL SERVICES Services listed below are provided after applicable hospital admission co-pay and/or the annual deductible.	POS IN-NETWORK YOU PAY	POS IN-NETWORK PLAN PAYS	POS OUT-OF-NETWORK YOU PAY	POS OUT-OF-NETWORK PLAN PAYS	HMO IN-NETWORK YOU PAY	HMO IN-NETWORK PLAN PAYS
Anesthesia	$0	100%	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible
Nursing Care • General	$0	100%	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible
• Private, if authorized by Plan	$0	100%	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible
Services and Supplies • Medications • Intravenous therapy • Supplies and dressing • Blood and administration	$0	100%	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible
Physician Visits and Services • Surgical • Medical	$0	100%	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible
Inpatient Therapy Services • Short-term physical therapy • Oxygen and respiration • Short-term rehabilitation	$0	100%	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible
Laboratory Diagnostic Imaging While confined overnight • X-ray • Nuclear medicine • Sonography • Radiation therapy	$0	100%	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible
Mental Health and Substance Abuse (prior notification required)	$100 per Admission	100% after Admission Charge	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible
	Limit to 30 days per calendar year for Mental Health Limit to 30 days per calendar year for Substance Abuse				Limit to 30 days per calendar year for Mental Health Limit to 30 days per calendar year for Substance Abuse	

$ All co-payment and co-insurance expenses are eligible for reimbursement through your Medical FSA.

* Eligible expenses = Contracted fees between United Healthcare and the licensed physicians, hospitals and facilities.

OTHER COVERED SERVICES Services listed below are provided after the applicable co-pay and/or the annual deductible.	POS IN-NETWORK YOU PAY	POS IN-NETWORK PLAN PAYS	POS OUT-OF-NETWORK YOU PAY	POS OUT-OF-NETWORK PLAN PAYS	HMO IN-NETWORK YOU PAY	HMO IN-NETWORK PLAN PAYS
Out-of-Area Hospitalization						
• Emergency	$100 (waived if admitted)	100% after co-pay	$100 (waived if admitted)	100% after co-pay	$100 (waived if admitted)	100% after co-pay
• Admission when referred by physician with approval	$150 per day Max $450 per Admission	100% after hospital admission charge	$150 per day Max $450 per Admission	100% after hospital admission charge	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible
Skilled Nursing Facilities (prior notification required)						
• Medically necessary	$0	100%	Balance	70% of allowable after annual deductible	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible
	(Limited to 90 days per calendar year)				(Limited to 60 days per calendar year)	
Emergency Ambulance Service	$50 co-pay	100% after co-pay	$50 co-pay	100% after co-pay	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible
Family Planning						
• Counseling and Evaluation	$15 co-pay in PCP's office	100% after co-pay	Not covered	$0	$20 co-pay	100% after co-pay
	$30 co-pay in Specialist's office	100% after co-pay	Not covered	$0	$20 co-pay	100% after co-pay
• Elective Sterilization performed in physician's office	$15 co-pay	100% after co-pay	Not covered	$0	$20 co-pay	100% after co-pay
• Implantable or Injectable Contraceptives	See prescription drug section		Not covered	$0	$20 co-pay	100$ after co-pay
					See prescription drug section	
Infertility Treatment (limited to diagnosis and correction only)						
Office visit including test and counseling	$30 co-pay	100% after co-pay	Not covered	$0	$20 co-pay	100% after co-pay
Infertility Surgery (including In-Vitro Fertilization, Artificial Insemination, GIFT, ZIFT, etc.)	Not covered	$0	Not covered	$0	Not covered	$0

$ All co-payment and co-insurance expenses are eligible for reimbursement through your Medical FSA.

* Eligible expenses = Contracted fees between United Healthcare and the licensed physicians, hospitals and facilities.

OTHER COVERED SERVICES Services listed below are provided after the applicable co-pay and/or the annual deductible.	POS IN-NETWORK YOU PAY	POS IN-NETWORK PLAN PAYS	POS OUT-OF-NETWORK YOU PAY	POS OUT-OF-NETWORK PLAN PAYS	HMO IN-NETWORK YOU PAY	HMO IN-NETWORK PLAN PAYS
Allergy						
• Treatment/injections administered by non-physician	$15 co-pay	100% after co-pay	Balance	70% of allowable after annual deductible	$20 co-pay	100% after co-pay
• PCP-evaluation/office visit	$15 co-pay	100% after co-pay	Balance	70% of allowable after annual deductible	$20 co-pay	100% after co-pay
• Specialist-evaluation/ office visit	$30 co-pay	100% after co-pay	Balance	70% of allowable after annual deductible	$20 co-pay	100% after co-pay
Home Health (prior notification required)	$15 co-pay	100% after co-pay	Balance	Maximum $1,000 per calendar year after annual deductible	20% of Eligible Expenses* after the annual deductible	80% of Eligible Expenses* after the annual deductible
Prosthetic Devices	$100 co-pay per item (initial purchase only)	100% after co-pay	Balance	$3,000 Maximum (initial purchase only) after annual deductible	20% of Eligible Expenses* after the annual deductible (initial purchase only) Benefits are limited to $2,500 per calendar year	80% of Eligible Expenses* after the annual deductible
Durable Medical Equipment	$100 co-pay per item (initial purchase only)	100% after co-pay	Balance	70% of allowable after annual deductible (initial purchase only)	20% of Eligible Expenses* after the annual deductible (initial purchase only) Benefits are limited to $2,500 per calendar year. Limits do not apply to Diabetic equipment & supplies	80% of Eligible Expenses* after the annual deductible
Audiology Screening	Not Covered	$0	Not Covered	$0	Not Covered	Not Covered
Podiatry (No Referral Required)	$30 co-pay	100% after co-pay	Balance	70% of allowable after annual deductible	$20 co-pay	100% after co-pay
Chiropractic (30 visit Maximum)	$30 co-pay	100% after co-pay	Balance	70% of allowable after annual deductible	$20 co-pay	100% after co-pay
Dermatologist	$30 co-pay	100% after co-pay	Balance	70% of allowable after annual deductible	$20 co-pay	100% after co-pay
Prescription Drugs						
• Network Pharmacy (up to 31-day supply)	$10 generic $30 brand name Preferred $50 brand name Non-Preferred	100% after co-pay	Balance	70% of allowable after annual deductible	$10 generic $30 brand name Preferred $50 brand name Non-Preferred	100% after co-pay
• Alternative Mail Away Program (only 90-day supply)	$25 generic/$75 brand name/$125 non-preferred (*Non-Preferred Brand) ***Note:** If member requests brand name drug when generic is available, member pays the Non-Preferred Brand name co-pay.		Not Applicable		$25 generic/$75 brand name/$125 non-preferred (*Non-Preferred Brand) ***Note:** If member requests brand name drug when generic is available, member pays the Non-Preferred Brand name co-pay.	

$ All co-payment and co-insurance expenses are eligible for reimbursement through your Medical FSA.

* Eligible expenses = Contracted fees between United Healthcare and the licensed physicians, hospitals and facilities.

United Healthcare Vision Program Overview

All employees and eligible dependents enrolled in the United Healthcare Choice Plus POS and United Healthcare Choice HMO plan will automatically be provided with the vision benefit described below. To view the physician listing and the approved vendor(s) where you may obtain your frames, lenses and contact lenses log on to www.dadeschools.net, click on the Open Enrollment button, then click on the button for United Healthcare.

	MEMBER PAYS
Routine Vision Exam	$15 Co-Payment, once a year (POS) $20 co-payment one every two years (HMO)

These benefits listed below are available in the South Florida region only for both POS and HMO.

FRAMES

Coordinated Collection Quality Series-	
$120 Retail Value	$60
Coordinated Collection Elite Series-	
$160 Retail Market Value	$85
Frames not included in the Coordinated Collection	Member receives 15% discount

BASE LENSES

Clear glass or plastic, all sizes, all powers, scratch resistant coating	
Single Vision Lenses	$45
Bifocal Lenses	$65
Trifocal Lenses	$95
Lens Options	Member pays Preferred Price

CONTACT LENSES

Fitting, follow up and materials	
Member receives 20% discount	
Replacement Contact Lenses	
(non-disposable)	Member receives 20% discount
Replacement Contact Lenses (disposable)	Member Pays Provider billed charges

Multiple Pairs of Eyeglasses

FRAMES

• Coordinated Collection Quality Series	$60
• Coordinated Collection Elite Series	$85
• Frames not included in the Collection	Member receives 15% discount

LENSES

• Single Vision Lenses	$45
• Bifocal Lenses	$65
• Trifocal Lenses	$95

Choice Plus POS - Exclusions & Limitations

Except as may be specifically provided in Section 1 of your Certificate of Coverage (COC) or through a Rider to the SPD, the following are not covered:

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aroma therapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of your COC under the heading Dental Services - Accident only and cleft lip / cleft palate treatment, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate, or as described in Section 1 of the COC under the heading of Dental Procedures - Anesthesia and Hospitalization. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly except in connection with cleft lip or cleft palate.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications except as described in Section 1 of the COC under the heading of Diabetes treatment. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded, except (a) bone marrow transplants and (b) medically appropriate medications prescribed for the treatment of cancer, for a particular indication, if that drug is recognized for the treatment of that indication in a standard reference compendium or recommended in medical literature. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings. Orthotic appliances that straighten or re-shape a body part (including some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of your COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Treatment of insomnia and other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias Mental Illnesses which will substantially improve beyond the current level of functioning, or for conditions not subject to favorable modification or management according to generally accepted standards of psychiatric care, as determined by the Mental Health/Substance Abuse Designee, including but not limited to... services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services for the treatment of mental illness or mental health conditions and substance abuse services and chemical dependency services that the Enrolling Group has elected to provide through a separate plan. Services or supplies that in the reasonable judgement of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the COC.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk except as described in Section 1 of the COC under the heading Prescription and Non Prescription External Formula.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Choice Plus POS - Exclusions & Limitations

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC. This exclusion does not apply to mammography testing.

L. Reproduction

Health services and associated expenses for in vitro fertilization; gamete intrafallopian transfer (GIFT) procedures; zygote intrafallopian transfer (ZIFT) procedures; embryo transport.

Surrogate parenting. The reversal of voluntary sterilization.

Fetal Reduction Surgery. Health services associated with the use of non-surgical or drug induced Pregnancy termination.

M. Services Provided under Another Plan

Health services for which other coverage is paid under arrangements required by federal, state or local law, including but not limited to coverage paid by workers' compensation, no-fault automobile insurance, or similar legislation.

Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of your COC. Any solid organ transplant that is performed as a treatment for cancer.

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services.

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of your COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.

In the event that a non-Network provider waives Co-payments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Co-payments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature, except as described in Section 1 of the COC under the heading Bones and Joints of the Jaw and Facial Region.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring.

Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

This Summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to your Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way the Certificate of Coverage, the Certificate of Coverage prevails. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.

Choice HMO - Exclusions & Limitations

Except as may be specifically provided in Section 1 of your Certificate of Coverage (COC) or through a Rider to the SPD, the following are not covered:

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aroma therapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of your COC under the heading Dental Services - Accident only and Cleft Lip / Cleft Palate treatment, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate, or as described in Section 1 of the COC under the heading of Dental Procedures - Anesthesia and Hospitalization. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly except in connection with cleft lip or cleft palate.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications except as described in Section 1 of the COC under the heading of Diabetes treatment. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded, except (a) bone marrow transplants and (b) medically appropriate medications prescribed for the treatment of cancer, for a particular indication, if that drug is recognized for the treatment of that indication in a standard reference compendium or recommended in medical literature. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of your COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Treatment of insomnia and other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias, Mental Illnesses which will substantially improve beyond the current level of functioning, or for conditions not subject to favorable modification or management according to generally accepted standards of psychiatric care, as determined by the Mental Health/Substance Abuse Designee, including but not limited to services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services for the treatment of mental illness or mental health conditions and substance abuse services and chemical dependency services that the Enrolling Group has elected to provide through a separate plan. Services or supplies that in the reasonable judgement of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the COC.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk except as described in Section 1 of the COC under the heading Prescription and Non Prescription Internal Formula.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC. This exclusion does not apply to mammography testing.

L. Reproduction

Health services and associated expenses for in vitro fertilization; gamete intrafallopian transfer (GIFT) procedures; zygote intrafallopian transfer (ZIFT) procedures; embryo transport.

Surrogate parenting. The reversal of voluntary sterilization.

Fetal Reduction Surgery. Health services associated with the use of non-surgical or drug induced Pregnancy termination.

M. Services Provided under Another Plan

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O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services.

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of your COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.

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Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring.

Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

This Summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to your Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way the Certificate of Coverage, the Certificate of Coverage prevails. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.

This year, **you** may decline Board-Paid Healthcare coverage, providing you agree to comply with provisions set forth in the Declination of Healthcare Affidavit. The affidavit is part of the web enrollment form.

In lieu of Board-Paid healthcare coverage, the Board has agreed to contribute $100 per month toward a FlexPlan Option. If you would like to select Family Coverage for any of the benefits below, refer to the specific benefits page for rates. The Cash Option will be paid to you through the payroll system on a monthly basis. It will be combined with regular gross pay for the pay period and will be subject to the regular applicable taxes.

NOTE: The Board will continue to provide Standard Short-Term Disability for all eligible, full-time employees.

You may select one of these options IF you decline Board-Paid Medical.

Employer-Paid FlexPlan Options

FlexPlan Benefits

Options	30	31	32	33	34	35
Long-Term Disability (Maximum)	●	●				
Legal* (Includes Family Coverage)	●	●				
MetLife Dental Plan (High)		●				
CompBenefits Dental Plan (High)	●					
Optix Vision Plan	●	●				
Cash Option (Monthly Payments)	$40.57/mo	$6.72/mo				$100/mo
Dependent Care FSA (Monthly Contribution)					$100/mo	
Medical Care FSA (Monthly Contribution)				$100/mo		
401(k)** Supplemental Retirement (Monthly Contribution)			$100/mo			

* Subject to withholdings and FICA tax.
** Subject to FICA tax.

Declination of Healthcare Coverage Affidavit

I hereby certify that:

1. I have been given an opportunity to fully participate in the group medical plans provided through Miami-Dade County Public Schools (M-DCPS).
2. The benefits of the plans have been thoroughly explained to me, and I decline to participate.
3. I have other medical coverage effective January 1, 2005.
4. I understand that if I desire to apply for medical insurance at a later date, I may enroll only during an annual enrollment period determined by M-DCPS or during a "special enrollment period" (change in status) following an IRS acceptable change in status. For example, you may in the future be able to enroll yourself or your dependents in a group medical plan through the School Board if you or your dependents lose coverage under an existing employer provided medical plan, provided that you request enrollment within 30 days after your other group product coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption (or placement for adoption), you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the event. In case of COBRA continuation coverage, you may be eligible for a special enrollment period if the COBRA coverage is exhausted. A special enrollment period is not available if coverage under your prior plan or COBRA coverage was terminated for cause or as a result of failure to pay any contributions toward the cost of coverage on a timely basis.
   NOTE: Internal Revenue Service (IRS) guidelines state that the loss of insurance through an **individual** healthcare **plan does not** constitute a valid Change in Status event.
5. I understand that I will not be enrolled in a Board paid medical plan. I will receive Board-paid Standard Short-Term Disability and will be eligible to select a Board-paid FlexPlan option valued at $100 per month. (May be subject to withholdings and FICA.)

I have read, understand and agree to comply with the requirements stated above.

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

FBMC Web Site

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

By entering **www.fbmc-benefits.com** into your Internet browser, you will open FBMC's homepage. Use the following navigational tabs located along the top portion of the homepage:

- **Account Information** - When you select the '**Account Information**' tab, you'll be prompted to enter your Social Security Number in the Employee Number field and your Personal Identification Number (PIN). After this login, the following menu items will be available to you.
  - **My Benefits**
  - **My Account Transactions**
  - **Account Balance**
  - **My Claims**
  - **Tax Savings Analysis**
- **Downloading Forms** - When you select the '**Download Forms**' tab, a choice of forms, including a Letter of Medical Need, FSA Reimbursement Request Claim Form and Direct Deposit Form, are posted for your convenience.
- **Frequently Asked Questions** - The '**Frequently Asked Questions**' tab provides answers to many of your general questions regarding Flexible Spending Accounts, 401(k) and enrollment information.
- **FBMC Customer Service** - The '**Customer Service**' tab gives you a direct link to the FBMC Customer Service Center.

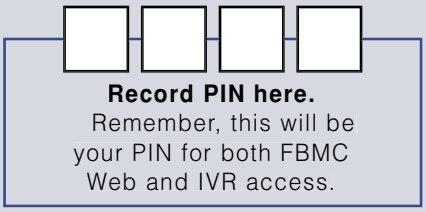
FBMC Interactive Benefits

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

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

NEW!
Personal Identification Number (PIN)

To access both the FBMC Web site and the Interactive Voice Response (IVR) system, all you need is your **Social Security Number**. The last four digits of your Social Security Number will be your first PIN. After your initial login, select a new confidential four-digit PIN for future access. Your new PIN cannot be the last four digits of your Social Security Number. Record your new PIN below.



MAIN MENU OPTIONS:

Press 1 for Flexible Spending Accounts
- Current or previous plan year information
- Dependent Care or Medical Expense FSA
- Status of last reimbursement request
- Last deposit or payment
- Request a reimbursement form
- Inquire about another FSA

Press 2 for form requests
- Claim forms
- Beneficiary or Change In Status/Election Forms
- VISTA 401(k) forms

Press 3 for current benefits
Press 4 to change your PIN
Press 5 to verify your address

Other Options:

Press 0 to transfer to a Customer Service Representative
Press 9 to return to Main Menu
Press * to repeat the menu
Press # to exit Information Line

What is a Flexible Spending Account?

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

Flexible Spending Accounts feature:

- IRS-approved reimbursement of eligible expenses tax free
- per-pay-period deposits from your pre-tax salary and
- savings on income and Social Security taxes.

Is an FSA right for me?

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

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

What types of FSAs are available?

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

Medical Expense FSAs

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

- birth control pills
- eyeglasses
- orthodontia and
- Over-the-Counter items.

Dependent Care FSAs

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

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

Refer to the *Medical Expense FSA* and *Dependent Care FSA* sections of this Open Enrollment Notebook for specifics on each type of FSA.

Receiving Reimbursement

Your reimbursement will be processed within 15-20 business days from the time FBMC receives your properly completed and signed FSA Reimbursement Request Form. To avoid delays, follow the instructions for submitting your requests located in the FSA materials you will receive following enrollment.

Direct Deposit

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

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

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

Where can I get information about FSAs?

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

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

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

FSA Savings Example*

With an FSA		Without an FSA
$31,000	Annual Gross Income	$31,000
- 5,000	FSA Deposit for Recurring Expenses	- 0
$26,000	Taxable Gross Income	$31,000
- 5,889	Federal, Social Security Taxes	-7,021
$20,111	Annual Net Income	$23,979
- 0	Cost of Recurring Expenses	-5,000
$20,111	Spendable Income	$18,979

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

$1,132!

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

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 March 31, 2006) at the end of the plan year for reimbursement of eligible FSA expenses incurred during your period of coverage within the 2005 Plan Year.
4. You may not receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
5. You cannot deduct reimbursed expenses for income tax purposes.
6. You may not be reimbursed for a service which you have not yet received.
7. Be conservative when estimating your medical and/or dependent care expenses for the 2005 Plan Year. IRS regulations state that any unused funds which remain in your FSA after a plan year ends and all reimbursable requests have been submitted and processed cannot be returned to you nor carried forward to the next plan year. Use the FSA Calculation Worksheet on Page 45 to determine your annual contribution estimate.

What documentation of expenses do I need to keep?

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

How do I get the forms I need?

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

Will contributions affect my income taxes?

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

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

Minimum Annual Deposit: $250
Maximum Annual Deposit: $5,000

What is a Medical Expense FSA?

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

Whose expenses are eligible?

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

- yourself
- your spouse and
- your tax-exempt dependents.

To qualify as your tax-exempt dependent, an individual must:

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

In either case, the individual must also be:

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

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

When are my funds available?

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

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

Are prescriptions eligible for reimbursement?

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

Partial List of Eligible Medical Expenses*

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

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

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

Can travel expenses for medical care be reimbursed?

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

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

Is orthodontic treatment reimbursable?

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

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

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

Should I claim my expenses on IRS Form 1040?

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

Are some expenses ineligible?

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

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

When do I request reimbursement?

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

How do I request reimbursement?

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

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

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

Fax to: 850-425-4608

* EOBs are not required if your coverage is through an HMO.

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

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

Over-the-Counter Expenses

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

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

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

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

Eligible Expense Categories

Allergy
Antihistamines
Nasal sprays

Antacids
Heartburn medicines

Cold Remedies
Cough drops
Decongestants
Nasal strips
Nasal sprays
Sinus medications
Throat lozenges

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

Other Medical Remedy Items
Anti-diarrheals
Anti-fungals
Antibiotics
Asthma medications
Bandages, gauze pads, rubbing alcohol, liquid adhesives
Carpel tunnel wrist supports
Cold/hot packs for injuries
Corn/callus removers
Eye products (including reading glasses, contact lens cleaning solutions)
First aid kits
Hemorrhoid treatments
Laxatives
Motion sickness treatments
Nicotine gum or patches for smoking cessation purposes
Thermometers
Wart removers

Items Requiring Special Documentation*

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

Ineligible OTC Expenses

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

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

Minimum Annual Deposit: $250

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

What is a Dependent Care FSA?

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

Whose expenses are eligible?

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

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

What is my maximum annual deposit?

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

When are my funds available?

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

Partial List of Eligible Dependent Care Expenses*

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

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

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

Should I claim tax credits or exclusions?

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

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

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

Are some expenses ineligible?

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

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

Will I need to keep any additional documentation?

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

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

When do I request reimbursement?

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

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

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

How do I request reimbursement?

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

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

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

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

Fax to: 850-425-4608

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

FSA WORKSHEET
Tax-Free Medical Expense FSA

Projected Expenses Plan Year 2005

1. **Uninsured Eligible Medical Expenses**
   - **Medical deductible, co-insurance** _____
   - **Medical & prescription co-payments** _____
   - **Dental deductible, co-insurance or co-payments** _____
   - **Immunizations, injections & vaccinations** _____
   - **Routine exams and physicals** _____
   - **Orthodontic expenses*** _____
   - **Vision exams** _____
   - **Eyeglasses & contacts (corrective)** _____
   - **Hearing exams** _____
   - **Other expenses** _____
2. **Total uninsured eligible expenses, January 1, 2005 through December 31, 2005. Amount cannot exceed $5,000.** _____
3. **Divide by number of payroll deductions in plan year. This is the amount taken from each paycheck and deposited into your Medical Expense FSA.** _____

* Medical expenses incurred for primarily cosmetic reasons, including orthodontic procedures, are not eligible for reimbursement.

Minimum annual amount: $250. Maximum: $5,000 contribution.

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit. Visit www.fbmc-benefits.com to download this form or call FBMC Customer Service at 1-800-342-8017.

FSA WORKSHEET
Tax-Free Dependent Care FSA

Estimate your eligible dependent care expenses from January 1 through December 31, 2005.

1. **Multiply your weekly day care expenses by the number of weeks you expect to have the expenses January 1, 2005 through December 31, 2005.** _____
2. **Divide by the number of payroll deductions in the plan year. This is the amount taken from each paycheck and deposited into your Dependent Care FSA. Amount cannot exceed your maximum tax filing status. See Page 41 for details.** _____

Minimum annual amount: $250. Maximum: $5,000 contribution (maximum amount based on your tax filing status)

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit. Visit www.fbmc-benefits.com to download this form or call FBMC Customer Service at 1-800-342-8017.

You may choose one of four dental plans, offered by two dental providers. Select one of the CompBenefits or one of the MetLife Dental Plans. Indicated below is a comparison chart of all the plans.

	COMPBENEFITS (Standard) CS450	COMPBENEFITS (High) CS150	METLIFE Standard Plan		METLIFE High Plan	
	• Low co-payments • No deductible • Use panel dentist	• Low co-payments • No deductible • Use panel dentist	• In-Network and Out-of-Network Benefits • Choose a MetLife Preferred Dentist for lower out-of-pocket costs			
DEDUCTIBLE (deductible applies to)	None N/A	None N/A	IN-NETWORK None N/A	OUT-OF-NETWORK $50/person $150/family (type A,B,C)	IN-NETWORK $50/person $150/family (type B,C)	OUT-OF-NETWORK $50/person $150/ family (type A,B,C)
Annual maximum (per person)	None	None	$1500	$1500	$1500	$1500
	EMPLOYEE PAYS	*EMPLOYEE PAYS*	*EMPLOYEE PAYS*	*PLAN PAYS*	*PLAN PAYS*	*PLAN PAYS*
TYPE A						
Office visit	$10	$5	No Charge	90% of PDP fees**	100% of PDP fees*	100% of PDP fees**
Oral exam	No Charge	No Charge	$5	90% of PDP fees**	100% of PDP fees*	100% of PDP fees**
Prophylaxis (routine cleaning)	No Charge	No Charge	$15	90% of PDP fees**	100% of PDP fees*	100% of PDP fees**
TYPE B						
Amalgam (fillings)						
2 surface (adult)	$35	No Charge	$45	60% of PDP fees**	80% of PDP fees*	80% of PDP fees**
3 surface (adult)	$40	No Charge	$55	60% of PDP fees**	80% of PDP fees*	80% of PDP fees**
TYPE C						
Endodontics (root canals)						
Anterior	$250	$100	$300	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Bicuspid	$350	$200	$355	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Molar	$450	$250	$490	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Dentures						
Resin Base	$375 + lab	$300 + lab	$420	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Cast Metal Framework	$375 + lab	$300 + lab	$820	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Periodontics (gum treatment)						
Scaling & root planing	$65 per quadrant	$50 per quadrant	$85	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Osseous surgery	$425 per quadrant	$350 per quadrant	$460	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Crowns						
Porcelain to metal	$370	$280	$475	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Post & Core (in addition to crown)			$125			
Cosmetic Procedures						
Labial veneers (bonding)	$370 + lab	$280 + lab	N/A	N/A	N/A	N/A
Tooth bleaching	R&C less 25%	R&C less 25%	N/A	N/A	N/A	N/A
TYPE D						
Orthodontia (braces)						
Evaluation	$35	$35		50% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Treatment plan & records	$250	$250		50% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Child	$2300	$1800		50% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Adult	$2500	$2000		50% of PDP fees*	50% of PDP fees*	50% of PDP fees**
Lifetime maximum per person	N/A	N/A	$2100***	$1500	$1500	$1500

† South Florida (Area 3) consists of zip codes that begin with the digits 330, 331, 333, 334, 339, 340, 349, 320-329, 335-338, 341-348. If you do not reside in a zip code that begins with these digits, please contact MetLife at 1-800-942-0854 for a more accurate in-network schedule of benefits and fees.

* In-Network: Member pays balance of PDP fees, after plan pays.

** Out-of-Network: Member pays balance of PDP fees, in addition to the remaining balance of claim. Balance equals the difference between total claim and PDP fee. For information on PDP fees in your area, contact MetLife directly at 1-800-942-0854.

*** The co-payment amount for a full course of treatment is $3600 minus your plan's lifetime orthodontic benefit maximum of $1500 ($3600 - $1500 = $2100).

Any co-payment or out-of-pocket cost may be reimbursed through your Medical FSA
See Page 40 for a partial list of eligible expenses or visit FBMC's Web site at www.fbmc-benefits.com for the full version of eligible expenses.

CompBenefits Corporation, offers you and your family the choice of a Standard (CS450) or High (CS150) managed dental care program. With either plan, members choose a primary dentist from CompBenefits' panel of dentists and receive excellent dental care without confusing claim forms. Members may also schedule an appointment with a Network Specialist without a referral. The Standard Plan (CS450) is designed for those who are primarily concerned with preventative and diagnostic dental services. The High plan (CS150) offers lower co-payments for more extensive dental procedures. Select the plan best suited for you and your family. Upon enrolling in the managed care program, you select a dentist from their list of providers as your primary dentist.

Family members can choose their own dentist, and children under age 10 may have primary care through a Pedodontist. These private practice dentists are contracted with CompBenefits to provide the comprehensive benefits the plan offers. Visit www.compbenefits.com to view the list of dentists.

Network access is within the State of Florida.

High Plan CS 150

BENEFITS	Your Cost
ADA CODE PROCEDURE	**PATIENT PAYS**
APPOINTMENTS	
9310 Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	$15.00
9430 Office Visit (normal hours)	$5.00
9440 Office Visit (after regularly scheduled hours)	$35.00
9999 Emergency visit during regularly scheduled hours, by report	$20.00
9999 Broken appointments (without 24 hr notice, per 15 min) Maximum $40 per broken appointment. No charge will be made due to emergencies	$10.00
DIAGNOSTIC	
120 Periodic oral evaluation	NO CHARGE
140/150/160 Limited/Comprehensive oral evaluation	NO CHARGE
180 Comprehensive periodontal evaluation - new or established patient	$10
210 X-Ray Intraoral - complete series including bitewings	NO CHARGE
220 X-Ray Intraoral - periapical - first film	NO CHARGE
230 X-Ray Intraoral - periapical - each additional film	NO CHARGE
270 X-Ray Bitewing - single film	NO CHARGE
272 X-Ray Bitewings - two films	NO CHARGE
274 Bitewings - four films	NO CHARGE
330 Panoramic film	NO CHARGE
460 Pulp vitality tests	NO CHARGE
470 Diagnostic casts	NO CHARGE
PREVENTIVE CARE	
1110/1120 Prophylaxis-adult/child-routine (once every 6 months)	NO CHARGE
1110/1120 Prophylaxis-adult/child-(additional)	$20.00
1201 Topical application of fluoride (including prophylaxis) child (up to 16 years of age)	NO CHARGE
1203 Topical application of fluoride (not including prophylaxis) child (up to 16 years of age)	NO CHARGE
1330 Oral hygiene instruction	NO CHARGE
1351 Sealant - per tooth	$10.00
1510 Space Maintainer - fixed - unilateral	$45.00 + LAB
1515 Space Maintainer - fixed - bilateral	$45.00 + LAB
1520 Space Maintainer - removable - unilateral	$85.00 + LAB
1525 Space Maintainer - removable - bilateral	$85.00 + LAB
1550 Recementation of space maintainer	$10.00
RESTORATIVE	
2140 Amalgam - one surface, primary or permanent	NO CHARGE
2150 Amalgam - two surfaces, primary or permanent	NO CHARGE
2160 Amalgam - three surfaces, primary or permanent	NO CHARGE
2161 Amalgam - four or more surfaces, primary or permanent	NO CHARGE
2940 Sedative filling	$15.00
2999 Sedative base (under fillings), by report	NO CHARGE

BENEFITS	Your Cost
RESIN RESTORATION	
2330 Resin - one surface, anterior	$35.00
2331 Resin - two surfaces, anterior	$40.00
2332 Resin - three surfaces, anterior	$50.00
2391 Resin-based composite - one surface, posterior	$60.00
2392 Resin-based composite - two surfaces, posterior	$80.00
2393 Resin-based composite - three surfaces, posterior	$100.00
2394 Resin-based composite - four or more surfaces, posterior	$120.00
2510 Inlay - metallic - one surface	$95.00
2520 Inlay - metallic - two surfaces	$105.00
2530 Inlay - metallic - three or more surfaces	$130.00
CROWN & BRIDGE	
2740 Crown - porcelain/ceramic substrate	$280 + LAB
2750* Crown - porcelain fused to high noble metal	$280.00
2751 Crown - porcelain fused to predominantly base metal	$280.00
2752* Crown - porcelain fused to noble metal	$280.00
2790* Crown - full cast high noble metal	$280.00
2791 Crown - full cast predominantly base metal	$280.00
2792* Crown - full cast noble metal	$280.00
2910 Recement inlay	$15.00
2920 Recement crown	$15.00
2930 Prefabricated stainless steel crown - primary tooth	$75.00
2950 Core buildup, including any pins	$45.00
2951 Pin retention - per tooth	$15.00
2952 Cast post and core in addition to crown	$90.00 + LAB
2953 Each additional cast post - same tooth	$90.00 + LAB
2954 Prefabricated post and core in addition to crown	$90.00
2962 Labial veneer (porcelain laminate) - laboratory	$280 + LAB
ENDODONTICS	
3220 Therapeutic pulpotomy	$35.00
3221 Pulpal debridement, primary and permanent teeth	$100.00
3310 Root canal therapy - anterior (excluding final restoration)	$100.00
3320 Root canal therapy - bicuspid (excluding final restoration)	$200.00
3330 Root canal therapy - molar (excluding final restoration)	$250.00
3410 Apicoectomy/periradicular surgery - anterior	$125.00
PERIODONTICS (Gum treatment)	
4210 Gingivectomy/gingivoplasty - 4+ teeth per quadrant	$125.00
4211 Gingivectomy/gingivoplasty - 1-3 teeth per quadrant	$40.00
4260 Osseous surgery - 4+ teeth per quadrant	$350.00
4261 Osseous surgery, 1-3 teeth per quadrant	$350.00
4271 Free soft tissue graft procedure (inc. donor site surgery)	$225.00
4341 Periodontal scaling and root planing - 4+ teeth per quadrant	$50.00
4342 Periodontal scaling and root planing, 1-3 teeth per quadrant	$50
4355 Full mouth debridement to enable eval and diagnosis	$45.00
4381 Localized delivery of chemotherapeutic agents (per tooth)	$45.00

Any co-payment or out-of-pocket cost may be reimbursed through your Medical Expense FSA. **See Page 40 for a partial list of eligible expenses or visit FBMC's Web site at www.fbmc-benefits.com for the full version of eligible expenses.**

High Plan CS 150

BENEFITS	Your Cost
4910 Periodontal maintenance	$50.00
PROSTHODONTICS	
5110 Complete denture - maxillary	$300.00 + LAB
5120 Complete denture - mandibular	$300.00 + LAB
5130 Immediate denture - maxillary	$300.00 + LAB
5140 Immediate denture - mandibular	$300.00 + LAB
5211 Maxillary partial denture - resin base	$300.00 + LAB
5212 Mandibular partial denture - resin base	$300.00 + LAB
5213 Maxillary partial denture - cast metal framework, resin denture bases	$300.00 + LAB
5214 Mandibular partial denture - cast metal framework, resin denture bases	$300.00 + LAB
5410 Adjust complete denture - maxillary	$15.00
5411 Adjust complete denture - mandibular	$15.00
5421 Adjust partial denture - maxillary	$15.00
5422 Adjust partial denture - mandibular	$15.00
REPAIRS TO PROSTHETICS	
5510 Repair broken complete denture base	$15.00 + LAB
5520 Replace missing or broken teeth - complete denture (each tooth)	$15.00 + LAB
5610 Repair resin denture base	$15.00 + LAB
5630 Repair or replace broken clasp	$15.00 + LAB
5640 Replace broken teeth - per tooth	$15.00 + LAB
5650 Add tooth to existing partial denture	$30.00 + LAB
5730 Reline complete maxillary denture (chairside)	$50.00
5731 Reline complete mandibular denture (chairside)	$50.00
5740 Reline maxillary partial denture (chairside)	$50.00
5741 Reline mandibular partial denture (chairside)	$50.00
5750 Reline complete maxillary denture (laboratory)	$35.00 + LAB
5751 Reline complete mandibular denture (laboratory)	$35.00 + LAB
5760 Reline maxillary partial denture (laboratory)	$35.00 + LAB
5761 Reline mandibular partial denture (laboratory)	$35.00 + LAB
5850 Tissue conditioning - maxillary	$30.00
5851 Tissue conditioning - mandibular	$30.00
PROSTHODONTICS (Fixed)	
6210* Pontic - cast high noble metal	$280.00
6211 Pontic - cast predominantly base metal	$280.00
6212* Pontic - cast noble metal	$280.00
6240* Pontic - porcelain fused to high noble metal	$280.00
6241 Pontic - porcelain fused to predominantly base metal	$280.00
6242* Pontic - porcelain fused to noble metal	$280.00
6750* Crown - porcelain fused to high noble metal	$280.00
6751 Crown - porcelain fused to predominantly base metal	$280.00
6752* Crown - porcelain fused to noble metal	$280.00

BENEFITS	Your Cost
6790* Crown - full cast high noble metal	$280.00
6791 Crown - full cast predominantly base metal	$280.00
6792* Crown - full cast noble metal	$280.00
6930 Recement fixed partial denture (per unit)	$10.00
EXTRACTIONS/ORAL AND MAXILLOFACIAL SURGERY	
7111 Coronal remnants, deciduous tooth	NO CHARGE
7140 Extraction, erupted tooth or exposed tooth	NO CHARGE
7210 Surgical removal of erupted tooth	$40.00
7220 Removal of impacted tooth - soft tissue	$50.00
7230 Removal of impacted tooth - partially bony	$70.00
7240 Removal of impacted tooth - completely bony	$85.00
7250 Surgical removal of residual tooth roots	$35.00
7310 Alveoloplasty in conjunction with extractions - per quadrant	$35.00
7320 Alveoloplasty not in conjunction with extractions - per quadrant	$70.00
7510 Incision and drainage of abscess - intraoral	$25.00
ORTHODONTICS	
8070/8080 Comprehensive orthodontic treatment of the transitional/adolescent dentition.	
Children up to 19 years of age	
Up to 24 months of routine (full-banded) orthodontic treatment for Class I and Class II cases	
Consultation	NO CHARGE
Evaluation	$35.00
Records/Treatment Planning	$250.00
Orthodontic Treatment	$1,800.00
8090 Comprehensive orthodontic treatment of the adult dentition.	
Adults 19 years of age and over	
Up to 24 months of routine (full-banded) orthodontic treatment for Class I and Class II cases	
Consultation	NO CHARGE
Evaluation	$35.00
Records/Treatment Planning	$250.00
Orthodontic Treatment	$2,000.00
8680 Retention	$450.00
ADJUNCTIVE GENERAL SERVICES	
9215 Local anesthesia	NO CHARGE
9230 Analgesia (nitrous oxide - per 15 minutes)	$15.00
9450 Case presentation, detailed and extensive treatment planning	NO CHARGE
9951 Occlusal adjustment limited	$25.00
9952 Occlusal adjustment - complete	$150.00

*** THE ABOVE COPAYMENTS DO NOT INCLUDE THE ADDITIONAL COST OF PRECIOUS (HIGH NOBLE) AND SEMI-PRECIOUS (NOBLE) METAL. THE ADDITIONAL COST OF PRECIOUS METAL SHALL NOT EXCEED $125 PER UNIT AND $75 PER UNIT FOR SEMI-PRECIOUS METAL.**

NOTE:

1. **NOT ALL PARTICIPATING DENTISTS PERFORM ALL LISTED PROCEDURES, INCLUDING AMALGAMS. PLEASE CONSULT YOUR DENTIST PRIOR TO TREATMENT FOR AVAILABILITY OF SERVICES.**
2. **UNLISTED PROCEDURES ARE AT THE DENTIST'S USUAL FEE LESS 25%.**
3. **WHEN CROWN AND/OR BRIDGEWORK EXCEEDS SIX UNITS IN THE SAME TREATMENT PLAN, THE PATIENT MAY BE CHARGED AN ADDITIONAL $50.00 PER UNIT.**

SPECIALISTS

Should you need a specialist, (i.e., Endodontist, Oral Surgeon, Periodontist, Pediatric Dentist), you may be referred by your Participating General Dentist, or you may refer yourself to any Participating Specialist. Copayment amounts are applicable when treatment is performed by Participating Specialists. Benefits for procedures not listed on the schedule, that are performed by a Participating Specialist, are available at the Participating Specialist's usual and customary fee less 25%.

CompBenefits Family of Companies

CompBenefits Company • CompDent • CompBenefits Insurance Company • CompBenefits Dental, Inc. • American Dental Plan of North Carolina, Inc. • National Dental Plans, Inc. • OHS of Alabama, Inc. • American Dental Plan of Georgia, Inc. • Texas Dental Plans, Inc. • Ultimate Optical, Inc. • VisionCare Plan • Primary Plus

Standard Plan CS 450

BENEFITS	Your Cost
APPOINTMENTS	
9310 Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	$30.00
9430 Office Visit (normal hours)	$10.00
9440 Office Visit (after regularly scheduled hours)	$35.00
9999 Emergency visit during regularly scheduled hours, by report	$20.00
9999 Broken appointments (without 24 hr notice, per 15 min) Maximum $40 per broken appointment. No charge will be made due to emergencies.	$10.00
DIAGNOSTIC	
120 Periodic oral evaluation	NO CHARGE
140/150/160 Limited/Comprehensive oral evaluation	NO CHARGE
180 Comprehensive periodontal evaluation - new or established patient	$25
210 X-Ray Intraoral - complete series including bitewings	NO CHARGE
220 X-Ray Intraoral - periapical - first film	NO CHARGE
230 X-Ray Intraoral - periapical - each additional film	NO CHARGE
270 X-Ray Bitewing - single film	NO CHARGE
272 X-Ray Bitewings - two films	NO CHARGE
274 Bitewings - four films	NO CHARGE
330 Panoramic film	NO CHARGE
460 Pulp vitality tests	NO CHARGE
470 Diagnostic casts	NO CHARGE
PREVENTIVE CARE	
1110/1120 Prophylaxis-adult/child-routine (once every 6 months)	NO CHARGE
1110/1120 Prophylaxis-adult/child-(additional)	$35.00
1201 Topical application of fluoride (including prophylaxis) child (up to 16 years of age)	NO CHARGE
1203 Topical application of fluoride (not including prophylaxis) child (up to 16 years of age)	NO CHARGE
1330 Oral hygiene instruction	NO CHARGE
1351 Sealant - per tooth	$20.00
1510 Space Maintainer - fixed - unilateral	$65.00 + LAB
1515 Space Maintainer - fixed - bilateral	$65.00 + LAB
1520 Space Maintainer - removable - unilateral	$105.00 + LAB
1525 Space Maintainer - removable - bilateral	$105.00 + LAB
1550 Recementation of space maintainer	$20.00
RESTORATIVE	
2140 Amalgam - one surface, primary or permanent	$30.00
2150 Amalgam - two surfaces, primary or permanent	$35.00
2160 Amalgam - three surfaces, primary or permanent	$40.00
2161 Amalgam - four or more surfaces, primary or permanent	$50.00
2940 Sedative filling	$30.00
2999 Sedative base (under fillings), by report	NO CHARGE
RESIN RESTORATION	
2330 Resin - one surface, anterior	$50.00
2331 Resin - two surfaces, anterior	$55.00
2332 Resin - three surfaces, anterior	$65.00
2391 Resin-based composite - one surface, posterior	$90.00
2392 Resin-based composite - two surface, posterior	$110.00
2393 Resin-based composite - three surfaces, posterior	$130.00
2394 Resin-based composite - four or more surfaces, posterior	$150.00
2510 Inlay - metallic - one surface	$155.00
2520 Inlay - metallic - two surfaces	$165.00
2530 Inlay - metallic - three or more surfaces	$190.00
CROWN & BRIDGE	
2740 Crown - porcelain/ceramic substrate	$370 + LAB
2750* Crown - porcelain fused to high noble metal	$370.00
2751 Crown - porcelain fused to predominantly base metal	$370.00
2752* Crown - porcelain fused to noble metal	$370.00
2790* Crown - full cast high noble metal	$370.00
2791 Crown - full cast predominantly base metal	$370.00
2792* Crown - full cast noble metal	$370.00
2910 Recement inlay	$30.00
2920 Recement crown	$30.00
2930 Prefabricated stainless steel crown - primary tooth	$120.00
2950 Core buildup, including any pins	$60.00
2951 Pin retention - per tooth	$30.00
2952 Cast post and core in addition to crown	$120.00 + LAB
2953 Each additional cast post - same tooth	$120.00 + LAB
2954 Prefabricated post and core in addition to crown	$120.00
2962 Labial veneer (porcelain laminate) - laboratory	$370 + LAB
ENDODONTICS	
3220 Therapeutic pulpotomy	$50.00
3221 Pulpal debridement, primary and permanent teeth	$130.00
3310 Root canal therapy - anterior (excluding final restoration)	$250.00
3320 Root canal therapy - bicuspid (excluding final restoration)	$350.00
3330 Root canal therapy - molar (excluding final restoration)	$450.00
3410 Apicoectomy/periradicular surgery - anterior	$200.00
PERIODONTICS (Gum treatment)	
4210 Gingivectomy/gingivoplasty - 4+ teeth per quadrant	$200.00
4211 Gingivectomy/gingivoplasty - 1-3 teeth per quadrant	$55.00
4260 Osseous surgery - 4+ teeth per quadrant	$425.00
4261 Osseous surgery, 1-3 teeth per quadrant	$425.00
4271 Free soft tissue graft procedure (inc. donor site surgery)	$300.00
4341 Periodontal scaling and root planing - 4+ teeth per quadrant	$65.00
4342 Periodontal scaling and root planning, 1-3 teeth per quadrant	$65
4355 Full mouth debridement to enable eval and diagnosis	$60.00
4381 Localized delivery of chemotherapeutic agents (per tooth)	$60.00
4910 Periodontal maintenance	$65.00
PROSTHODONTICS	
5110 Complete denture - maxillary	$375.00 + LAB
5120 Complete denture - mandibular	$375.00 + LAB
5130 Immediate denture - maxillary	$375.00 + LAB
5140 Immediate denture - mandibular	$375.00 + LAB
5211 Maxillary partial denture - resin base	$375.00 + LAB
5212 Mandibular partial denture - resin base	$375.00 + LAB
5213 Maxillary partial denture - cast metal framework, resin denture bases	$375.00 + LAB
5214 Mandibular partial denture - cast metal framework, resin denture bases	$375.00 + LAB
5410 Adjust complete denture - maxillary	$30.00
5411 Adjust complete denture - mandibular	$30.00
5421 Adjust partial denture - maxillary	$30.00
5422 Adjust partial denture - mandibular	$30.00
REPAIRS TO PROSTHETICS	
5510 Repair broken complete denture base	$30.00 + LAB
5520 Replace missing or broken teeth - complete denture (each tooth)	$30.00 + LAB
5610 Repair resin denture base	$30.00 + LAB
5630 Repair or replace broken clasp	$30.00 + LAB
5640 Replace broken teeth - per tooth	$30.00 + LAB
5650 Add tooth to existing partial denture	$45.00 + LAB
5730 Reline complete maxillary denture (chairside)	$65.00
5731 Reline complete mandibular denture (chairside)	$65.00
5740 Reline maxillary partial denture (chairside)	$65.00

Any co-payment or out-of-pocket cost may be reimbursed through your Medical Expense FSA. **See Page 40 for a partial list of eligible expenses or visit FBMC's Web site at www.fbmc-benefits.com for the full version of eligible expenses.**

Standard Plan CS 450

BENEFITS	Your Cost
5741 Reline mandibular partial denture (chairside)	$65.00
5750 Reline complete maxillary denture (laboratory)	$50.00 + LAB
5751 Reline complete mandibular denture (laboratory)	$50.00 + LAB
5760 Reline maxillary partial denture (laboratory)	$50.00 + LAB
5761 Reline mandibular partial denture (laboratory)	$50.00 + LAB
5850 Tissue conditioning - maxillary	$45.00
5851 Tissue conditioning - mandibular	$45.00
PROSTHODONTICS (FIXED)	
6210* Pontic - cast high noble metal	$370.00
6211 Pontic - cast predominantly base metal	$370.00
6212* Pontic - cast noble metal	$370.00
6240* Pontic - porcelain fused to high noble metal	$370.00
6241 Pontic - porcelain fused to predominantly base metal	$370.00
6242* Pontic - porcelain fused to noble metal	$370.00
6750* Crown - porcelain fused to high noble metal	$370.00
6751 Crown - porcelain fused to predominantly base metal	$370.00
6752* Crown - porcelain fused to noble metal	$370.00
6790* Crown - full cast high noble metal	$370.00
6791 Crown - full cast predominantly base metal	$370.00
6792* Crown - full cast noble metal	$370.00
6930 Recement fixed partial denture (per unit)	$25.00
EXTRACTIONS/ORAL AND MAXILLOFACIAL SURGERY	
7111 Coronal remnants, deciduous tooth	$35.00
7140 Extraction, erupted tooth or exposed root	$35.00
7210 Surgical removal of erupted tooth	$55.00
7220 Removal of impacted tooth - soft tissue	$100.00
7230 Removal of impacted tooth - partially bony	$125.00
7240 Removal of impacted tooth - completely bony	$150.00
7250 Surgical removal of residual tooth roots	$65.00
7310 Alveoloplasty in conjunction with extractions - per quadrant	$65.00
7320 Alveoloplasty not in conjunction with extractions - per quadrant	$100.00
7510 Incision and drainage of abscess - intraoral	$40.00

BENEFITS	Your Cost
ORTHODONTICS	
8070/8080 Comprehensive orthodontic treatment of the transitional/adolescent dentition. Children up to 19 years of age. Up to 24 months of routine (full-banded) orthodontic treatment for Class I and Class II cases	
Consultation	NO CHARGE
Evaluation	$35.00
Records/Treatment Planning	$250.00
Orthodontic Treatment	$2,500.00
8680 Retention	$450.00
8090 Comprehensive orthodontic treatment of the adult dentition. Adults 19 years of age and over. Up to 24 months of routine (full-banded) orthodontic treatment for Class I and Class II cases	
Consultation	NO CHARGE
Evaluation	$35.00
Records/Treatment Planning	$250.00
Orthodontic Treatment	$2,500.00
8680 Retention	$450.00
ADJUNCTIVE GENERAL SERVICES	
9215 Local anesthesia	NO CHARGE
9230 Analgesia (nitrous oxide - per 15 minutes)	$30.00
9450 Case presentation, detailed and extensive treatment planning	NO CHARGE
9951 Occlusal adjustment - limited	$40.00
9952 Occlusal adjustment - complete	$225.00

*** THE ABOVE CO-PAYMENTS DO NOT INCLUDE THE ADDITIONAL COST OF PRECIOUS (HIGH NOBLE) AND SEMI-PRECIOUS (NOBLE) METAL.**

THE ADDITIONAL COST OF PRECIOUS METAL SHALL NOT EXCEED $125 PER UNIT AND $75 PER UNIT FOR SEMI-PRECIOUS METAL.

NOTE:

1. **NOT ALL PARTICIPATING DENTISTS PERFORM ALL LISTED PROCEDURES, INCLUDING AMALGAMS. PLEASE CONSULT YOUR DENTIST PRIOR TO TREATMENT FOR AVAILABILITY OF SERVICES.**
2. **UNLISTED PROCEDURES ARE AT THE DENTIST'S USUAL FEE LESS 25%.**
3. **WHEN CROWN AND/OR BRIDGEWORK EXCEEDS SIX UNITS IN THE SAME TREATMENT PLAN, THE PATIENT MAY BE CHARGED AN ADDITIONAL $50.00 PER UNIT.**

SPECIALISTS

Should you need a specialist, (i.e., Endodontist, Oral Surgeon, Periodontist, Pediatric Dentist), you may be referred by your Participating General Dentist, or you may refer yourself to any Participating Specialist. Co-payment amounts are applicable when treatment is performed by Participating Specialists. Benefits for procedures not listed on the schedule, that are performed by a Participating Specialist, are available at the Participating Specialist's usual and customary fee less 25 percent.

CompBenefits Family of Companies

CompBenefits Company • CompDent • CompBenefits Insurance Company • CompBenefits Dental, Inc. • American Dental Plan of North Carolina, Inc. • National Dental Plans, Inc. • OHS of Alabama, Inc. • American Dental Plan of Georgia, Inc. • Texas Dental Plans, Inc. • Ultimate Optical, Inc. • VisionCare Plan • Primary Plus

Exclusions/Limitations:

- No service or any dentist other than a Participating General Dentist or Participating Specialist will be covered, except out-of-area emergency care. Emergency care means treatment due to injury, accident, or severe pain requiring the services of a dentist which occurs under the circumstances where it is neither medically nor physically possible for the Member to be treated by any Company Participating General Dentist or Participating Specialist. An acute periodontal abscess and an acute periapical abscess which occur under circumstances where it is not possible for the Member to be treated by any Company Participating General Dentist or Participating Specialist are examples where emergency benefits would be applicable. When more than one hundred (100) miles from the nearest available Company Dental Facility, the Member may obtain reimbursement for expense for Emergency Care rendered by any licensed dentist, less applicable Company co-payments, up to one hundred dollars ($100), per Member per year, upon presentation of an itemized statement of emergency services from the dental office. Company must be notified of such treatment within ninety (90) days of its receipt.
- Whenever any contributions or co-payments are delinquent, members will not be entitled to receive benefits, transfer dental facilities, or enjoy any of the other privileges of a member in good standing.
- CompBenefits does not provide coverage for the following services:
  - Cost of hospitalization and pharmaceuticals, drugs or medications
  - Services which, in the opinion of the Participating General Dentist or Participating Specialist, are not necessary treatment to establish and/or maintain the member's oral health.
  - Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which, in the opinion of the Participating General Dentist or Participating Specialist, would endanger the health of the member.
  - Any service or procedure which the Participating General Dentist or Participating Specialist is unable to perform because of the general health or physical limitations of the member.
  - Any dental treatment started prior to the member's effective date of eligibility for benefits.
  - Services for injuries and conditions which are paid or payable under Worker's Compensation or Employer's Liability laws.
  - Treatment for cysts, neoplasms and malignancies.
  - General anesthesia.

Employee-Paid Benefits:

1. You may cover yourself by selecting the "Employee Only" benefit.
2. You may cover yourself and your eligible dependent(s) by selecting the "Employee and Family" benefit.
3. You may select "Family Only" if your coverage is included in a FlexPlan Option.
4. Indicate your facility choice in the space provided for each family member under the Employee-Paid Benefits section of the Web enrollment form.

If you choose one of the CompBenefits Dental Plans and desire dependent dental coverage, your dependents must also be covered by the same level of coverage under your CompBenefits plan. You may choose a different dentist for each family member on your Web enrollment form, the CompBenefits Web site or by calling CompBenefits Member Services Department at 1-800-432-3376 during the plan year.

Your rates are listed below.

COMPBENEFITS DENTAL PLAN	10-MONTH		11-MONTH		12-MONTH	
	High	Standard	High	Standard	High	Standard
Employee	$8.06	$5.21	$6.72	$4.34	$6.20	$4.01
Employee & Family	$20.35	$13.13	$16.96	$10.94	$15.66	$10.10
Family Only	$12.29	N/A	$10.24	N/A	$9.45	N/A

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance companies.

How to use dental benefits:

A list containing the Select Panel Providers in Miami-Dade, Broward, Monroe and Palm Beach Counties can be viewed online at www.compbenefits.com. You may call the CompBenefits Member Services Department at 1-800-432-3376 to verify your dentist's continued participation in your selected plan.

How can I make an appointment with my CompBenefits dentist?

You may schedule an appointment by calling the dental office you selected on or after your effective date of coverage. When you call to schedule your appointment, inform the office that you are a member of the CompBenefits dental plan. It will not be necessary to use any claim forms. If you need to cancel your appointment for any reason please let your provider know twenty-four (24) hours in advance of your scheduled appointment. The Benefits Schedule allows the provider to charge a fee (up to a maximum of $40) for any broken or cancelled appointment without twenty-four (24) hours notice.

Who is an eligible dependent for this coverage?

Eligible dependents for this plan include:

- Spouse/Domestic Partner
- Unmarried natural children, adopted children, and stepchildren under you or your spouse's legal guardianship until the end of the month in which the child reaches age 19
- Children of a Domestic Partner, as long as the Domestic Partner is also covered.

NOTE: Children may be covered under this plan until the end of the calendar year in which the child reaches age 25, provided he/she is unmarried and resides in your home and depends upon you for support, or is registered as a full-time or part-time student. Children with a mental or physical handicap are also eligible for coverage beyond the age of 19.

What should I do if I wish to change my selection of dentist?

You may change your dental office selection once a month. To change dental offices, call the **CompBenefits Member Services Department at 1-800-432-3376. You will be transferred to the new dental office effective the first of the following month if notice is given prior to the 20th of the month**. Transfers can only be processed if you have no balance due or pending appointments at your dental office.

What if I need the services of a Specialist?

There are certain procedures that are beyond the scope and competency level of a General Dentist and may require the services of a Specialist. To receive the services of a Specialist, you will be referred to CompBenefits participating Specialist (where available). The co-payments listed on your Schedule of Benefits will apply at the participating Specialist's office. If you have questions regarding referrals, please call the CompBenefits Member Services Department at 1-800-432-3376.

What can I do if I have questions about the treatment plan prescribed by my General Dentist?

You may contact the CompBenefits Member Services Department to make arrangements for a Second Opinion for a $15 fee. Second Opinions will not be covered if they are from a non-participating dentist or if arrangements are made on your own.

What if I'm currently seeing a dentist under one plan and I change plans to CompBenefits, but would like to maintain the same dentist?

As long as the dentist is part of the CompBenefits network and is accepting patients, you may select the facility as your primary dentist. If the facility is not open to new membership, you will have to obtain approval from the dental office and contact CompBenefits prior to your assignment.

How can I receive Emergency Care within the service area?

If you require emergency care, first contact your General Dentist for an emergency appointment. If you cannot reach your General Dentist, contact the CompBenefits Member Services Department at 1-800-432-3376 for assistance. Arrangements will be made at the closest available office to receive emergency treatment.

How can I receive Emergency Care outside of the service area?

If you require emergency care and are temporarily one hundred (100) miles or more from your participating dental office, contact any licensed General Dentist to receive emergency treatment (relief of pain, bleeding or swelling). Pay for the services rendered and submit the receipt to CompBenefits with your name, social security number, address, phone number and your employer's name. CompBenefits will reimburse up to $100, less applicable co-payments. Please refer to Exclusions/Limitations for more information.

Where may I call for inquiries or additional questions?

All inquiries and questions should be directed to the CompBenefits Member Services Department at Miami-Dade: (305) 262-7329 or toll-free: 1-800-432-3376. Representatives are available Monday through Friday, 8 a.m. to 6 p.m., ET.

Upon request, CompBenefits shall provide written information about the terms and conditions of the plan to prospective enrollees.

To access the provider directory, log on to www.dadeschools.net to access the directory or you may contact the provider at 800-432-3376.

The MetLife dental plans are the traditional indemnity insurance plan whereby you and your family may select the dentist of your choice. MetLife offers you a choice of two different plans. The Standard Plan is a low cost plan that is designed for those individuals who primarily would need only diagnostic and preventive dental services. The Standard Plan includes a co-pay schedule that applies to the various dental procedures. You do not have to satisfy an annual calendar year deductible if you seek services from an in-network PDP dentist. The High Plan is designed for those individuals who have more extensive dental needs. This plan provides a reimbursement of either 100 percent, 80 percent or 50 percent of the plans Preferred Dental Program fees, depending on the service provided, after you have satisfied the plan deductible. MetLife offers quality dental care at affordable prices with their Preferred Dental Program (PDP). This program includes a nationwide network of dentists who have agreed to reduce their fees below the average reasonable and customary charge for their services. You are free to choose an in-network or out-of-network dentist at the time you make your appointment. However, when using an out-of-network dentist, the level of coverage is reduced and your out-of-pocket expenses will increase.

	STANDARD		HIGH	
	In-Network South Florida (Area 3)†	**Out-of-Network**	**In-Network**	**Out-of-Network**
ANNUAL CALENDAR YEAR DEDUCTIBLE Deductible applies to	**None** N/A	**$50/person** $150/ family (type A,B,C)	**$50/ person** $150/ family (type B,C)	**$50/ person** $150/ family (type A,B,C)
ANNUAL CALENDAR YEAR MAXIMUM Maximum benefit allowed per person for Types A, B & C Combined	$1500	$1500	$1500	$1500
PREVENTIVE (Type A)	**EMPLOYEE PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**
X-rays (bitewing 2 per year)	$0	90% of PDP fees**	100% of PDP fees*	100% of PDP fees**
X-rays (full mouth or panoramic every 3 years)	$0	90% of PDP fees**	100% of PDP fees*	100% of PDP fees**
Cleaning and scaling (2 per year)	$15	90% of PDP fees**	100% of PDP fees*	100% of PDP fees**
Fluoride treatment (up to age 19 - one per year)	$0	90% of PDP fees**	100% of PDP fees*	100% of PDP fees**
BASIC SERVICE (Type B)				
Space Maintainers - unilateral (up to age 19)	$105	60% of PDP fees**	100% of PDP fees*	100% of PDP fees**
Sealants (Dependent child up to age 19 - 2 per lifetime on permanent molars only)	$15	60% of PDP fees**	100% of PDP fees*	100% of PDP fees**
Amalgams (2 surfaces)	$45	60% of PDP fees**	80% of PDP fees*	80% of PDP fees**
Periodontics maintenance (unlimited after periodontic treatment)	$40	60% of PDP fees**	80% of PDP fees* 80% of PDP fees*	80% of PDP fees** 80% of PDP fees**
MAJOR SERVICE (Type C)				
Denture relining (chairside)	$105	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Denture adjustments	$30	30% of PDP fees**		
General anesthesia	$155	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Impacted Teeth	$145	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Periodontics (gum treatment) scaling and root planning	$85 per quad	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Crowns	$475	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Bridges	$435	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Full dentures	$535	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Partial dentures resin base	$420	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Inlays	$330	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Onlays	$475	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Simple extractions	$50	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Additional extraction	$50	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Surgical extractions	$105	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Root canal therapy				
Anterior	$300	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Bicuspid	$355	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Molar	$490	30% of PDP fees**	50% of PDP fees*	50% of PDP fees**
Repairs to prosthetics	$80	30% of PDP fees**		
ORTHODONTIA (Type D) Amount	$2,100***	50% of PDP fees** $1500/person	50% of PDP fees* $1500/person	50% of PDP fees** $1500/person

† South Florida (Area 3) consists of zip codes that begin with the digits 330, 331, 333, 334, 339, 340, 349, 320-329, 335-338, 341-348. If you do not reside in a zip code that begins with these digits, please contact MetLife at 1-800-942-0854 for a more accurate in-network schedule of benefits and fees.

* In-Network: Member pays balance of PDP fees, after plan pays.

** Out-of-Network: Member pays balance of PDP fees, in addition to the remaining balance of claim. Balance equals the difference between total claim and PDP fee.

*** The co-payment amount for a full course of treatment is $3600 minus your plan's lifetime orthodontic benefit maximum of $1500 ($3600 - $1500 = $2100).

$ Any co-payment or out-of-pocket cost may be reimbursed through your Medical FSA

See Page 40 for a partial list of eligible expenses or visit FBMC's Web site at www.fbmc-benefits.com for the full version of eligible expenses.

Your Rates are listed below.

MetLife Dental Plan Rates

Standard Indemnity	10-MONTH	11-MONTH	12-MONTH
Employee	$16.30	$13.58	$12.54
Employee & Family	$49.98	$41.65	$38.45

High Indemnity	10-MONTH	11-MONTH	12-MONTH
Employee	$28.37	$23.65	$21.83
Employee & Family	$84.80	$70.67	$65.23
Family Only	$56.42	$47.02	$43.40

Limitations

Type A (Preventive & Diagnostic)

- 2 oral exams per calendar year
- 1 fluoride treatment per calendar year up to age 19
- 2 cleanings (oral prophylaxis) per calendar year
- Full mouth and panorex x-rays: once per 36 months
- Bitewing x-rays: twice per calendar year for adults; twice per calendar year for children

Type B (Operative & Restorative)

- Space maintainers for premature loss of primary teeth for dependent children to age 19
- Sealants: limitation of one appliance of sealant material for each non-restored permanent 1st and 2nd molar tooth of a dependent child to age 19, once every 60 months
- Periodontal maintenance where periodontal treatment (including scaling, root planning, and periodontal surgery such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to 4 times in any year less number of teeth cleanings received during such 12-month period.

Type C (Prosthodontics)

- Relines and rebases to dentures are limited to one per 36 months (minimum is six months after initial installation)
- Adjustment of dentures (minimum is 6 months after initial installation)
- Consultations are limited to two times per year
- Periodontal scaling and root planning, but not more than once per quadrant in any 24-month period
- Periodontal surgery, including gingivectomy or gingivoplasty, gingival curettage, osseous surgery, bone replacement graft and guided tissue regeneration once per quadrant every 36 months
- Root canal treatment is limited to once per tooth in a 24-month period
- Initial installation of fixed bridgework
- Initial installation of partial or full removable dentures
- Denture replacement: 10 years
- Initial installation of crowns, inlays and onlays
- Immediate denture replacement: 12 months
- Crown replacement: five years

Type D (Orthodontics)

- Benefit for initial preparation, work up and installation of Orthodontic appliances is 20 percent of the total covered expense
- All dental procedures performed in connection with Orthodontic treatment are payable as Orthodontia
- Payments are on a repetitive basis (quarterly installments)
- Benefits end at cancellation

Exclusions

- Temporomandibular joint disorder (TMJ)
- Implantology
- Services or supplies received before dental expense benefits start for that person
- Services not performed by a Dentist except for those of a licensed dental hygienist for scaling and polishing of teeth, fluoride treatment
- Cosmetic surgery, treatment of supplies, unless required for the treatment or correction of a congenital defect of a newborn Dependent child
- Replacement of a lost, missing or stolen crown, bridge or denture
- Services or supplies covered by any workers' compensation laws or occupational disease laws
- Services or supplies which are covered by any employers' liability laws
- Services or supplies received through a medical department or similar facility which is maintained by the Covered Person's employer
- Repair or replacement of an orthodontic appliance
- Services or supplies for which no charge would have been made in the absence of Dental Expense Benefits
- Services or supplies for which a Covered Person is not required to pay
- Services or supplies which are deemed experimental in terms of generally accepted dental standards
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace
- Adjustment of a denture or a bridgework which is made within six months after installation by the same dentist who installed it

Continuation of Exclusions

- Any duplicate appliance or prosthetic device
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride provided in a dental office
- Instruction for oral care such as hygiene or diet
- Periodontal splinting
- Temporary or provisional restorations
- Temporary or provisional appliances
- Services or supplies to the extent that benefits are otherwise provided under the plan or under any other plan which the Employer contributes to or sponsors
- Appliances or treatment for bruxism (grinding teeth) including but not limited to occlusal guards and night guards
- Initial installation of a denture or bridgework to replace one or more natural teeth lost before Dental Expense Benefits started or as a replacement for congenitally missing natural teeth
- Charges for broken appointments
- Charges by the Dentist for completing dental forms
- Sterilization supplies or charges
- Services or supplies furnished by a family member

To access the provider directory, log on to www.dadeschools.net or you may contact the provider at 800-942-0824.

How to select the MetLife Dental Plans

Employee-Paid Benefits:

1. You may cover yourself by selecting the "Employee Only" benefit.
2. You may cover yourself and your eligible dependent(s) by selecting the "Employee and Family" benefit.
3. You may select Family only if your coverage is included in a FlexPlan Option.

NOTE: If you choose dependent dental coverage, your dependents must be covered by the same dental plan and level of coverage (Standard or High) which you selected for yourself.

About the MetLife Dental Plans

Pre-determination of benefits:

Pre-determination of benefits should be requested for a program of treatment which the dentist estimates will be more than $200. This provision does not apply to charges for emergency treatment.

How does the MetLife Preferred Dentist Program (PDP) work?

Dentists who participate in MetLife's Preferred Dentist Program (PDP) have agreed to accept a schedule of maximum fees for services rendered. These scheduled fees are below the average Reasonable & Customary charge. Additionally, dentists agree not to charge for the oral examination during periodic checkups other than the initial exam under the program. **At the point of service, you decide whether to use a dentist in the PDP or any other dentist. Your out-of-pocket costs are less when services are rendered by a participating dentist.**

IN-NETWORK (PDP)	
Preferred Dentist's Fee	$62.60
Plan pays 80% of PDP Fee	— $50.08
You pay 20% of PDP Fee	**$12.52**
Your Cost	**$12.52***

OUT-OF-NETWORK	
Dentist's Fee	$190.00
PDP Fee	$62.60
Plan pays 80% of PDP Fee	— $50.08
You pay 20% of PDP Fee	**$ 12.52**
charge over Dentist Fee	**$ 127.40**
Your cost	**$139.92****

This example indicates your savings using the MetLife High Dental Plan (Filling-Type B service):

Total $$$ saved by using a MetLife Preferred Dentist = $127.40

* Example assumes $50 deductible has been satisfied.

** Example assumes $150 deductible has been satisfied.

How do I know if a dentist is in the MetLife Preferred Dentist Program (PDP)?

Visit www.metlife.com/mybenefits for a PDP listing of the participating dentists in the South Florida area. To find a participating dentist in your area, call 1-800-474-PDP1(7371), Monday-Friday, 6 a.m.-11 p.m. (ET), and Saturday, 7 a.m.-4 p.m. (ET). Input the information as requested and a customized PDP directory will be mailed to you.

How can I make an appointment with my dentist?

You may schedule appointments by calling a dentist with MetLife's Preferred Dentist Program (PDP) or any other licensed dentist you choose on or after your effective date of coverage. When you arrive at your dental office, notify them that you have insurance benefits through Metropolitan Life Insurance Company. It will be necessary to use claim forms in order to receive reimbursement.

Where can I get MetLife Dental Plan claim forms?

Dental claim forms will be provided to you upon request at your work location or you may download forms online at www.fbmc-benefits.com or call Fringe Benefits Management Company at 1-800-342-8017, Monday-Friday, 7 a.m.-10 p.m. (ET). For claims assistance or status, log on to www.metlife.com/mybenefits or call MetLife's Customer Service at 1-800-942-0854.

Where may I call for inquiries or additional questions?

All inquiries and questions should be directed to Metropolitan Life Insurance Company Customer Service at 1-800-942-0854.

Who is an eligible dependent for this coverage?

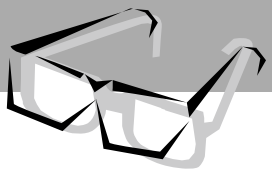
Eligible dependents for this plan include:

- Spouse/Domestic Partner
- Unmarried natural children, adopted children, and stepchildren to age 25
- Children older than age 25 will remain covered under this plan only if proof is submitted that he/she suffers from a physical handicap or mental retardation, provided the child remains chiefly dependent upon you for support.
- Children of a Domestic Partner, as long as the Domestic Partner is also covered.

Plan Provider: Metropolitan Life Insurance Company.

NOTE: This product does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance companies. All employees selecting the MetLife Dental Plans will receive a Benefit Certification Kit which includes a MetLife certificate.

Optix Vision Plan



The Optix Vision Plan provides access to independent eyecare professionals (optometrists and ophthalmologists) who are committed to providing quality vision care.

The Plan offers a Preferred Panel or Indemnity (Non-Panel) benefit. The Panel Plan offers a network of providers that service your eye care needs with only a modest co-payment as shown in the Schedule of Benefits. The Non-Panel Plan allows you to select any licensed Non-Panel provider and reimburses a fixed dollar amount based on the schedule shown for the Non-Panel Plan. The chart below indicates the benefits the plan pays for the services you receive.

As part of your benefits package, you are entitled to receive frames with a wholesale cost of $25 or less for a co-payment of $10.00. This will cover approximately 6,000 frames, including designer frames, on a paid in full basis. Under the contact lens benefit†, fitting and follow up will be covered in the $10 co-payment, allowing the full $100 allowance to be used for contact lens materials. Furthermore, you can save an additional 20 percent off your second pair of frames. The Optix Vision Plan also offers many other advantages such as a contact lens replacement program, out-of-network benefits and other provider discounts. Please review your schedule of benefits for further details.

† Contact lenses are in lieu of glasses.

Schedule of Benefits

COVERED SERVICES*	PANEL	NON-PANEL REIMBURSEMENT
One-Time Co-Payment (Applies to frames and/or lenses, contact lens fitting and follow up)	$10	N/A
Vision Exam (once every plan year)	Paid in full	up to $40
Single Lenses (once every plan year)	**Paid in full	up to $40
Bifocal Lenses (once every plan year)	**Paid in full	up to $50
Trifocal Lenses (once every plan year)	**Paid in full	up to $60
Frames		
From Select Group ($25 or less wholesale)	Paid in full w/ $10 co-payment	N/A
From Non-Select Group (more than $25 wholesale)	two times the $25 wholesale allowance	up to $40
Frequency	once a year	every 2 years
Contact lenses		
Elected by Insured	***Paid in full or up to $100 allowance	up to $100
Medically Necessary	***Paid in full or up to $175 allowance	up to $175
Mail Order Contact Replacement	20% provider discount	

OPTIONAL SERVICES AT ADDITIONAL COSTS (for Panel Plan only)

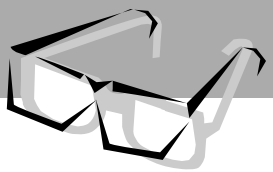
	You Pay	You Pay
Solid Tint	$12	N/A
Gradient Tint	$12	N/A
Ultra Violet Filter	$20	N/A
Scratch Resistance Coating	$20	N/A
Anti-Reflection Coating	$60	N/A
Glass PGX		
Single Vision	$35	N/A
Multifocal	$45	N/A

* During any plan year, you may elect either the frames and/or lenses covered service or the contact lenses allowance, but not both.

** Single vision, bifocal (flat top 25) or trifocal (7x 25) are paid in full. At the provider's option, lenses can be made at either the doctor's office lab or sent to a participating lab.

*** Limited to a select group of daily wear contacts (Ocular Science Edge III thin, Cooper Silver 07); extended wear (Ocular Science Z4, Ciba Softcon EW); or disposable (two boxes only of Softlens 66, Seequence 11/Optima EW, Plyform Private label OSI).

Any co-payment or out-of-pocket cost may be reimbursed through your MFSA
See Page 40 for a partial list of eligible expenses or call FBMC Customer Service at 1-800-342-8017.



Notes on the Optix Vision Panel Plan:

1. The eye exam, contact lenses (new or replacement), and lenses are provided once every plan year regardless of prescription change. Frames are provided once a year.
2. Your out-of-pocket cost for the service rendered is paid by you upon receipt of services. Oversize lenses, tinted lenses, sunglasses, and nonstandard and photochromatic lenses may be purchased with an additional charge. Contact lenses are in lieu of frames and lenses.
3. Certain therapeutic and diagnostic procedures are available to the participants of Optix on a co-payment basis. There is no annual deductible with this plan.

How to use the Optix Vision Panel Plan Benefits:

Using a Panel Eye Doctor

1. A list of participating optometrists and ophthalmologists can be accessed through www.dadeschools.net. Benefits listed are valid at all participating eye doctors.
2. Identification cards are not needed. Your eligibility for service is verified by identifying yourself as an Optix Panel Plan participant when you make an appointment with a participating eye doctor.
3. The eye doctor's office will handle all claim forms.

Notes on the Optix Vision Non-Panel Plan:

1. You are responsible for payment of the entire fee. There will be a one-time reimbursement by the Optix vision care Non-Panel Plan up to the amounts listed on the previous page.
2. The vision exam is provided once every plan year, with a maximum $40 reimbursement.
3. Lenses are provided once every plan year, if needed, as determined by your optometrist or ophthalmologist.
4. Frames are provided every two years, if needed. Frames are limited to a maximum $40 benefit.
5. Contact lenses will be provided once every plan year under the plan, if needed, as determined by your optometrist or ophthalmologist. Payment will be made for only one pair of lenses, either single, bifocal, trifocal, or contacts during a plan year. No frame or lens benefits are available during the plan year that contact lenses are elected.

How to use Optix Vision Non-Panel Plan Benefits:

1. Optix Non-Panel Plan vision benefits are valid at any non-panel licensed ophthalmologist, optometrist or optician.
2. Vision claim forms are available at your worksite or will be provided upon request by calling Fringe Benefits Management Company at 1-800-342-8017, Monday-Friday, 7 a.m.-10 p.m ET.

Optix Vision Plan

	10-MONTH	11-MONTH	12-MONTH
Employee	$5.17	$4.31	$3.98
Employee & Family	$12.41	$10.34	$9.54
Family Only	$7.24	$6.03	$5.57

Any co-payment or out-of-pocket cost may be reimbursed through your MFSA
See Page 40 for a partial list of eligible expenses or call FBMC Customer Service at 1-800-342-8017.

Can you explain the wholesale allowance in greater detail?

Employees have two ways to get frames covered under their Optix vision plan.

Select Group

You may choose from the select group of frames which can be purchased with a $10 co-payment. This includes any frame with a $25 or less wholesale price. The $25 wholesale price covers frames with an average retail cost of $50-$75. There are approximately 6,000 frames manufactured to date.

Non-Select Group

If you select a frame that exceeds the $25 wholesale price, you will only be responsible for paying two times the wholesale difference of the cost of the frame and your applicable co-payment.

For example, if the frame you select has a wholesale cost of $35, you will pay an additional $20 to purchase the upgraded frame.

$35 wholesale cost
- $25 wholesale allowance
$10 = difference
x 2
$20 = your cost

The new wholesale frame allowance benefit could save you more than 60 percent over the old plan, if you choose a frame that is not part of the select group. To get more information about the two ways to purchase frames, call Optix Vision at 1-800-342-8017.

What services and materials does the plan exclude?

- Cosmetic contact lenses.
- Medical or surgical treatment of the eyes.
- Any services or material under Preferred Panel when the plan procedures are not followed.
- Services and materials for orthoptics or vision training, subnormal vision aids, aniseikonic lenses, two pair of glasses in lieu of bifocals, and nonprescription glasses.
- Lost or broken lens replacement or repair, unless it is time for your annual exam.
- Any services and material that Workers' Compensation, another plan or a government agency provides.
- Any employer-required exam as a condition for employment.

Who is an eligible dependent for this coverage?

Eligible dependents covered under this plan include:

- Spouse/Domestic Partner
- Unmarried children under age 19
- Children (including children of a Domestic Partner, as long as the Domestic Partner is also covered) will be covered under this plan until the end of the calendar year in which he/she reaches age 25 provided the child is a full-time or part-time student or is residing in an eligible employee's home. Coverage for eligible children will also be extended beyond age 19 if the child is incapable of self-care due to a mental or physical handicap and is predominantly dependent upon the covered employee for support and maintenance.

How to select Optix Vision Plan benefits:

1. You may cover yourself by selecting the “Employee Only” benefit.
2. You may cover yourself and your eligible dependent(s) by selecting the "Employee and Family" benefit.
3. You may select “Family Only” if your coverage is included in a FlexPlan Option.

Plan Provider:

This product is offered by Vision Care Plan, through its parent company, CompBenefits Corporation.

Upon request, Vision Care Plan shall provide written information about the terms and conditions of the plan to prospective enrollees. Vision Care Plan is a prepaid limited health service organization licensed under Chapter 636, Florida Statutes.

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance companies.

To access the provider directory, log on to www.dadeschools.net or you may contact at FBMC Customer Service at 800-342-8017.

It is important that you have legal counseling available when you need it. The Legal Plan allows you to consult an attorney before your legal problems become costly and complicated. The plan, which covers employees and their eligible dependents, provides legal services from Network or Non-Network Attorneys.

The Legal Plan consists of more than 950 Network Attorneys in Florida with most attorneys fees for covered legal services paid-in-full when using a network attorney. A list of Network Attorneys can be accessed online at www.dadeschools.net. You may select a Non-Network Attorney and the plan will reimburse you according to scheduled limits. The legal services that are available are listed on the chart on Page 60.

Legal benefits include these services as well:

Personal Financial and Tax Planning - The Financial Planning Center

Personal Financial Counseling - With personal financial counseling, you have access to:

- Toll-free, confidential telephone access to an experienced financial planner
- One-on-one counseling: there are no sales pitches
- Planners who are familiar with all areas of financial planning
- Assistance in integrating all resources into an overall financial plan
- Personalized reports on topics such as Investment for Retirement, Asset Allocation and College Funding.

Interactive Financial Web site

Via the online Plan Member Service Center, you will also have access to a Web site that features:

- Assessment and tracking of financial planning priorities
- Interactive modeling tools for calculating savings for retirement, savings for college, debt-to-income ratio, asset allocation, insurance needs and mortgage refinancing
- Updates newsletter
- Approved List of Mutual Funds
- Educational materials on cash flow, investments, estate planning, insurance, education funding, tax planning and key life events
- Hot links to other planning resources.

Immigration Assistance

Immigration assistance is a value-added feature that comes at no additional cost to you. Plan members will receive toll-free access to an immigration case manager who will:

- Explain the immigration benefit in detail
- Provide educational and administrative materials
- Provide practical and cautionary information
- Monitor and assist plan members as they deal with immigration issues.

Telephone Legal Advice on Immigration

You receive toll-free telephone advice from a network attorney on how immigration law relates to the plan member's legal matter and what actions may be taken. You will receive advice regarding:

- General immigration process education and guidelines
- Advice on filing and processing of applications or petitions, including which forms should or should not be filed
- Laws and regulations governing various types of immigration benefits, including asylum, adjustment of status, business visas and employment authorizations.
- Advice and information to individuals facing deportation and removal proceedings.
- Breaking issues in immigration law, including the latest changes and programs for immigration benefits.

For specific immigration matters that cannot be handled over the phone, or if you need to see a state-specific attorney, our Network Attorneys will offer reduced rates up to 25 percent off their normal fees and rates for any review, preparation, or representation-based immigration services.

Online Legal Services

If you want to learn more about your legal needs or have simple matters you prefer to handle yourself, the following legal information and resources are available online.

- Law Guide - Law Guide teaches you about your legal situation, thanks to comprehensive overviews of the most common legal issues. Law Guide provides overviews for general areas including family law, wills and estate planning, consumer law, and real estate law; and specific information on legal issues such as simple wills, divorce and child custody. Law Guide helps you become an informed legal consumer and save time and money by preparing you for professional or self-help legal services.
- Do-it-Yourself Legal Documents™- For do-it-yourselfers, you can prepare your own legal documents with a new product, Rapidocs®, from Epoch Technologies. From a simple will to a power of attorney to a name change petition, Rapidocs allows you to create legally valid documents through interactive questioning. Plus, each document you prepare, can be reviewed by a designated attorney.

Identity Theft Services

As a legal plan member, you will have, toll-free access to an identity theft case manager who will:

- Explain what identity theft is and how to prevent it
- Provide resources to minimize and recover from identity theft
- Explain relevant plan coverage
- Monitor and follow-up on the situation.

Telephone Legal Services

Telephone Legal Services allow you convenient access to a selected Florida law firm. The firm's attorneys provide general legal advice regarding personal legal matters. The Telephone Legal Services number is 1-800-247-4184.

What if I have a legal concern that existed before I became insured under this plan?

Coverage for pre-existing matters are included as long as the legal action or charge is filed and the attorney is first retained after the effective date of the policy. (Most attorneys' fees are paid-in-full when a Network Attorney is used.) Coverage is provided for matters in process at the time of termination of employment or plan termination. Coverage is provided anywhere in the United States or Canada.

How to Use Legal Benefits

1. **Telephone Legal Services:** Insured employees can reach a Telephone Network Attorney by calling 1-800-247-4184, Monday through Friday, 9 a.m. to 5 p.m., ET.
2. **In-office Legal Services Network Attorney:** Contact an attorney and identify yourself as an insured M-DCPS employee and ARAG® member. The Network Attorney will file a claim with ARAG® to receive reimbursement and, for most benefits, legal fees are paid-in-full. You will be responsible for any filing fees, court costs and miscellaneous costs.
3. **In-office Legal Services Non-Network Attorney/ Indemnity Coverage:** You may use any non-network attorney and be reimbursed by ARAG® up to schedule maximums by submitting a claim form and your attorney's billing statement directly to ARAG®. Claim forms can be obtained by calling FBMC Customer Service at 1-800-342-8017, Monday through Friday, 7 a.m.-10 p.m., ET.

How to Select Legal Benefits

You may cover yourself and your family by selecting Legal under the Employee-Paid FlexPlan Benefits section of the online enrollment.

How does the Legal Coverage benefit affect taxes?

According to IRS rules, the Legal Plan is not qualified to be included in the FlexPlan as a tax-free benefit. If you select legal coverage, your premium is deducted on an after-tax basis.

Your rates are listed below.

NOTE: These premiums will be deducted on a post-tax basis.

	10-MONTH	11-MONTH	12-MONTH
Legal Plan	$ 10.38	$ 8.65	$ 7.98

What Legal Services Does the Plan Exclude?

Actions between you and your employer, union, fellow employees, Fringe Benefits Management Company, insurance carriers, ARAG® Insurance Company, or anyone else when prohibited by law; business matters, preparation of tax returns, patents or copyrights, summary procedure actions; class actions, interventions or amicus curiae filings, citizen's dispute settlements program procedures; filing fees, court costs, and miscellaneous costs, or matters where other reimbursement is available; contingency fee, workers' compensation, unemployment compensation and probate cases; actions between you and your dependents; duplication of services previously claimed, title search and title insurance, and legal proceedings where you are entitled to legal representation or reimbursement from any other source; and matters related to structural damage to dwellings, appurtenances, paved surfaces and matters not specifically listed.

Who is an eligible dependent covered under this plan?

Eligible dependents covered under this plan include:

- Spouse (until a final degree of divorced has been filed)
- Domestic Partner
- Unmarried natural children, step children, children under your care through court-approved guardianship, and children of a Domestic Partner through the end of the calendar year in which he/she reaches age 19.
- Children may be covered until the end of the calendar year in which the child reaches age 25 if he/she is a full-time or part-time student who receives more than half of his/her financial support from the eligible employee. Children may also be covered until the end of the calendar year in which he/she reaches age 25 if the child suffers from a mental or physical handicap, is incapable of self-support, and is fully dependent upon the employee for support.

Which insurance company makes this plan available to me?

ARAG Insurance Company underwrites this plan. A.M. Best's Reports, an organization that compares and rates the financial strength and performance of insurance companies, rates ARAG® "A, Excellent." The plan is administered by ARAG®.

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance companies.

What legal services are available?

The chart below shows the legal services available.

COVERAGE In-Office Legal Services	Network Attorney	Non-Network Attorney*
Consumer protection actions	Paid in full	$2200**
IRS audit protection (attorney or accountant)		
Audit consultation	$420	$420
Representation at audit before litigation	$900	$900
Defense for IRS litigation	$5000	$5000
Personal bankruptcy/wage-earner plan	Paid in full	$420
Dissolution		
Divorce, legal separation or annulment (coverage for employee)		
Uncontested	Paid in full	$600
Contested	See below	$600
ARAG® GROUP will pay a Network Attorney in full for the first 10 hours of the attorney's time. The Network Attorney will bill the insured at $70 per hour for all additional hours.		
Employee's Spouse's legal fees	$300	$300
Defense of motion to modify a prior divorce decree	Paid in full	$360
Adoption	Paid in full	$350
Uncontested Guardianship/Conservatorship	Paid in full	$300
Incompetency or infirmary proceedings	Paid in full	$2200**
Name change	Paid in full	$240
Juvenile court proceedings (excluding traffic matters)	Paid in full	$2080**
Habeas corpus	Paid in full	$300
Defense of DWI	Paid in full	$2080**
Criminal misdemeanor defense (except involving motorized vehicles)	Paid in full	$2080**
Traffic charges where your license could be suspended or revoked	Paid in full	$2080**
Felony (named insured only)	Paid in full	$2500**
Estate planning		
Individual simple will	Paid in full	$100
Husband and wife simple wills	Paid in full	$125
Codicil	Paid in full	$60
Wills with trust	Paid in full 6 hrs.	$240
Living will	Paid in full	$60
Durable power of attorney	Paid in full	$60
Purchase/sale of principal residence (1 attempt at each per year)	Paid in full	$360
Real estate refinancing (limit of one hour)	Paid in full	$60
Administrative hearings (excluding employment related)	Paid in full	$1200
Preventive law***		
Office consultations for legal advice, negotiation, document preparation and review	2 hours every 6 months per family, noncumulative***	$120
TELEPHONE LEGAL SERVICES	Paid in Full	N/A
Toll free telephone advice also includes advice relating to criminal or civil matters arising out of the named insured's employment with the policy holder.	Unlimited	N/A
Immigration/Elder Care		
Assistance provided under Preventive Law and/ or Telephone Legal Services	Covered under Preventive Law	$60 per hour*
FINANCIAL PLANNING AND TAX ADVICE	Paid in full	N/A
IDENTITY THEFT SERVICES	Paid in full	N/A
ONLINE LEGAL SERVICES	Paid in full	N/A

* Non-Network Attorney coverage is at $60 per hour to the stated amount for pre-trial; $200 for 1/2 day trial.

** Trial coverage of $1600 is included in these amounts ($200 for half-day trial, and major coverage). Pretrial coverage is the stated amount less $1600.

*** You cannot use the 2 hours to increase any other plan benefits or waive their limitations.

Miami-Dade County Public Schools offers a one-stop resource with the expert legal, financial, tax and adult care assistance you need to take care of your family: SeniorAdvocate™, administered by ARAG®.

Who is the Senior Advocate Program for?

If you are buying the plan to help care for senior family members, you can use the plan for matters related only to your parents, grandparents, spouse's parents and spouse's grandparents.

What are the Legal Services offered?

Telephone Legal Services

You will have toll-free access to a Senior Advocate Telephone Network Attorney for the following services:

- Telephone Legal Advice - Toll-free telephone advice on how the law relates to senior family members personal legal matters and which actions may be taken.
- Document Preparation - Assistance with the preparation or review of the following documents as they relate to the senior family members:
  - Special powers of attorney and revocations
  - Challenge to denial of credit
  - Bad check notice
  - Promissory notes and affidavits related to their personal property
  - Bills of sale related to personal property
- Document Review - Legal services to review legal documents of the senior family member, up to four pages, except those related to trusts or real estate property transfers.
- Follow-up Calls/Correspondence - Assistance with follow-up telephone calls and correspondence to third parties, related to the senior family member.

In-Office Legal Services

If a matter requires an in-office visit, you can meet with a SeniorAdvocate Network Attorney and you are guaranteed at least a reduced fee of 25 percent off of his/her normal rates.

What Financial Tax Planning Services are available?

Personal Financial Counseling - With personal financial counseling, members have access to:

- Toll-free, confidential telephone access to an experienced financial planner
- One-on-one counseling: there are no sales pitches
- Planners who are familiar with all areas of financial planning
- Assistance in integrating all resources into an overall financial plan
- Personalized reports on topics such as Investment for Retirement, Asset Allocation and College Funding.

Interactive Financial Web site - via the online Plan Member Service Center, employees will also have access to a Web site that features:

- Assessment and tracking of financial planning priorities
- Interactive modeling tools for calculating savings for retirement, savings for college, debt-to-income ratio, asset allocation, insurance needs and mortgage refinancing
- Updates newsletter
- Approved List of Mutual Funds
- Educational materials on cash flow, investments, estate planning, insurance, education funding, tax planning and key life events
- Hot links to other planning resources.

Identity Theft Services

As a legal plan member, you will have, toll-free access to an identity theft specialist who will:

- Explain what identity theft is and how to prevent it
- Provide resources to minimize and recover from identity theft
- Explain relevant plan coverage
- Monitor and follow-up on the situation

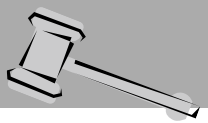
What are the Independent Living services?

Independent Living Services

You can receive assistance in planning for your own or your senior family member's immediate or future adult care needs through toll-free, telephone access from geriatric care specialists. They assist plan members in matters relating to:

- Nursing homes
- Home health care
- Long distance caregiving
- Emergency and respite care
- Discharge planning
- Residential care
- Housing options
- Senior centers
- Caregiver issues and concerns
- Adult day care
- Long-term care insurance
- Transportation services
- Medicare and Medicaid
- Social Security
- Community services
- Funeral planning
- Grief and bereavement
- Hospice services
- Meal delivery programs

The geriatric care specialist conducts a comprehensive intake and needs assessment with plan members. Once the specialist has fully assessed your needs, you will be provided with a basic overview of the types of providers and resources available.



Which insurance company makes this plan available to me?

ARAG® Insurance Company underwrites this plan. A.M. Best's Reports, an organization that compares and rates the financial strength and performance of insurance companies, rates ARAG® "A, Excellent." The plan is administered by ARAG®.

Visit the ARAG® Web site at
http://www.members.araggroup.com/mdps

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in benefit issued by the ARAG®.

Life the Way You Want to Live™

For your convenience, attorney information and an online Network Attorney locator can be found by logging on at the Plan Member section of our Web site, **http://members.araggroup.com/mdps** or by calling our Customer Service Center at **888-718-4793**, Monday through Friday, 8:00 a.m. – 8:00 p.m. ET. The ARAG attorneys average more than 20 years of experience.

Is your personal attorney a member of our network? If not, let us know and we will contact the attorney about joining.

To use a Network Attorney:

- Contact the attorney to make an appointment. Identify yourself as an ARAG® plan member.
- Ask the attorney what materials you should bring with to your appointment.
- The attorney will provide the needed services.
- The Network Attorney will bill you directly at the discounted rate.

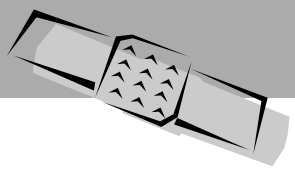
Your rates are listed below.

NOTE: These premiums will be deducted on a post-tax basis.

	10-MONTH	11-MONTH	12-MONTH
Senior Advocate Program	$ 4.80	$ 4.00	$ 3.69

To access the provider directory, log on to www.dadeschools.net or you may contact the provider at 800-247-4184.

Short-Term Disability (STD)



The School Board is providing all eligible, full-time employees with Standard Short-Term Disability (STD). You may upgrade this benefit by purchasing the High STD Plan.

What is a Short-Term Disability?

STD provides benefits for short periods of disability due to injury or illness.

When can I begin collecting benefits?

There are two levels of coverage.

Standard - Benefits are paid up to 22 weeks after a 30 calendar day elimination period.

High - Benefits are paid up to 24 weeks after a 15 calendar day elimination period.

NOTE: Disability due to childbirth. If you have a Cesarean section, you will be considered disabled for a minimum period of eight weeks beginning on the date of your Cesarean section. If you have vaginal birth, you will be considered disabled for a minimum period of six weeks beginning on the date of your vaginal delivery.

What services does this benefit include?

STD replaces up to 60 percent of your earnings, up to a maximum of $500 per week. This benefit covers maternity as well as other short-term disabling illnesses or injuries. UNUM recognizes that an employee may have additional sources of income available following a disability. To prevent over insurance, UNUM will subtract from your gross disability payment other sources of income (see your certificate for a definition of other sources of income, if any). You do not have to use up your sick days to receive benefits. However, if you do choose to use your sick days, UNUM will NOT subtract from the gross disability payment income you receive from salary continuation or sick leave plan.

When should I submit a claim form?

Your claim should be submitted within 30 days after the date of your disability begins or as soon as possible. However, UNUM must receive written proof of your claim no later than 90 days after your elimination period. If this is not possible, proof must be given no later than one year after the time proof is required except in the absence of legal capacity.

You may download a claim for online at www.dadeschools.net or request a form by calling FBMC Customer at 1-800-342-8017. Contact his/her office regarding your claim. Allow approximately two weeks from date completed form is submitted for processing,

Your rates are listed below.

	10-MONTH	11-MONTH	12-MONTH
Upgrade to High STD	$3.67	$3.06	$2.82

Is there a survivor benefit?

No. There is no survivor benefit included with this Short-Term Disability plan.

What is the minimum weekly benefit?

The minimum weekly benefit is $25.

What are the exclusions?

The policy will not cover any disability due to:

- War, declared or undeclared, or any act of war
- Intentionally self-inflicted injuries, while sane or insane
- Active participation in a riot
- The covered person's committing of, or the attempting to commit, an indictable offense
- Loss of a professional license, occupational license or certification
- Any period of disability during which the employee is incarcerated
- Occupational sickness or injury covered by workers' compensation.
- Elective cosmetic surgery.

Are benefits taxable?

If your premiums to upgrade to the High plan are paid on a pre-tax basis, you will receive a W-2 form for the calendar year in which benefits were paid. However, if your premiums were paid on a post-tax basis, benefits paid to you will not be taxed. The premiums paid by the School Board for the Standard Disability plan will be on a pre-tax basis.

Am I eligible for benefits under this plan if I am totally disabled prior to the plan effective date?

No. If you are totally disabled, the effective date of insurance or change in coverage will be delayed until the date of your return to active employment from all such disability.

What insurance company makes this plan available to me?

The Short-Term Disability benefit is offered through UNUM Life Insurance Company of America, a member company of the UnumProvident Group. UNUM is rated "A-, (Excellent)" by *A.M. Best's Reports*, which compares and rates the financial strength and performance of insurance companies.

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in the certificates of insurance issued by the participating insurance companies.

The Long-Term Disability Plan will provide you with a percentage of your income if you are totally disabled and qualify for benefits. Total disability is the inability to perform the material and substantial duties of your regular occupation and you have a 20 percent or more loss in your monthly earnings. After 24 months of payments, you are disabled when UNUM determines that you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

Am I eligible for benefits under this plan if I am totally disabled prior to the plan effective date?

No. If you are totally disabled, the effective date of insurance or change in coverage will be delayed until the date of your return to active employment from all such disability.

What are the amounts of Long-Term Disability benefits available?

You can choose the level of coverage that best suits your needs. They are as follows:

Standard: 60 percent of monthly earnings, not to exceed a maximum monthly benefit of $1,800

Maximum: 60 percent of monthly earnings, not to exceed a maximum monthly benefit of $3,000

Maximum Plus: 60 percent of monthly earnings, not to exceed a maximum monthly benefit of $5,000

Benefits are reduced by any disability benefits received from other sources, as defined on Page 66. A person currently disabled will not be eligible to increase their benefit.

How do I know which level of coverage to select?

You should consider your annual salary when selecting a level of coverage to provide you and your family the most protection.

If your annual salary is less than $36,000, you should select Standard Coverage.

If your annual salary is $36,000 - $60,000, you should select Maximum Coverage.

If your annual salary is greater than $60,000, you should select Maximum Plus Coverage.

What is the minimum benefit?

The minimum monthly benefit is $100, or 10 percent of your gross disability benefit, whichever is greater.

How long must I be totally disabled before I receive benefits?

There is an elimination period. “Elimination period” means a period of consecutive days of disability for which no benefit is payable. The elimination period begins on the first day of disability. A period of disability will be considered continuous even if disability temporarily ceases due to a return to work for up to 30 days. The elimination period will be extended by the number of days which total disability temporarily ceased and you returned to work.

When are benefits payable?

Benefits are payable after the 180th day of continuous disability resulting from injury or sickness, or the expiration of accrued sick leave, whichever is greater.

How long are benefits payable?

If you are disabled prior to age 62, your benefits will cover you to age 67. If you are disabled at age 62 or after, benefits will be paid according to a decreasing maximum benefit period as indicated below:

Age at Disability	Maximum Benefit Period
Less than age 62	to age 67
62	60 months
63	48 months
64	42 months
65	36 months
66	30 months
67	24 months
68	18 months
69 and over	12 months

Must I pay my premiums if my disability prevents me from working?

Your premium payments are waived while benefits are being paid.

What limitations apply for Mental Illness?

The monthly benefit payments for disabilities due to sickness or injury, which are primarily based on self-reported symptoms and disabilities due to mental illness, will not exceed 24 months unless you are in a hospital or institution at the end of the 24-month period, at which time the monthly benefit will be paid during the confinement up to the Maximum Benefit Period. "Hospital" or "institution" means a facility licensed to provide care and treatment for the condition causing your disability. If you are still disabled when discharged, the monthly benefit will be paid for a recovery period up to 90 days. If you are re-confined during the recovery period for at least 14 days in a row, benefits will be paid for the confinement and another recovery period up to 90 more days.

Mental illness means mental, nervous or emotional diseases or mental disorders of any type.

What benefits are included in Long-Term Disability?

If you become disabled, the following benefits can help until you get back to full time work.

Work Incentive Benefit - This benefit offers an effective incentive if you are ready to return to work, but not full time. You may receive your full disability benefit during the first 12 months after returning, as long as your benefit and earnings are not more than 100 percent of pre-disability earnings.

Rehabilitation and Return to Work Assistance - UNUM vocational rehabilitation experts provide qualified employees with formalized assessment and planning as well as financial support to help you return to productive, independent lifestyles. UNUM will pay an additional benefit of 10 percent of the gross disability payment to a maximum benefit of $1,000 per month.

Worksite Modification Benefit - We help your employer make the worksite accommodations necessary to enable employees to return to work. This benefit provides up to $1,000 or the equivalent of two monthly benefit payments for worksite modifications for each employee.

Child Care Benefit - When you are disabled and incurring child care expenses for your dependent child(ren) and participating continuously in the Rehabilitation and Return to Work Assistance program, UNUM will pay for the Child Care Expense Benefit Amount. The payment will begin immediately after you start the Rehabilitation and Return to Work Program.

The Child Care amount is $250 per month per child, and will not exceed $1,000 per month for all child(ren) expenses combined. The child must be under 15 years of age or incapable of providing their own care on a daily basis due to their own physical handicap or mental retardation.

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Other available services include 24-hour multilingual service, medical consultation, hospital admission guarantee, critical care monitoring, emergency prescription services, return of mortal remains, care for minor children, legal and interpreter referrals.

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What is a recurrent disability?

A recurrent disability is a disability that is related to, or due to the same cause or causes of a prior disability for which a monthly benefit was paid. A recurrent disability will be treated as part of the prior disability if, after receiving disability benefits under the plan, an employee returns to work on a full-time basis for less than 6 months and performs all of the duties of the employee's own occupation. Benefit payments will be subject to the terms of the plan for the prior disability.

What are the limitations?

The policy will not cover any disability due to:

- War, declared or undeclared, or any act of war
- Intentionally self-inflicted injuries, while sane or insane
- Active participation in a riot
- The covered person's committing of, or the attempting to commit, an indictable offense
- Loss of a professional license, occupational license or certification
- Any period of disability during which the employee is incarcerated
- Pre-existing conditions.

Are benefits taxable?

If your premiums are paid on a pre-tax basis, you will receive a W-2 form for the calendar year in which benefits were paid. However, if your premiums were paid on a post-tax basis, benefits paid to you will not be taxed.

When should I submit a claim form?

Your claim should be submitted within 30 days after the date of your disability begins or as soon as possible. However, UNUM must receive written proof of your claim no later than 90 days after your elimination period. If this is not possible, proof must be given no later than one year after the time proof is required except in the absence of legal capacity.

You may download a claim form online at www.dadeschools.net or request a form by calling FBMC Customer at 1-800-342-8017.

Notify your attending physician that UNUM may contact his/her office regarding your claim. Allow approximately two weeks from date completed form is submitted for processing.

What if I receive benefits from another group disability plan or other source?

Disability benefits will be reduced by any disability benefit that you are eligible for or are entitled to receive from the following sources: US Social Security and Canada and State Disability Plan payments, or no-fault automobile insurance benefits. Other employer-sponsored group disability income plans, and any disability benefits or retirement benefits received by the employee from any pension plan provided through the employer. This plan will also coordinate with retirement or social security benefits which your spouse or children are eligible to receive as a result of your eligibility for Social Security or retirement benefits.

Disability benefits are not reduced by: informal salary continuations, individual disability income plans, IRS, 401(k) plans, TSAs, stock ownership plans or non-qualified plans of deferred compensation, military disability benefits, professional franchise, or association plans not purchased through the employer.

Is there a survivor benefit?

Yes, if you die after having been disabled for a minimum of 180 days and were receiving benefits under the policy, the plan will pay your eligible survivor a lump-sum benefit equal to three times your gross monthly disability benefit.

Is there a pre-existing condition clause?

Yes. You will not be covered for pre-existing conditions if you were not insured under the plan on December 31, 2004 and elected coverage on or after January 1, 2005. A pre-existing condition means a sickness or injury for which an employee receives medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines in the three months prior to the effective date of coverage; or had symptoms for which an ordinary prudent person would have consulted a health care provider in the three months just prior to the effective date of coverage; and the disability begins in the first 12 months after the employee's effective date. This pre-existing condition clause will not apply once the person has been insured under the elected plan for 12 consecutive months.

What insurance company makes this plan available?

The Long-Term Disability benefit is offered through Unum Life Insurance Company of America, a member company of the UnumProvident Group. Unum is rated "A-, (Excellent)" by A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies.

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance companies.

Your rates are listed below.

	10-MONTH	11-MONTH	12-MONTH
Standard	$11.29	$9.41	$8.69
Maximum	$14.47	$12.06	$11.13
Maximum Plus	$21.82	$18.18	$16.78

Hospital Indemnity Coverage provides benefits if you or your insured dependents are confined in a hospital as an inpatient. The levels of daily coverage are $50, $100 or $150. The Employee-Paid daily benefit levels combined cannot exceed $150. You must be enrolled for coverage in order to enroll your dependent(s). Coverage for your dependents cannot exceed your own.

If a child is born to anyone under this policy while family coverage is in force, the child shall automatically become a covered dependent from the moment of birth. Otherwise, you must contact FBMC at 1-800-342-8017 and complete a Change in Status form. You may also visit www.dadeschools.net to download forms.

This includes coverage for sickness or injury, and the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and premature birth. Routine care for the child is not covered under this policy.

You and your dependents may select different levels of coverage as long as (a) your amount does not exceed $150 and (b) your dependent's level of coverage does not exceed your own.

Who is an eligible dependent for this coverage?

Eligible dependents covered under this plan include:

- Legal Spouse/Domestic Partner
- Unmarried children who are under age 25 provided:
  - the child is dependent upon the insured for support
  - the child is living in the insured's household, or
  - the child is a full-time or part-time student.

NOTE: 'Child' includes stepchild, legally adopted child, a child pending finalization of adoption proceedings, natural child, and children of a Domestic Partner (provided the Domestic Partner is also covered).

When will my benefit payments start?

You are eligible for benefits on the first day of a covered hospitalization.

How long will the benefits continue?

These benefits are payable for each day you are confined as an inpatient in a covered hospital (see exclusions) for any period from one to 365 days. Successive periods of hospital confinement, due to the same or related causes, not separated by 60 days shall be considered as one period of hospital confinement.

Must I still pay my premiums if I am hospitalized or disabled and unable to work?

If you are confined in a hospital before your 60th birthday, coverage will be continued without further payment of premiums:

a) after you have received benefits for 60 consecutive days during which premiums are paid, and
b) while you remain in the hospital as an inpatient for the same or related injury or sickness and benefits continue to be paid to a maximum of 365 days.

If you become disabled before your 60th birthday, coverage will be continued without further payment of premiums after you have been disabled for nine (9) straight months during which premiums were paid. Premiums will continue to be waived as long as you remain hospitalized or disabled provided you are eligible to continue receiving benefits, but no more than 365 days.

Waiver of Premium applies only to you; however, coverage for your covered dependents will also be continued without further payments while premiums are waived.

When are benefits payable?

Benefits are payable for each day of a necessary hospital confinement when the insured is confined in a hospital as an inpatient as recommended by a doctor for care that is reasonably and medically necessary.

How do I obtain claim forms?

To obtain claim forms, call FBMC Customer Service at 1-800-342-8017, Monday through Friday, 7 a.m. - 10 p.m. (ET). You may also visit www.dadeschools.net to download forms.

Are benefits taxable?

The IRS may require you to pay taxes on payments you receive from the Hospital Indemnity Coverage plan under current law. For further information, consult your personal tax advisor.

Definitions

"Doctor" means a duly licensed practitioner of the healing arts acting within the scope of his/her license. Doctor does not include: the Insured or the Insured's spouse; or the Insured or the Insured spouse's child, parent, brother, sister; or a person living with the Insured.

"Hospital" means an institution which:

a) is licensed as a hospital pursuant to applicable law;
b) is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
c) is under the supervision of a staff of doctors
d) provides 24-hour nursing service by or under the supervision of a graduate registered nurse (R.N.)
e) has medical, diagnostic and treatment facilities, with major surgical facilities:
   1) on its premises, or
   2) available to it on a prearranged basis, and
f) charges for its services.

Is there a survivor benefit?

Yes, if benefits are unpaid at the time of your death, one lump sum payment will be made to the first surviving class of the following classes of persons:

- wife or husband
- child(ren)
- mother or father
- sister or brother

If there is no surviving member as stated above, the benefits will be paid to the Insured's estate.

What injuries or sicknesses are excluded from coverage?

Benefits will not be paid for a loss caused by or resulting from:

- Intentionally self-inflicted injuries
- Voluntary self-administration of any drug or chemical substance not prescribed by, or taken according to the directions of a doctor (accidental ingestion of a poisonous substance is not excluded)
- Driving while intoxicated or driving under the influence of a controlled substance unless administered on the advice of a doctor
- Commission or attempt to commit a felony
- Participation in a riot or insurrection
- Declared or undeclared war or act of war
- Active duty service in any armed forces (proof of service will result in a refund of premium; reserve or national guard active duty or training is not excluded unless it extends beyond 31 days)
- Elective or cosmetic surgery (unrelated to trauma, infection or other disease of the involved part, or congenital disease or anomaly of a covered dependent child, which resulted in a functional defect)
- Dental surgery, unless the surgery is the result of an accidental injury
- Confinements in hospitals owned or operated by the national government, unless a charge is made, whether or not there is insurance coverage
- Injury or sickness covered by Workers' Compensation or any occupational disease law.
- Outpatient procedures
- Confinement in a clinic, facility or unit of a hospital that provides custodial care, educational care, nursing care, aged care, care for drug addicts or alcoholics or rehabilitation
- Confinement in a military or veterans hospital, contracted for, or operated by, a national government or its agency unless the services are rendered on an emergency basis and in the absence of insurance, a legal liability exists to pay the charges for services given.

What insurance company makes this plan available to me?

Life Insurance Company of North America (LINA), a CIGNA company, underwrites this plan. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates LINA "A-, Excellent."

This plan provides HOSPITAL INDEMNITY insurance only. This information is a brief description of important features of the plan. It is not a contract. Terms and conditions of coverage are set forth on Policy Form No. XX-60452 (FL), issued in Florida. The group policy is subject to the laws of the state in which it is issued.

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance companies.

CIGNA Hospital Indemnity

Coverage at $50.00 Per Day	10-MONTH	11-MONTH	12-MONTH
Employee	$3.90	$3.25	$3.00
Family	$5.10	$4.25	$3.92

Coverage at $100.00 Per Day	10-MONTH	11-MONTH	12-MONTH
Employee	$7.80	$6.50	$6.00
Family	$10.20	$8.50	$7.85

Coverage at $150.00 Per Day	10-MONTH	11-MONTH	12-MONTH
Employee	$11.70	$9.75	$9.00
Family	$15.30	$12.75	$11.77

You may purchase $10,000 to $50,000 (in $10,000 increments) of group term life insurance. This insurance supplements your Board-provided life insurance. You can have up to $50,000 in tax-free life insurance.

Who is eligible?

All full-time employees are eligible; however, if you are totally disabled, your effective date of insurance or change in coverage will be delayed until the date of your return to Active Service.

Are the premiums taxable?

Under current Internal Revenue Code rules and regulations, employees whose life insurance is more than $50,000 will have premiums for any amount more than $50,000 included as taxable income on their W-2 forms. Please refer all tax-related questions to your tax advisor.

Must I still pay my premiums if I'm disabled and unable to work?

If you become totally disabled prior to age 60 and that disability lasts for six consecutive months, during which time premiums are paid, the insurance company will continue your life insurance in force without further payment of premiums if proof of such disability is provided and until you reach 65 or retire, whichever occurs first.*

Is there any situation that would exclude my benefits?

If you commit suicide while you are sane or insane within two years of the effective date of coverage, benefits will not be paid; however, your beneficiary will receive a refund of the premiums you have paid for this insurance.

Also, if coverage was elected while you were on a leave of absence due to a disability and you did not return to work, benefits will not be paid. However, your beneficiary will receive a refund of the premiums you have paid for this insurance.

How much does the plan cost?

EMPLOYEE ONLY	10-MONTH	11-MONTH	12-MONTH
$10,000	$2.04	$ 1.70	$1.57
$20,000	4.08	3.40	3.14
$30,000	6.12	5.10	4.71
$40,000	8.16	6.80	6.28
$50,000	10.20	8.50	7.85

* Disability is defined as the inability to perform all the essential duties of any occupation for which you may reasonably become qualified based on training, education or experience.

Does the plan pay any benefits if I am terminally ill ?

The plan will pay a lump sum—50 percent of the life insurance benefit amount in force to a maximum of $50,000 if you are terminally ill and your life expectancy is 12 months or less, as diagnosed by a physician. Your benefits paid to you will reduce the death benefit. This benefit is payable only once in your lifetime.

Is there any situation that would reduce my benefit amount?

All benefits are subject to reduction after age 64 as follows:

- At age 65, to 65 percent of the original face value of coverage in force
- At age 70, to 45 percent of the original face value of coverage amount in force
- At age 75, to 30 percent of the original face value of coverage amount in force
- At age 80, to 20 percent of the original face value of coverage amount in force

Can I continue my Employee-Paid life insurance if I terminate employment?

Yes. You may apply for a conversion policy for all or any portion of life insurance in effect at termination, if you make a request. You must complete a conversion application within 31 days of termination. To request a Conversion application contact Fringe Benefits Management Company Customer Service at 1-800-342-8017. You may also visit www.dadeschools.net to download forms.

Can I continue my Employee-Paid life insurance if I retire?

Yes. Upon retirement, employees may continue their coverage at their current level of coverage. This product will not be available for an increase or addition to existing coverage. If at any time of your retirement you do NOT elect to continue this coverage, you will no longer be eligible for coverage under this plan and your group life coverage will be terminated.

What insurance company makes this plan available to me?

Life Insurance Company of North America (LINA), a CIGNA company, underwrites this plan. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates LINA "A-, Excellent."

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is a summary of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance companies.

Accidental Death and Dismemberment (AD&D)

Accidental Death and Dismemberment (AD&D), provides benefits for you or your insured dependents in the event of a covered accident—on or off the job—which results in loss of life, limbs, use of limbs, eyesight, hearing or speech. You may select $25,000 to $300,000 (in $25,000 increments) of coverage.

You must be enrolled for coverage in order to cover your dependents. Your dependent's coverage is a percentage of your selected benefit amount. They are as follows:

Spouse - The spouse's benefit amount will be 40 percent of the employee's, or 50 percent if the employee has no dependent children. This amount cannot exceed $150,000.

Children - Each covered child's benefit amount will be 10 percent of the employee's, or 15 percent if the employee has no spouse. The maximum children's benefit is $25,000.

What accidents are not covered?

Benefits will not be paid for a loss caused by or resulting from:

- Sickness, disease, bodily or mental infirmity, or medical or surgical treatment thereof or bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external cut or wound, or accidental food poisoning.
- Intentionally self-inflicted injuries or any attempt to self-inflict injuries, while sane or insane
- Declared or undeclared war or act of war
- Accident occurring while the insured is serving on full-time active duty for more than 30 days in any armed forces
- Commission of a felony by the insured
- Travel or flight (including getting in or out, on or off) in any aircraft or device which can fly above the earth's surface if the aircraft or device is being used:
  A. 1) for test or experimental purposes; 2) for travel or is designed to travel beyond the earth's atmosphere; 3) by or for the military authority; 4) or by or for the named organization or any of its subsidiaries and affiliates. (this exclusion applies whether the aircraft or device is owned, leased, operated or controlled, as defined. Chartered aircraft, as defined, are not excluded)
  B. 1) The insured is serving as a pilot or crew member, (or student taking flying lessons) and is not riding as a passenger or 2) hang gliding; or 3) parachuting, except when the covered person has to make a parachute jump for self-preservation.

Who is eligible?

All full-time employees are eligible; however, if you are totally disabled, your effective date of insurance or change in coverage will be delayed until the date of your return to Active Service.

Eligible dependents include:

- Spouse/Domestic Partner
- Children (from live birth until the end of calendar year in which the child reaches age 25) if he/she lives in the insured's household, is dependent on the insured for support, or is enrolled full-time or part-time as a student in an accredited school/college.

NOTE: Children include natural children, adopted children, children in the insured's custodial care and children of a Domestic Partner (provided the Domestic Partner is also covered). A newborn child (based on the above definition of "children") is covered from the moment of birth until the 31st day of age, provided family coverage is in force at the time of birth. Otherwise, you must contact FBMC at 1-800-342-8017 and complete a Change in Status form. You may also visit www.dadeschools.net to download forms.

What injuries are covered and for how much?

Accidental Death and Dismemberment (AD&D) will pay the following percentage of the amount of coverage you purchase (from $25,000 up to $300,000 for employee coverage) if, within 365 days of an eligible accident, bodily injuries result in:

• Loss of life	100%
• Total paralysis of arms and legs	100%
• Loss of any combination of two: hands, feet or eyesight	100%
• Loss of speech and hearing in both ears	100%
• Total paralysis of both legs	50%
• Total paralysis of arm and leg on one side of the body	50%
• Loss of one hand, foot or sight in one eye	50%
• Loss of speech or hearing in both ears	50%
• Loss of thumb and index finger on the same hand	25%

For example, if you purchase $200,000 in coverage for yourself and you are in an accident that results in your death, the benefit would pay $200,000.

If the accident results in total paralysis of both your legs, the benefit would pay $100,000. If the accident results in loss of your thumb and index finger on the same hand, the benefit would pay $50,000.

If you suffer several of the above losses in one accident, you will receive one amount, which will be the largest amount to which you are entitled.

For example, if you suffer total paralysis of both your legs (a 50 percent benefit) and you also lose a thumb and index finger on the same hand (a 25 percent benefit), you will receive only the larger benefit amount of 50 percent.

Benefits will be reduced based upon the age of you or your spouse:

- If you are age 70 to 74, benefits will be reduced to 70 percent of the amount of coverage.
- If you are age 75 to 79, benefits will be reduced to 45 percent of the amount of coverage.
- If you are age 80 to 84, benefits will be reduced to 30 percent of the amount of coverage.
- If you are age 85 and over, benefits will be reduced to 15 percent of the amount of coverage.
- Coverage for children ends when they no longer qualify as eligible dependents.

What other benefits does this policy offer?

BENEFIT	WHEN IT APPLIES	AMOUNT
SEATBELT	Upon accidental death of insured person wearing a properly fitting seatbelt or properly secured child restraint if the insured person is in an accident and in a private passenger vehicle and the seatbelt or restraint fails to protect them.	An additional 10 percent of the benefit amount up to $10,000; minimum amount is $1,000.
EDUCATION*	If you have coverage for your family and an accident results in your death, each dependent child who enrolls as a full-time student at a school of higher learning before reaching age 25 and incurs expense for tuition, fees, books, room and board, transportation and any other costs payable directly to, or approved and certified by, such school.	An extra 3 percent of insured's amount or $7,500, whichever is less, for each qualifying child payable for four consecutive years as long as they continue their education in college or institution of higher learning*.
SPOUSE TRAINING	If you have coverage for your family and an accident results in your death, and your spouse enrolls within one year of your death in an accredited school to retrain or refresh skills needed for employment AND incurs expenses paid to school or approved and certified by school.	Up to $3,000 to reimburse spouses who receive educational training for employment for not more than one year after enrollment begins.
INCREASED DEPENDENT CHILD BENEFIT	If a dependent child has bodily injuries resulting in a covered loss.	Double the benefit amount, up to a maximum of $50,000**.
COBRA	If you have coverage for your family and an accident results in your death and your survivors elect to continue with coverage under your employer's medical plan as permitted by COBRA or state continuation law.	An extra 3 percent of employee's benefit amount, up to $4,500 per year, reimbursed once per year for not more than three years.
HOSPITAL CONFINEMENT DAILY INCOME BENEFIT	This benefit becomes payable for a covered accident, when you or an insured family member is registered as an in-patient at a hospital and is provided at least one day's room and board by the hospital.	An additional 1/30th of 1 percent of the Principal sum; maximum $50 per day of hospitalization once you have satisfied a four day inpatient confinement while under doctor's care.
MAMMOGRAPHY BENEFIT	This benefit becomes payable for 1) one baseline mammogram for each covered woman age 35 to 39; 2) One mammogram every two years, or more frequently based on physicians recommendation for each covered woman age 40 to 49; and 3) one mammogram every year for each covered woman age 50 and over.	

* If, at the time of the accident, you have coverage for your family but there is no dependent who is or could become eligible for the education or spouse education benefits, an additional benefit of $1,000 will be paid to the insured's designated beneficiary.

** If dependent child has more than one covered loss from a single covered accident, then only the benefit for the largest amount will be doubled to a maximum of $50,000.

Can I purchase coverage for my dependents?

If you sign up for employee coverage under the Employee-Paid FlexPlan Benefit you can also choose to select coverage for your family. The amount of insurance applies to only those dependents insured at the time the loss occurs. Benefits are as follows:

- Spouse-only coverage will provide 50 percent of the employee's coverage to a maximum of $150,000
- Children-only coverage will provide 15 percent of the employee's coverage, with a maximum of $25,000 per child.
- Spouse and children coverage will provide 40 percent of the employee's coverage for the spouse and 10 percent of the employee's coverage for each dependent child, with a maximum of $25,000 per child.

How do I obtain claim forms?

To obtain claim forms, call FBMC Customer Service at 1-800-342-8017, or the Interactive Benefits Line at 1-800-865-FBMC (3262). You may also visit www.dadeschools.net to download forms.

Can I convert my Employee-Paid insurance if I terminate employment?

Yes. You may apply for a conversion policy for all of your Accidental Death and Dismemberment (AD&D) in effect at termination (Convertible maximum amount is $250,000). You must complete a conversion application within 31 days after coverage ends. To request a Conversion application contact FBMC Customer Service at 1-800-342-8017. You may also visit www.dadeschools.net to download forms.

What insurance company makes this plan available to me?

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

Are benefits taxable?

The IRS may require you to pay taxes on payments you receive from the (AD&D) Coverage plan under current law. For further information, consult your personal tax advisor.

Your Personal Insurance rates are listed below.

CIGNA® Accidental Death and Dismemberment (AD&D)

Employee Coverage

	10-MONTH		11-MONTH		12-MONTH	
	EE Only	EE & Family	EE Only	EE & Family	EE Only	EE & Family
$25,000	$.48	$.78	$.40	$.65	$.37	$.60
$50,000	$.96	$1.56	$.80	$1.30	$.74	$1.20
$75,000	$1.44	$2.34	$1.20	$1.95	$1.11	$1.80
$100,000	$1.92	$3.12	$1.60	$2.60	$1.48	$2.40
$125,000	$2.40	$3.90	$2.00	$3.25	$1.85	$3.00
$150,000	$2.88	$4.68	$2.40	$3.90	$2.22	$3.60
$175,000	$3.36	$5.46	$2.80	$4.55	$2.58	$4.20
$200,000	$3.84	$6.24	$3.20	$5.20	$2.95	$4.80
$225,000	$4.32	$7.02	$3.60	$5.85	$3.32	$5.40
$250,000	$4.80	$7.80	$4.00	$6.50	$3.69	$6.00
$275,000	$5.28	$8.58	$4.40	$7.15	$4.06	$6.60
$300,000	$5.76	$9.36	$4.80	$7.80	$4.43	$7.20

Benefit payout will be:

Spouse only coverage = 50 percent of employee's coverage
Children only coverage = 15 percent of employee coverage
Spouse & Children = Spouse 40 percent of employee's coverage
Each child 10 percent of employee's coverage

NOTE: This product description does not constitute an insurance certificate or policy. The information provided is a summary of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance company.

Beneficiary Change Form

Employee Number _____ Employee Name _____

NAME	%	DOB	ADDRESS	RELATIONSHIP
Primary				
Contingent				

You must indicate your beneficiaries if you have selected Life Insurance or Accidental Death and Dismemberment (AD&D).

Employee Signature_____ Date _____

Complete and return via school mail to:
Office of Risk and Benefits Management
SBAB Annex, Room 127S
WL# 9112

FBMC/M-DCPS/1004

401(k) Supplemental Retirement Plan

The VISTA 401(k) Supplemental Retirement Plan is specifically designed for M-DCPS employees and is offered to you as an employee benefit. The plan provides 14 tax-deferred mutual fund choices that allow for diversification of your retirement savings.

Is it time to start planning for your retirement?

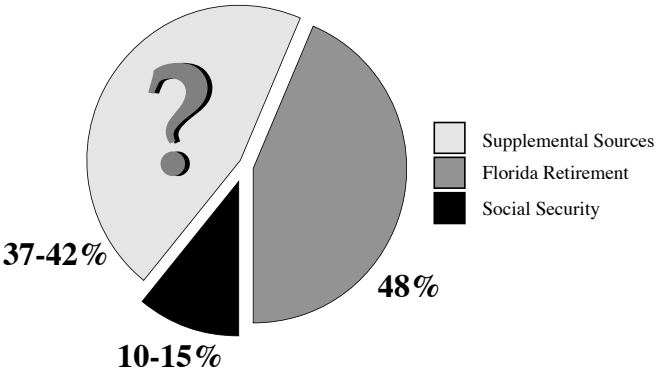
According to the U.S. Bureau of Census, of individual Americans age 65 and over:

- 46 percent have incomes under $10,000 annually
- 39 percent have incomes from $10,000 to $24,999
- 11 percent have incomes from $25,000 to $49,999
- 3 percent have incomes of $50,000 or more.

The earlier you start, the greater chance you will have in reaching your goal.

How can you improve your retirement income for the future?

The chart below shows the approximate percentages of retirement income provided from the Florida Retirement System* (figured as 48 percent of your highest five earning years of employment) and Social Security (10-15 percent). The other 37-42 percent of your retirement income would come from supplemental sources, such as 401(k) plans, options and other investment vehicles. To maintain the same level of income after you retire depends upon how you save and invest through your supplemental sources. That is why you should begin saving today.



Your school board has made available the VISTA 401(k) Plan, a qualified employer supplemental retirement plan. The plan provides mutual fund choices that allow for diversification of your retirement savings dollars.

* You will receive full retirement benefits after 30 years of service, or after 25 years of service if you have reached age 62.

How does it work?

The VISTA 401(k) Plan is specifically designed to help you save for retirement. During your working years you make tax-deferred contributions, which can be invested in one or more of the available funds. Taxes remain deferred on your contributions, earnings or any capital appreciation until you withdraw your money from the plan. Please remember that a 401(k) plan is a long-term retirement savings plan. Therefore, the government limits your access to your funds until age 59 1/2, or termination of employment.

Why do I need a VISTA 401(k) Plan?

Retirement planning is essential to maintain your lifestyle during your retirement years. The VISTA 401(k) Plan helps you minimize the effects of inflation and taxes on your retirement savings and compliments your Social Security benefits. The plan strives to maximize the long-term growth opportunities of your earnings by deferring tax on your contributions. The plan saves you money because your per-pay-period contributions reduce your taxable income.

What are the advantages of this plan?

- You defer income from your peak earning years to your retirement years, when, typically, you will be in a lower tax bracket.
- You pay no taxes on your contributions or on any earnings until you withdraw your money from the plan.
- Your tax savings are immediate because your VISTA 401(k) Plan contributions are deducted each pay period from your pre-tax salary.

EXAMPLE	POST-TAX	PRE-TAX
Gross	$1,000	$1,000
Investment	$ 0	$ 100
Taxable Income	$1,000	$ 900
Tax 20%	($ 200)	($ 180)
Net Income	$ 800	$ 720
Investment	$ 100	$ 0
Available Income	$ 700	$ 720

- Your tax-deferred contributions are professionally managed for you in the retirement fund(s) of your choice.
- You have a convenient, disciplined, and diversified method for creating your nest egg.

The chart below compares your potential accumulated savings with a tax-deferred retirement plan to your potential savings with an after tax account.

End of Year	Accumulated After-tax Savings (Bank, Credit Union, etc.)	401(k) Accumulated
1	$881	$1,233
2	$10,783	$16,388
3	$27,379	$46,204
4	$52,923	$100,451

This comparison assumes an employee contributes $100 per month, is in a 27 percent tax bracket, and earns 6% interest on the money contributed. However, this does not guarantee that a bank, credit union or the VISTA 401(k) plan will pay the 6% interest rate.

How much can I contribute?

- The maximum contribution for the 2005 calendar year is $14,000.
- The minimum annual contribution for this plan is $500.
- If you also have a 403(b) Tax-Deferred Annuity, the total annual contribution for both accounts usually cannot exceed $14,000. Consult your personal tax advisor for further information.
- You may contribute an additional $4,000 if you are age 50 or older.
- You may roll over your 403(b) Plan, IRA, and/or governmental 457 Plan (excluding tax-exempt 457 Plans) to the VISTA 401(k) Plan.
- If you are a surviving spouse, you can roll over distributions to the VISTA 401(k) Plan.

Investing your contributions

You can direct your contributions to any one of following 14 funds, or to any combination of funds:

American Century Investments

Ultra Fund

Seeks capital growth. The fund typically invests at least 90 percent of assets in equities selected for their appreciation potential. The majority of these securities are common stocks issued by companies that meet management's standards for earnings and revenue growth.

The fund may only purchase securities of companies that have operated continuously for three or more years. Fund inception date: 11/1981.

Fund Symbol: TWCUX

Inflation-Adjusted Bond Fund

Seeks to hedge inflation through a high quality portfolio of inflation-indexed bonds primarily issued by the U.S.Treasury. Fund inception date 2/1997.

Fund Symbol: ACITX

American Funds Group

EuroPacific Growth Fund

Seeks long-term growth of capital. The fund normally invests at least 65 percent of assets in equity securities of issuers domiciled in Europe or the Pacific Basin. It may invest up to 20 percent of assets in securities issued in developing countries. In addition to direct foreign investment, the fund may purchase American Depository Receipts. It may also invest in convertible securities and straight debt securities; no more than 5 percent of assets may be invested in debt securities rated below investment-grade. Fund inception date: 4/1984.

Fund Symbol: AEPGX

The Investment Company of America

Seeks long-term growth of capital and income. The fund invests primarily in common stocks, but it may also invest in high-quality convertibles and debt securities. When choosing securities, management gives the possibility of appreciation and potential dividends more weight than current yield. The fund may invest up to 10 percent of assets in foreign issues. Fund inception date: 1/1934

Fund Symbol: AIVSX

Delaware Investments

Growth Opportunities Fund

Seeks long-term capital growth. The fund invests primarily in equities that are selected based on the financial strength of the company, the expertise of its management, the growth potential of the company, and the growth potential of the industry itself. The fund may invest up to 25 percent of assets in foreign securities. The fund was formerly known as DELCAP. Fund inception date:
3/1986.

Fund Symbol: DFCIX

Goldman Sachs Group

Balanced Fund

Seeks to provide investors with a combination of current income and long-term growth of capital. The fund seeks to achieve its objective by investing in a diversified portfolio that includes equity and fixed income securities. Under normal market conditions, the fund is expected to maintain an asset mix of approximately 50 percent to 70 percent invested in equity related securities, with the remainder (at minimum 25 percent) in bonds and other fixed income senior securities. Fund inception date: 5/1994.

Fund Symbol: GSBFX

Capital Growth Fund

Fund can hold a range of equity investments from large-capitalization stocks of companies in mature industries to smaller capitalization stocks of growing companies in new fields. Fund inception date: 4/1990.

Fund Symbol: GSCGX

Oppenheimer Funds

Equity Fund

Seeks total return. The fund invests primarily in equities, though it may invest in cash and fixed-income securities without restrictions. In selecting investments, management emphasizes securities that provide opportunities for reasonable income as well as capital appreciation. The fund may invest without limit in foreign equity and debt securities. Fund inception date: 10/1947

Fund Symbol: OEQAX

T. Rowe Price Funds

Equity-Income Fund

Seeks dividend income; potential for capital appreciation is also considered. The fund invests at least 65 percent of assets in income-producing common stocks. In evaluating a security, the advisor considers the yield and prospects for earnings and dividend growth, the relative valuation of the security, and the overall competitive and financial strength of the company. Fixed-income securities may be held for enhancement of income. The fund may invest up to 25% of assets in foreign securities. Fund inception date: 10/1985.

Fund Symbol: PRFDX

T. Rowe Price Funds

Small-Cap Stock Fund

Seeks long-term growth by investing in stocks of small companies. Active bottom-up investment process, employing fundamental research and rigorous financial analysis. Blend of both growth and value investments. Portfolio core of value stocks; growth component driven by relative valuation of growth versus value. Broadly diversified portfolio on undervalued, well capitalized, cash generating niche business. Fund inception date: 06/1956.

Fund Symbol: OTCFX

Vanguard Group

Balanced Index Fund

Seeks growth and income. The fund normally invests 60 percent of assets in equities and 40 percent in debt. The equity portion seeks to replicate the Wilshire 5000 Index performance; to this end, the fund invests primarily in the 500 largest companies on the index and samples the rest. The fixed-income portion seeks to replicate the Lehman Brothers Aggregate Bond index performance; it may purchase investment-grade U.S. government obligations, corporate debt, and mortgage-backed securities to secure this goal. Fund inception date: 9/1992.

Fund Symbol: VBINX

Institutional Prime Money Market Fund

Seeks high income and a stable share price of $1. Fund inception date: 10/1989.

Fund Symbol: VMRXX

Institutional money market funds are only listed periodically.

500 Index Fund

Seeks investment results that correspond with the price and yield performance of the S&P 500 index. The fund allocates the percentage of net assets each company receives on the basis of the stock's relative total-market value: its market price per share multiplied by the number of shares outstanding. Fund inception date: 8/1976.

Fund Symbol: VFINX

Van Kampen

Emerging Growth Fund

Seeks capital appreciation. The fund normally invests at least 65 percent of assets in common stocks of small and mid-size companies in the early stages of their life cycle. It may invest up to 20 percent of assets in foreign securities. The fund may also invest in special situations involving new management, special products, mergers or liquidations. Fund inception date: 10/1970.

Fund Symbol: ACEGX

A complete description of these funds is enclosed in the VISTA 401(k) Enrollment Packet.

Directing your contributions

You direct your contributions when you complete your VISTA 401(k) enrollment form. If you do not specify where you want to direct your contributions, they will automatically be invested in the plan's money market fund.

How do I know what I am earning?

The VISTA 401(k) Plan mails account statements at the end of each calendar quarter to all participants. The statements show your account balance and contributions for that quarter. You may also check your account balance by calling the automated phone system at 1-877-204-4015 or by visiting the Web site at www.vista401k.com. If you need additional information, call FBMC Customer Service at 1-800-342-8017, Monday through Friday, 7 a.m.-10 p.m. ET

Can I change my fund allocations during the plan year?

Yes. To change your fund allocations during the year, simply call the automated phone system at 1-877-204-4015 or visit the Web site at www.vista401k.com. You will receive information on how to use both the automated phone system and Web site, along with your personal PIN number, approximately 10 days after your first contribution. You can redirect your current balance, your future contributions or both. You can make these changes at any time.

Can I change my contribution amount during the plan year?

Yes. You may increase, decrease or restart your contribution amount twice each plan year. You can stop your contributions at any time, even if you have made a change during the year. Call FBMC Customer Service at 1-800-342-8017 or visit www.vmc.cc for a Change of Contribution Form.

When do I pay taxes on my money?

You pay taxes on your VISTA 401(k) Plan contributions and earnings when you withdraw them. If you want to avoid paying taxes when you withdraw your funds, IRS regulations allow you to roll over all or part of your VISTA 401(k) Plan proceeds to an IRA or any qualified 401(k) plan without being taxed, when you reach withdrawal eligibility. Before making a withdrawal, call FBMC Customer Service at 1-800-342-8017 (Monday through Friday, 7 a.m.-10 p.m. ET) to request a copy of the IRS "Special Tax Notice Regarding Plan Payments."

When can I withdraw my funds?

Plan rules approved by IRS stipulate you can withdraw your money only:

- when you reach age 59 1/2
- when you retire or terminate employment
- upon death or becoming totally and permanently disabled, or
- upon incurring a financial hardship.

The IRS strictly regulates hardship withdrawals. Elective deferrals and earnings accruing before December 31, 1988 can be distributed to you in the event of certain hardships. Elective deferrals, but not earnings, occurring after January 1, 1989 can also be distributed to you in the event of these hardships.

Withdrawal Penalties

A 10 percent penalty tax is imposed for non-qualified distributions. The tax is excluded on distributions for the following circumstances:

- Distributions to you if you have reached age 55 and have separated from service
- Hardship distributions for deductible medical expenses that exceed 7.5 percent of adjusted gross income
- Distributions to an alternate payee under a qualified domestic relations order, issued by a court in a divorce or dissolution of marriage proceeding
- Distributions made because of the employee's death or disability

What are the fees?

- Overall Management - The fees vary from .0035 to .0100 depending upon whether the mutual fund company pays management fees and/or education and enrollment allowances to VISTA Management Company, as disclosed in their prospectuses.
- Administration - $3.00 per calendar quarter.
- Mutual Fund - There are investment fees that are different for each fund as described in their prospectus. A detailed summary is available upon request.

NOTE: Some of these funds normally charge a percentage from contributions by individual investors. All of those charges have been waived by each fund for the VISTA 401(k) Plan. Therefore, your contributions purchase shares at Net Asset Value (NAV).

Can I borrow money from my 401(k) plan?

The VISTA 401(k) plan has a loan provision. The following are some of the rules that govern the plan:

1. You must have at least a $2,000 balance, your minimum loan amount is $1,000, and the maximum is up to one-half the account balance (excluding employer contributions) or $50,000, whichever is less.
2. The interest you pay on the loan is deposited into your 401(k) account. The interest rate will be the current prime rate plus two percent (2%) and will remain fixed for the life of the loan.
3. There is a $65.00 loan origination fee.

When can I contribute to the VISTA 401(k) plan?

- You are eligible to open a 401(k) account any time during the year.
- In the spring, you may request to roll over sick leave into the plan.
- You may be eligible to roll funds into this 401(k) plan from a previous employer's 401(k) plan.

How do I enroll in the VISTA 401(k) plan?

You must request an Enrollment Packet by calling FBMC Customer Service at 1-800-342-8017. Upon receipt of the Enrollment Packet, follow the simple instructions provided and mail the completed form to VISTA Management Company. If you have questions or need assistance, call FBMC Customer Service at 1-800-342-8017 (Monday-Friday, 7 a.m.-10 p.m. ET).

If you wish to open a 401(k) retirement plan through pre-tax payroll deductions, please print the form that follows, complete and mail to:

Vista Management Company
P.O. Box 1878
Tallahassee, Fl 32302-1878

Contribution Chart and Enrollment Form

NAME _____ SOC. SEC.# _____ EMPLOYEE# _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

E-MAIL: _____ FAX# (If desired method of communication): _____

1 CONTRIBUTION INSTRUCTIONS AND AMOUNT

Indicate below the per pay period amount **you** wish to contribute to your 401(k) Plan.
The minimum **annual** contribution is **$500.00**.

$ _____ Per Pay Period Number of Pay Periods Per Year _____

PAYROLL CODE (If applicable): _____

FOR DEDUCTION CONTROL USE ONLY	
Current Contribution:	Begin Date:
New Contribution:	P/R Date:
Date Proc. by:	Date Ck'd. by:

Please initial any corrections.

2 INVESTMENT ELECTION INSTRUCTIONS

Indicate below how you want your contributions invested.
Divide your investment choices by whole numbers.
The total percentages invested in all funds combined must equal 100%.

If you do not complete this section, your contributions will automatically be invested in the Vanguard Institutional Prime Money Market Fund.

INVESTMENT ELECTIONS FOR NEW CONTRIBUTIONS

American: EuroPacific	_____%	Oppenheimer: Equity	_____%
American: Investment Company of America	_____%	T. Rowe Price: Equity Income	_____%
American Century: Ultra	_____%	T. Rowe Price: Small Cap Stock	_____%
American Century: Inflation-Adjusted Bond	_____%	Vanguard: Balanced Index	_____%
Delaware: Growth Opportunities	_____%	Vanguard: Institutional Prime Money Market	_____%
Goldman Sachs: Balanced	_____%	Vanguard: 500 Index	_____%
Goldman Sachs: Capital Growth	_____%	Van Kampen: Emerging Growth	_____%
		Total	**100%**

For information on the investment funds refer to the Fund Prospectus. Please initial any corrections.

*Desired method for future communications** (check one): ❑ Mail to my home ❑ E-mail ❑ Fax

*Quarterly Statements will be mailed to the home address.

DATE OF BIRTH: _____ ❑ MARRIED ❑ SINGLE

HOME PHONE: (___)_____ WORK PHONE: (___) _____

EMPLOYER: _____ WORK LOCATION: _____

Please initial any corrections.

3 SELECTION OF BENEFICIARIES

If you have more than one primary beneficiary, your account balance will be divided as you specify below. In the event a primary beneficiary does not survive you, your account balance will be divided among your contingent beneficiaries as specified below. Your percent of assets must be in whole numbers and equal to 100%.

PRIMARY BENEFICIARIES*

1. Name _____
   Home Address _____
   Social Security Number _____
   Relationship _____% of Assets _____

2. Name _____
   Home Address _____
   Social Security Number _____
   Relationship _____% of Assets _____

CONTINGENT BENEFICIARIES

1. Name _____
   Home Address _____
   Social Security Number _____
   Relationship _____% of Assets _____

2. Name _____
   Home Address _____
   Social Security Number _____
   Relationship _____% of Assets _____

* NOTE: If you are married and wish to designate a primary beneficiary other than your spouse, please complete a **Spousal Consent Form**, even if you wish to divide the primary beneficiary between your spouse and another person. This form requires notarization and can be obtained from VISTA Customer Service at 1-800-342-8017. Federal Rules require this procedure. In addition, if you wish to add more beneficiaries, please attach a separate list.

Please initial any corrections.

4 EMPLOYEE AUTHORIZATION

This agreement shall be legally binding and irrevocable as to both of the parties hereto while employment continues; provided, however that either party may change or terminate this agreement by giving notice in writing and in accordance with Board procedures, rules and prescribed methods concerning said changes or terminations. Further, no more than one agreement for such salary reduction may be made within any taxable year of the undersigned employee except to the extend otherwise permitted under Section 401(k) of the Internal Revenue Code, as amended. However, in the event the amount of earnings due the undersigned Employee during any regular pay period shall be insufficient to pay the corresponding reduction (as described in Section 1a of the agreement), or in the event the Board fails because of error to make said reduction, then the amount of reduction provided for in Section 1a of this agreement shall be reduced by the amount of said reduction or reductions not made through insufficiency or through error as therein above provided.

That except as herein set forth, the contract of employment of the Employee is not otherwise amended and shall remain in full force and effect. It is agreed and understood that the School Board and VISTA Management Company undertake no obligation by making available a salary reduction agreement through payroll deduction to make contributions to any Section 401(k) Tax Sheltered Investment Plan. You have selected your own investments from the selection list and the School Board or VISTA Management Company has no responsibility for investment results.

I understand and agree that my employer, union and VISTA Management Company, the Plan Administrator, will be held harmless from any liability resulting from either my participation in the VISTA 401(k) Plan or my failure to accurately complete this enrollment form. I understand that my salary reduction contributions are not subject to federal income tax until distribution from the VISTA 401(k) Plan but the salary reduction contributions are subject to Social Security taxes.

Employee Signature_____ Date Signed _____

FOR USE BY VISTA MANAGEMENT COMPANY

Registered Representative | General Principal

FBMC Privacy Notice 4/14/03

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

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

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

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

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

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

Notice of Administrator's Capacity

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

1. FBMC has been authorized by your employer to provide administrative services for your employer's insurance plans offered herein. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits offered herein to provide certain services, including (but not limited to) marketing, underwriting, billing and collection of premiums, processing claims payments, and other services. FBMC is not the insurance company or the policyholder.

2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

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