COBB COUNTY
SCHOOL DISTRICT

2012 Benefits

for Active Employees

CCSD Benefits Office Mailing Address:

P.O. Box 1088, Marietta, GA 30061

Physical Location:

590 Commerce Park Drive, Suite 150, Marietta, GA 30060

Telephone: 770-426-3537

Email: benefits@cobbk12.org

Table of Contents

Benefit Plan year is from January 1, 2012 – December 31, 2012

Note: This book is a summary of the employee benefits offered by Cobb County School District. Refer to the summary plan description or policies and regulations for the specific details, requirements, and stipulations. All benefits are subject to change.

Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information, contact the CCSD Benefits Office at (770) 426-3537.

MEDICAL INSURANCE
(Please reference the SHBP Active Employee Decision Guide 2012 for all carrier/vendor names and phone numbers (www.dch.georgia.gov/shbp)

DENTAL INSURANCE
Delta Dental Insurance Company
1-800-521-2651

VISION DISCOUNT INSURANCE
CompBenefits/Humana
1-800-865-3676

LIFE INSURANCE (BASIC, SUPPLEMENTAL, DEPENDENT)
The Hartford
1-800-523-2233

CANCER INSURANCE
Allstate Benefits
1-800-521-3535

LEGAL PLAN
ARAG
1-800-821-6400

DISABILITY PLANS (SHORT TERM/LONG TERM)
The Hartford
1-800-523-2233

TAX-DEFERRED SAVINGS PLANS
(Please refer to pages 53-56)

OPTIONAL SPENDING ACCOUNTS, LEAVES OF ABSENCE, RETIREMENT AND CATASTROPHIC ILLNESS LEAVE BANK
CCSD Benefits Office
770-426-3537

OTHER REFERENCE NUMBERS
Credit Union of Georgia
678-486-1111

Health Care Reform

Effective January 1, 2012, the CCSD local benefit plans will observe the "age 26 rule for dependents" for all CCSD local plans (i.e. dental, vision, cancer, legal, etc.) This means that covered dependents will have coverage through the month in which they turn 26, regardless of college enrollment status, marital status or if offered coverage elsewhere.

Thank you.

Who is an Eligible Dependent?

An eligible dependent that may be covered on your benefit plan includes any one of the following:

- **Spouse** – (your legal spouse as defined by Georgia Law). You will be required to provide a copy of a certified marriage license or copy of your most recent jointly filed federal tax return with your spouse's signature.

- **Natural Child** – You will be required to provide a copy of the certified birth certificate showing parents' names (birth card issued by hospital for newborn is also acceptable).

- **Step-Child** – You will be required to provide a copy of the birth certificate showing your spouse as parent, a copy of the certified marriage license for yourself and your spouse and you, AND a notarized statement that your step-child lives in your home at least 180 days per year.

- **Other Children** – Other children refers to those adopted and for whom you have temporary or permanent guardianship. You will be required to provide a copy of the court decree showing your financial responsibility for the dependent, a copy of the certified birth certificate, and a notarized statement that the dependent lives in your home on a permanent basis.

The Cobb County School District Flexible Benefit Plan

Section 125 is an IRS code that permits an eligible employee to elect and purchase designated insurance benefits, and to have the premiums for the elected benefits deducted from his or her paycheck before taxes are taken out. This results in the employee paying lower taxes and having more take home pay.

The Cobb County School District Flexible Benefits Plan is divided into two parts, respectively: (1) Insured Benefits and (2) the Optional Spending Accounts. Eligible employees are automatically enrolled in the Insured Benefits portion of the Plan when they choose health, dental, cancer, vision and/or employee life insurance (up to $50,000 coverage).

The Flexible Benefits Plan simply changes the order in which your paycheck is calculated. By deducting eligible expenses BEFORE taxes are calculated, you reduce your taxable income. Payment with pretax dollars means increased take home pay.

CHANGING FAMILY STATUS UNDER THE PLAN

In compliance with IRS Regulations and Section 125, elections under the plan may not be changed outside the Open Enrollment period unless you have a change in family status. A change in family status includes, but is not limited to:

- marriage
- divorce
- legal separation
- death of a spouse
- child, birth or adoption of a child
- change in legal custody
- a significant change in your dependent care provider plan
- spouse's employment or termination of employment
- switching from full-time to part-time or vice versa

- significant increase in cost or a curtailment of benefits that amount to a loss of coverage
- an unpaid leave of absence by the employee or spouse

You must request a Family Status Change within 31 days of the event and provide the necessary documentation substantiating the change. If you change your election because of a change in family status, the change is generally effective on the first day of the month following your election. Changes can be made for health, dental, vision and life insurance. Refer to each individual insurance policy for details

In an effort to assist you with a complete understanding of how the total Flexible Benefit Plan works, let us now examine the first part of the Plan, your insured benefits:

- ★ Health
- ★ Dental
- ★ Cancer
- ★ Vision
- ★ Life
- ★ Legal Services
- ★ Short- and Long-Term Disability Insurance

We will also examine additional retirement planning options, such as the Teachers Retirement System, the Public School Employees Retirement System, and tax sheltered annuity options available to CCSD employees.

How Do I Know What CCSD Benefits I'm Eligible For?

Health Insurance

You are eligible for health benefits with CCSD if you are:

- A certified employee working half-time or more, but not less than 18 hours a week –or-
- A non-certified employee who participates in the Teachers Retirement System, working at least 60% of a standard schedule for that position, but not less than 20 hours a week –or-
- An employee eligible to participate in the Public School Employees Retirement System, working at least 60% of a standard schedule for that position, but not less than 15 hours a week –or-
- A retired employee of one of the eligible group state retirement plans.

Examples:

Position	Minimum hour/day scheduled to work
Teachers	4 hours a day
Clerical and Paraprofessionals	4 1/2 hours a day
Bus Drivers and Bus Monitors	5 hours a day
Food Service Assistants	4 hours a day
Custodians	5 hours a day

Local Benefits

You are eligible for these benefits if you are considered a regular employee consistently working at least 20 hours a week (4 hours a day).

Dental Insurance	Life Insurance
Short and Long Term Disability Insurance	Cancer Insurance
Vision Discount Plan	Legal Service
	Optional Spending Accounts

Teachers Retirement System

All employees who are employed one-half time or more (at least 20 hours a week) in a TRS-covered position of the State's public school system are required to be a member of the Teachers Retirement System of Georgia (TRSGA) or its equivalent as a condition of employment.

Examples:	Teachers	Administrators
	Supervisors	Clerical Workers
	Paraprofessionals	Campus Police Officers

Public School Employees Retirement System

Regular employees of public school systems who are NOT eligible to participate in the TRSGA must establish membership in the Public School Employees Retirement System (PSERS) as a condition of employment. This does not include substitute employees who work less than 60% of a monthly reporting period.

Examples:	Bus Drivers and Bus Monitors	Custodians
	Food Service Assistants	Maintenance Workers

Tax Deferred Savings Plans 403(b), Roth 403(b), 457(b), and 457(b) with mutual fund plans

Eligibility to participate in the Tax Deferred Savings Plans is available to all regular employees and to all temporary employees who have worked consistently 20 hours/week for 90 days.

Temporary Employees

Temporary employees are eligible to join the Tax Deferred Savings Plans. Temporary employees are not eligible for any other benefits.

Examples:	ASP Workers	Lunchroom Monitors
	Substitute Teachers	Seasonal Employees

Health Insurance Plans

The Cobb County School District offers health benefits through the Georgia Department of Community Health and the State Health Benefit Plan (SHBP). This brief overview will help you determine which option fits your health care needs.

NOTE: Employees with a hire date of January 1, 2009 or later have the opportunity to choose between two health plan options by CIGNA Healthcare and UnitedHealthcare: the High Deductible Health Plan (HDHP) and the Health Reimbursement Arrangement (HRA).

Consumer Driven Health Plan Options

The Health Reimbursement Arrangement (HRA) and the High Deductible Health Plan (HDHP) are consumer driven health plan options. These options are structured to provide lower out-of-pocket expenses for many participants and are explained in the SHBP Decision Guide. Participation in these options impacts your eligibility and the amount you can contribute to a Flexible Spending Account. Additional information to assist you with understanding the rules and differences may be found in the SHBP Decision Guide.

Health Reimbursement Arrangement (HRA)

The HRA is a consumer driven health care option whose plan design offers you a different approach for managing your health care needs. It is similar to the PPO with an in-network and out-of-network benefit; however, in an HRA, SHBP funds monetary credit to provide first dollar coverage for eligible health care and pharmacy expenses. The amount in your HRA is used to reduce the deductible and maximum out-of-pocket. After satisfying your deductible, you will pay your coinsurance amount until you reach your out-of-pocket maximum.

High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)

The High Deductible Health Plan (HDHP) design is very similar to that of the PPO with an in-network and out-of-network benefit. In return for a low monthly premium, you must satisfy a high deductible that applies to all health care expenses except preventive care. **If you have family coverage, you must meet the ENTIRE family deductible before benefits are payable for any family member. You pay co-insurance after you have satisfied the deductible rather than set dollar co-payments for medical expenses and prescription drugs.** Also, you may qualify to start a Health Savings Account (HSA) to set aside tax-free dollars to pay for eligible health care expenses now or in the future. HSAs typically earn interest and may even offer investment options. See the benefits comparison chart in the SHBP Decision Guide to compare benefits under the HDHP to other Plan options. An HSA is like a personal savings account with investment options for health care, except it's all tax-free.. You may open an HSA with an independent HSA administrator/custodian. You may locate HSA Administrators at www.healthsavingsinfo.com/finding.htm. You may open an HSA if you enroll in the SHBP HDHP and do not have other coverage through: 1) Your spouse's employer's plan, 2) Medicare, 3) Medicaid, 4) General Purpose Health Care Spending Account (GPHCSA), or any other non-qualified medical plan.

Health Maintenance Organization (HMO)

A Health Maintenance Organization (HMO) allows you to receive benefits from participating providers only and does not require you to select a Primary Care Physician (PCP). HMOs provide 100 percent benefit coverage for preventive health care needs after paying applicable co-payments. Certain services are subject to a deductible and co-insurance. See the SHBP Decision Guide for more information.

TRICARE Supplement

The TRICARE Supplement Plan is an alternative to SHBP coverage that is offeed to employees and dependents who are eligible for SHBP coverage and are also eligible for TRICARE. The TRICARE Supplement is not sponsored by the SHBP, the Department of Community Health or any employer. The TRICARE Supplement is sponsored by the American Military Retirees Association and is administered by the Association & Society Insurance Corporation. In general, to be eligible, the employee and dependents must each be under age 65, ineligible for Medicare and registered in the Defense Enrollment Eligibility Reporting System (DEERS). For complete information about eligibility and benefits, contact 1-866-637-9911 or visit www.asicorporation.com

Dental Insurance Plans

Cobb County School District is pleased to provide two dental benefit plan options from Delta Dental Insurance Company**:**

- **Delta Plus Plan Option**
- **Delta Base Plan Option**

Both plan features permit you to have dental coverage with real advantages. You decide which plan best fits your individual needs. Because there are differences in coverage levels and costs, you should become familiar with the enclosed plan summary information so you can make the most informed decision possible.

NOTE: Please be aware that if your dependent spouse is an employee of the Cobb County School District, your spouse can enroll for coverage as an employee or spouse, but not as both.

Delta Dental Insurance Company is not content to just provide you with great dental protection – they want you to have a great experience. If you have questions, simply call **1-800-521-2651** to access all the tools and information you will need to be better informed about your dental plan options.

Like most group health insurance policies, Delta Dental group policies contain certain exclusions, limitations, waiting periods, and terms for keeping them in force. Please contact Delta Dental for complete details.

Benefits Tip:

You may set aside pre-tax dollars in the CCSD Optional Spending Account to pay for health care related expenses such as dental work, deductibles, vision exams, over the counter medications and much more! See the section on Optional Spending for additional information.

Delta Dental PPO℠ – Easy, Friendly, Accessible

We'll do **whatever it takes and then some.**

Greatest potential savings when you visit a Delta Dental PPO dentist

OUT-OF-POCKET COSTS

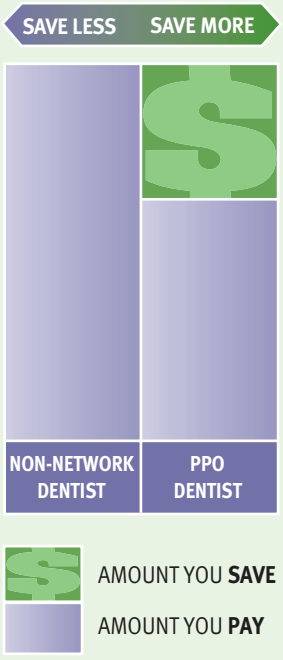

Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and by group contract.

We're pleased to be your partner in maintaining great oral health. The Delta Dental PPO* plan makes it easy for you to find a dentist, and easy to control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

- **Save money with a Delta Dental PPO dentist.** Our PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental dentists won't balance bill you the difference between the contracted amount and their usual fee.
- **Visit the dentist of your choice.** Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest when you see a PPO dentist.
- **Many network dentists to choose from.** Since Delta Dental offers access to some of the largest dentist networks in the U.S., chances are there's a wide choice of network dentists near your home or office. Four out of five dentists nationwide are contracted Delta Dental dentists, giving more enrollees convenient access to more dentists. Visit us at www.deltadentalins.com to search our dentist directory by location or specialty.
- **Easy to use your benefits.** When you visit a Delta Dental dentist, pay only your portion for services. Delta Dental dentists will file claim forms for you and receive payment directly from us. Many non-Delta Dental dentists ask that you pay the entire cost up front and wait for reimbursement.
- **Delta Dental's Online Services make getting information quick and easy.** Access your benefits and eligibility, print ID cards and get information about your claims. And check out Delta Dental's oral health resources too for tips and information that can help keep your smile healthy.

** In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.*

DELTA DENTAL®

WE KEEP YOU SMILING®

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Plan Benefit Highlights for: Cobb County School District - Plus Plan

Group No: GA15540 **Effective Date:** 1/1/2012

Eligibility	Primary enrollee, spouse and eligible dependent children to age 26
Deductibles	$50 per person / $150 per family each calendar year
Deductibles waived for D & P?	Yes
Maximums	$1,000 per person each calendar year
D & P counts toward maximum?	Yes

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays, sealants	100 %	100 %
Basic Services Fillings, simple tooth extractions	75 %	75 %
Endodontics (root canals) Covered Under Basic Services	75 %	75 %
Periodontics (gum treatment) Covered Under Basic Services	75 %	75 %
Oral Surgery Covered Under Basic Services	75 %	75 %
Major Services Crowns, inlays, onlays and cast restorations, bridges and dentures	50 %	50 %
Orthodontic Benefits adults and dependent children	40 %	40 %
Orthodontic Maximums Lifetime	$ 1,000 Lifetime	$ 1,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and 90th percentile for non-Delta Dental dentists.

Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

Customer Service
800-521-2651

Claims Address
P.O. Box 1809
Alpharetta, GA 30023-1809

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

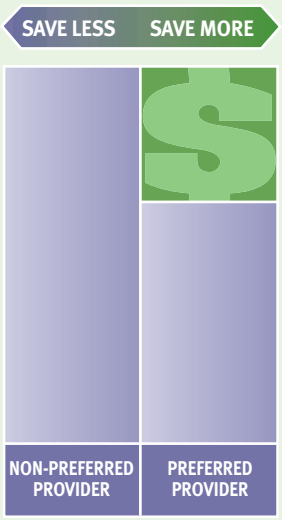
Delta Dental – Easy, Friendly, Accessible

Cobb County School District

We'll do **whatever it takes and then some.**

Greatest potential savings when you visit a Preferred Provider (Delta Dental PPO provider).

OUT-OF-POCKET COSTS



AMOUNT YOU **SAVE**

AMOUNT YOU **PAY**

Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and by group contract.

We're pleased to be your partner in maintaining great oral health. The Delta Dental plan makes it easy for you to find a dentist, and easy to control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

- **Save money with a Preferred Provider.** Our PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a Delta Dental PPO dentist. This also ensures Delta Dental PPO dentists won't balance bill you the difference between the contracted amount and their usual fee.
- **Visit the dentist of your choice.** Want to visit a Non-Preferred Provider (Delta Dental Premier® or non-Delta Dental dentist)? No problem. You can visit any licensed dentist, but your costs are usually lowest when you see a Preferred Provider.
- **Many network dentists to choose from.** Since Delta Dental offers access to some of the largest dentist networks in the U.S., chances are there's a wide choice of network dentists near your home or office. Four out of five dentists nationwide are contracted Delta Dental dentists, giving more enrollees convenient access to more dentists. Visit us at www.deltadentalins.com to search our dentist directory by location or specialty.
- **Easy to use your benefits.** When you visit a Delta Dental PPO or Delta Dental Premier dentist, you pay only your portion for services. Delta Dental dentists will file claim forms for you and receive payment directly from us. Many non-Delta Dental dentists ask that you pay the entire cost up front and wait for reimbursement.
- **Delta Dental's Online Services make getting information quick and easy.** Access your benefits and eligibility, print ID cards and get information about your claims. And check out Delta Dental's oral health resources too for tips and information that can help keep your smile healthy.

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Plan Benefit Highlights for: Cobb County School District - Base Plan
Group No: GA15540 **Effective Date:** 1/1/2012

Eligibility	Primary enrollee, spouse and eligible dependent children to age 26
Deductibles	**Preferred Providers** None **Non-Preferred Providers** $50 per person / $150 per family each calendar year
Deductibles waived for D & P?	No
Maximums†	**Preferred Providers** $750 per person each calendar year **Non-Preferred Providers** $500 per person each calendar year
Orthodontic Maximums	**Preferred Providers** $750 lifetime **Non-Preferred Providers** $500 lifetime

† The maximum amount payable for all services received from all dentists will not exceed the maximum amount payable for PPO dentists.

Sample Benefits and Covered Services*	Preferred Providers[1] Enrollee Pays[2]	Non-Preferred Providers[3] Plan Pays
Diagnostic & Preventive Services (D & P)	D0120 Periodic oral exam – established patient: $0 D0272 Bitewings (two films): $5 D1110 Prophylaxis (cleaning): $15	85 %
Basic Services	D2150 Amalgam fillings, two surfaces – primary or permanent: $45 D2160 Amalgam fillings, three surfaces – primary or permanent: $55	50 %
Endodontics	D3310 Root canal, (anterior – excluding final restoration): $300	40 %
Non-Surgical Periodontics	D4341 Periodontal scaling and root planing - four or more teeth per quadrant: $90	40 %
Surgical Periodontics	D4210 Soft tissue surgery – gingivectomy (per quadrant): $230	40 %
Oral Surgery	D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal): $55	40 %
Major Services	D2750 Crown; porcelain fused to high noble metal: $480 D5110 Complete denture – maxillary: $620	40 %
Orthodontic Benefits dependent children	50%	50%

* Limitations or waiting periods may apply for some benefits; some services may be excluded. Reimbursement is based on PPO Contracted Fees for all dentists.

[1] Preferred Providers are Delta Dental PPO® dentists.

[2] Copayments specified above represent only a few examples from your plan's table. Please refer to your Benefit Booklet for a full schedule of copayments and for any limitations and exclusions on these benefits.

[3] Non-Preferred Providers include Delta Dental Premier® and non-Delta Dental dentists.

Delta Dental Insurance Company	**Customer Service**	**Claims Address**
1130 Sanctuary Parkway, Suite 600	800-521-2651	P.O. Box 1809
Alpharetta, GA 30009	**deltadentalins.com**	Alpharetta, GA 30023-1809

Visit the Delta Dental website www.deltadentalins.com

We'll do **whatever it takes and then some.**

Convenient services and information on our website

Our website* makes it easy for you to manage your dental plan. Tools, services, information, forms – you'll find everything you need just a click away.

1 Log in to:

- Check benefits, eligibility and claims status
- Print your ID card
- Find the average cost of a dental procedure in your area

2 Find a dentist:

- Select your plan
- Enter options such as state and ZIP code
- Search for a dentist and link to a map with driving directions

3 Oral health information
Read articles, watch videos, find a glossary of dental terms and subscribe to *Dental Wire*, our free dental health newsletter

4 Oral Health Quizzes
Assess your risk for cavities and gum disease and learn how to prevent them

5 Just for kids
See our kids' website also available at MySmileKids.com

* *The website www.deltadentalins.com is the home of the Delta Dental companies listed on the reverse side and their subsidiaries and affiliates. For other Delta Dental companies, visit the Delta Dental Plans Association website at www.deltadental.com.*

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Why do 54 million enrollees trust their smiles to Delta Dental?

- More dentists
- Simpler process
- Less out-of-pocket

Free Newsletter

Get the latest in oral health with *Dental Wire*, our bi-monthly e-mail newsletter. Sign up at: deltadentalins.com/oral_health

Delta Dental Customer Service

DeltaCare USA®
800-422-4234

Delta Dental PPO℠ and Delta Dental Premier®
Delta Dental of California
800-765-6003

Delta Dental of Delaware
Delta Dental of the District of Columbia
Delta Dental of New York
Delta Dental of Pennsylvania (and Maryland)
Delta Dental of West Virginia
800-932-0783

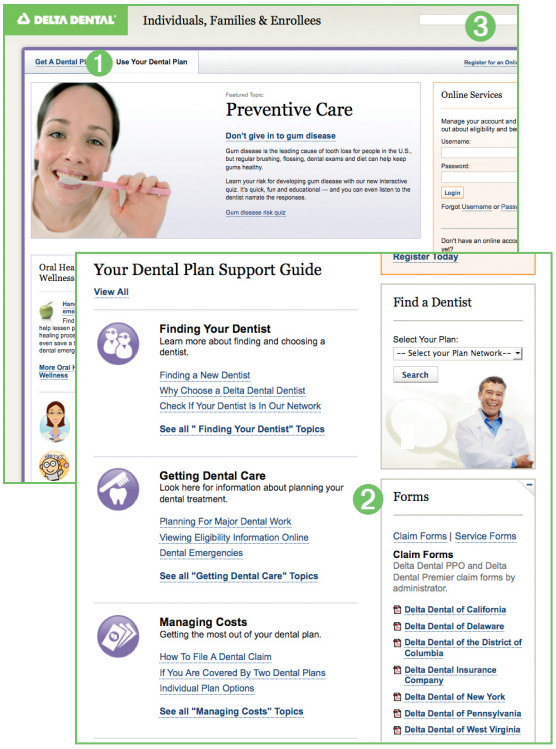
Delta Dental Insurance Company (Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas, Utah)
800-521-2651

California School District Employees
800-499-3001

www.deltadentalins.com

Delta Dental includes these companies in these states: Delta Dental of California – CA • Delta Dental of Pennsylvania – PA & MD • Delta Dental of West Virginia – WV • Delta Dental of Delaware – DE • Delta Dental of the District of Columbia – DC • Delta Dental of New York – NY • Delta Dental Insurance Company – AL, FL, GA, LA, MS, MT, NV, TX, UT

DELTA DENTAL®



1 Other tools and information:

Visit the "Use Your Dental Plan" page for a helpful plan support guide and answers to frequently asked questions.

- Download and print a claim form
- Find general information about how your plan works
- Get instructions for using our website

2 Forms and support:

- Find quick links to claim, grievance and customer service request forms

3 Delta Dental en Español:

- Visit a Spanish version of our website

Q: How do I log in to the website?

A: Simply enter your user name and password in the designated boxes and submit. If you don't already have a user name or password, click the "Register Today" link to complete the quick registration process.

Q: What if I have trouble logging in to the website?

A: If you have problems, use the Online Services Login Customer Service Form to contact us for assistance. You can find the form on the "Individuals & Enrollees" page of the website. Scroll down the "Individuals & Enrollees" page to find the Forms box on the right-hand side of the page. You can find the Online Services Login Service Form link at the end of the Customer Service Forms section.

Q: What if I don't have Internet access?

A: You can check your benefits, eligibility and claim information on our interactive voice response telephone line or speak to a Customer Service agent Monday through Friday by calling Delta Dental toll-free. For DeltaCare® USA enrollees, please call 800-422-4234. For Delta Dental PPO℠ and Delta Dental Premier® enrollees, please use the appropriate number listed at the left to call your local Customer Service.

Q: Can I contact Delta Dental through the website?

A: Yes. You don't have to log in to contact us from the website. Simply click on "Contact us" at the top of the home page and follow the appropriate links for your plan. You'll be presented with a number of contact options, including Online Customer Service Request Forms for specific issues.

Q: How can I check on the average cost of a dental procedure in my area?

A: Log in by entering your user name and password and click on "Fee Finder" in the main navigation menu.

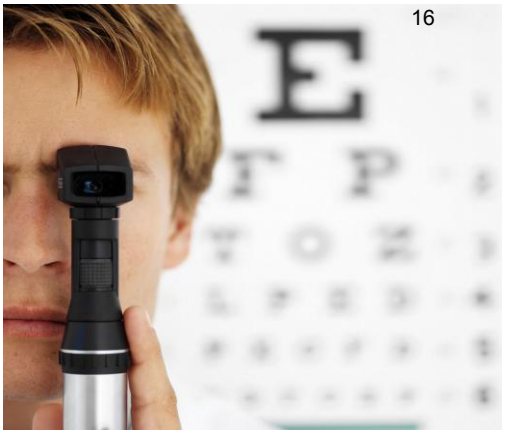
Q: How current is the information in the online dentist directory?

A: The "Find a Dentist" directory is updated daily.

Q: What if I have more questions?

A: For detailed instructions on checking your benefits and eligibility, finding a dentist, printing an ID card and submitting a claim form, visit the "Use Your Dental Plan" page of our website for these and other helpful topics.

EF30 #59823 (rev. 8/10)



Vision Discount Plan and Insurance

Cobb County School District offers a comprehensive vision package through Humana CompBenefits. There are three distinct plan options from which employees may select.

Please reference the following Humana CompBenefits Employee Decision Guide to select the vision plan option that is most appropriate for you and your family.

Benefits Tip:

Some CCSD health insurance plans also have vision benefits. Please review the health insurance carefully to ensure that you are making the best decision regarding vision benefits!

Cobb County School District

Group Voluntary Vision Insurance Coverage – *NEW!*

About CompBenefits' VisionCare Plan

All CCSD benefits eligible employees may participate in the new group Voluntary Vision Insurance Coverage from CompBenefits beginning January 1, 2008.

To fit your needs, you can choose one of the three (3) plan options offered by CCSD. A summary of plan features and pricing is below. Detailed plan provisions, claims information, examples of how the plan works and contact information are on the following pages.

NOTE: You can go to non-network providers but your out-of-pocket costs for services and materials may be higher. The *Discount Plan* does not have out-of-network benefits.

CCSD Employee Vision Insurance Option Summary

	Option 1 **Discount Plan** In Network Benefits	*Option 2* **Enhanced Plan** In Network Benefits	*Option 3* **Premier Plan** In Network Benefits	**Out of Network** (Options 2 or 3 Only)
Examination Benefits	[$20 Co-pay]	[$15 Co-pay]	[$15 Co-pay]	
Comprehensive eye health examination	Covered in Full Every **12** Months after Exam Co-pay	Covered in Full Every **12** Months after Exam Co-pay	Covered in Full Every **12** Months after Exam Co-pay	$40 Allowance Every 12 Months
Materials Coverage		[$25 Co-pay]	[$25 Co-pay]	
Contact Lens Coverage *In lieu of traditional glasses.	Discounted Materials up to 20%	**$**110 Elective Allowance Every **24** Months (Covered in Full if Medically Necessary)	**$**110 Elective Allowance Every **12** Months (Covered in Full if Medically Necessary)	$110 Allowance
Frame Benefit (National Wholesale Pricing In Network)	Discounted Materials up to 20%	$50 Wholesale Allowance (Approx $130-$150 Retail) Every **24** Months after Materials Co-pay	$50 Wholesale Allowance (Approx $130-$150 Retail) Every **24** Months after Materials Co-pay	$50 Allowance Every 12 Months
Lens Benefit (Pair of Single, Bifocal, Trifocal, Lenticular Vision Lenses)	Discounted Materials up to 20%	Covered in Full Every **24** Months after Materials Co-pay	Covered in Full Every **12** Months after Materials Co-pay	Allowances: Single - $33 Bifocal - $50 Trifocal - $65
Lens Options Coverage (member pays the indicated co-pays in the *Enhanced & Premier Plans* only)	Discounted Materials up to 20%	Fixed Co-pay Amounts	Fixed Co-pay Amounts	None
Basic Progressives		$52.00	$52.00	
Basic SV Polycarbonate		$26.00	$26.00	
Ultra Violet Coating		$15.00	$15.00	
Basic Anti-Reflective		$46.00	$46.00	
Tints (Solid/Gradient) on Plastic		$13.00/$15.00	$13.00/$15.00	
Basic Scratch Resistant Coating		$16.00	$16.00	
LASIK Coverage (TLC Centers & Extended Network)	Discounted Services Available	Discounted Services Available	Discounted Services Available	None
CCSD Employee Monthly Pre-tax Rates				
Employee ONLY	**$1.24**	**$4.32**	**$4.84**	
Employee + FAMILY	**$2.98**	**$10.46**	**$11.74**	

This summary is for illustrative purposes only. This is not a Summary Plan Description.

How the plan works – Accessing Plan Benefits is Easy!

STEP 1: Enroll for coverage during open enrollment. You will need to select one of the offered plans. You may choose to cover just yourself or full-family coverage. CompBenefits will send ID Cards to you at home.

STEP 2: Make an appointment. Once you receive the VisionCare Plan ID Cards and welcome letter you can select a network doctor and make an appointment. You can call our Customer Care Center (8am-6pm EST, M-F) or access the provider directory and view plan information anytime online at www.mycompbenefits.com. Identify yourself as a member through Cobb County School System's vision plan with CompBenefits.

STEP 3: Show up for the appointment with your ID Card! The doctors office will verify eligibility and plan provisions before you arrive.

STEP 4: You will be responsible for co-pays plus the cost of upgrades to frames and lenses based on CompBenefits national wholesale and negotiated prices. You can choose any frame you want – not just a small selection of covered-in-full frames. When the frame selected exceeds the allowance you will receive a full credit for the $50 wholesale allowance and pay the difference based on wholesale.

Examples [Why Pay Retail?]

Examples assume retail costs: $85 Exam; $30 UV coating; $40 SV lenses; $116 progressive lenses; $75 AR coating. Premium, taxes not considered. Option 1 assumes ~20% member discount.

	Option 1 **Discount Plan** In Network Benefits	*Option 2* **Enhanced Plan** In Network Benefits	*Option 3* **Premier Plan** In Network Benefits
Illustrative Example 1		Contact & Traditional Lenses Covered Every 24 Months	Contact & Traditional Lenses Covered Every 12 Months
Member chooses an eye exam, $130 retail frame, standard single vision (SV) lenses and standard ultra violet (UV) coating. [$285.00 Retail Value]	Member Pays: $ 20.00 Exam Co-pay $104.00 Frame Cost $ 32.00 Lens Cost $ 24.00 UV Coating Cost **$180.00 Total**	Member Pays: $15.00 Exam Co-pay $25.00 Materials Co-pay $15.00 UV Coating Co-pay **$55.00 Total**	Member Pays: $15.00 Exam Co-pay $25.00 Materials Co-pay $15.00 UV Coating Co-pay **$55.00 Total**
Illustrative Example 2			
Member chooses an eye exam, $180 retail frame, progressive bi-focal lenses and standard anti-reflective (AR) coating. [$456.00 Retail Value]	Member Pays: $ 20.00 Exam Co-pay $144.00 Frame Cost $ 92.00 Lens Cost $ 60.00 AR Coating Cost **$316.00 Total**	Member Pays: $ 20.00 Exam Co-pay $ 25.00 Materials Co-pay $ 20.00 Frame Upgrade $ 52.00 Lens Upgrade $ 46.00 AR Coating Co-pay **$163.00 Total**	Member Pays: $ 20.00 Exam Co-pay $ 25.00 Materials Co-pay $ 20.00 Frame Upgrade $ 52.00 Lens Upgrade $ 46.00 AR Coating Co-pay **$163.00 Total**

FAQ [Frequently Asked Questions]

? **What are the advantages of using a network provider?** CompBenefits' national network of providers provides you with one-stop shopping. You'll receive eye exams and materials and pay nothing more than your co-payment (cosmetic options and selections exceeding plan allowances will include additional charges).

? **What if I want to see a provider not in your network?** If you prefer, you can visit a non-network doctor. You will pay the doctor's regular charges, and CompBenefits will reimburse you according to the plan's non-network benefit schedule.

? **Can I nominate a doctor to become an in-network provider with CompBenefits?** Yes. A provider nomination form is available – please refer to your employer's benefits website or contact CompBenefits for a form.

Contact CompBenefits Customer Care [Questions or Help Finding Area Providers]

CompBenefits Customer Care
[8:00 am – 6:00 pm EST]

800-865-3676

24/7 Online Access & Information

www.compbenefits.com

LASIK & PRK

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

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

reduced fees

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

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

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

quality providers

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

easy access to service

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

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

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

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

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

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

compbenefits
vision
dental

CompBenefits
1511 N. Westshore Blvd
Suite1000
Tampa, FL 33607
(800) 749-5855
(813) 289-2020
www.compbenefits.com

Plan Limitations and Exclusions

This summary is intended to provide general information regarding the coverage offered; it is not a Summary Plan Description or Certificate of Insurance (which will be available to you). For any specific terms, provisions, definitions, limitations, exclusions or restrictions related to your coverage refer to the Certificate of Insurance. The indications of the Certificate of Coverage will prevail over those contained in this summary.

In no event will coverage exceed the lesser of the actual cost of covered services or Materials, the limits or allowances of the policy as described in the Schedule of Benefits. Materials covered by the Policy that are lost or broken will be replaced at normal intervals as provided in the Schedule of Benefits.

We will pay only the basic cost for lenses and frames covered by the Policy. The insured is responsible for extras selected. Members will receive discounted pricing only at providers participating in the VisionCare Plan network for options and upgrades as described in the Certificate of Coverage.

We will not cover: orthoptic or vision training and any associated supplemental testing; two pair of glasses, in lieu of bifocals, trifocals or progressives; medical or surgical treatment of the eyes; any services or materials required by an Employer as a condition of employment; service for any injury or illness covered under Workers' Compensation or similar law; sub-normal vision aids, aniseikonic lenses or non-prescription lenses; charges incurred after the policy ends or the insured's coverage under the policy ends except as stated in the Policy; experimental treatment or non-conventional treatment or device(s); contact lenses except as specifically covered by the Policy; hi-index, aspheric and non-aspheric styles, oversized 61 and above lens or lenses; cosmetic items unless otherwise specifically listed.

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

Claims Information

Before visiting a network provider it is recommended that you call ahead to the providers and make an appointment identifying yourself as a Cobb County School District vision plan participant. You will also want to identify that you have vision insurance coverage with CompBenefits VisionCare Plan. If you go to a network provider you will not need to file a claim form. You will be responsible for your co-payment and any optional or cosmetic enhancements based on the provisions of the plan you select. You will also owe any applicable state or local tax for the costs which exceed the plan allowances.

Once you enroll and CompBenefits receives eligibility information from your employer you can go online to set up a member profile at www.mycompbenefits.com - you will have access to specific information about your plan, eligibility and instructions on how to use your vision insurance plan.

When visiting non-network providers you will need to pay for services as indicated above and file a claim with CompBenefits. We will review your claim and reimburse you according to the provisions of the plan you select. We must receive written notice of your claim within 60 days after the occurrence or commencement of loss covered by the Policy, or as soon thereafter as reasonably possible. Please forward claims to:

CompBenefits VisionCare Plan

P.O. Box 30349

Tampa, FL 33630-3349

For claim forms contact your benefits administrator or call CompBenefits Customer Care at (800) 865-3676.

GROUP BENEFITS

Basic Life and AD&D Insurance

THE HARTFORD

Benefit Highlights

Cobb County School District

What is Basic Life and AD&D Insurance?

Your employer provides, at no cost to you, Basic Life and AD&D Insurance in an amount equal to $10,000 for Smokers and $13,000 for Non-Smokers.

Life Insurance pays your *beneficiary* (please see below) a benefit if you die while you are covered.

This highlight sheet is an overview of your Basic Life and AD&D Insurance. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.

How much additional Basic Life and AD&D Insurance can I purchase?

You have the option to elect additional Basic Life and AD&D Insurance coverage in the following amounts:

Base Annual Earnings	Additional Basic Life and AD&D Smoker Amount	Additional Basic Life and AD&D Non-Smoker Amount
less than $6,000	Not Available	Not Available
$6,000 but less than $9,999	$10,000	$13,000
$10,000 but less than $13,999	$20,000	$23,000
$14,000 but less than $17,999	$30,000	$33,000
$18,000 but less than $21,999	$40,000	$43,000
$22,000 but less than $25,999	$50,000	$53,000
$26,000 but less than $29,999	$60,000	$63,000
$30,000 but less than $33,999	$70,000	$73,000
$34,000 but less than $37,999	$80,000	$83,000
$38,000 but less than $41,999	$90,000	$93,000
$42,000 but less than $45,999	$100,000	$103,000
$46,000 and above	$110,000	$113,000

Why do I need Basic Life and AD&D Insurance?	Basic Life and AD&D Insurance provides affordable financial security for your loved ones, although when it comes down to it, contemplating some pretty unpleasant things is hard to do. But when you consider the fact that between 1995 and 1997, almost 40% of all deaths that occurred were people between the ages of 25 and 64[1], it's harder to ignore. Especially when your family depends on your income. [1]Death Rates by Age, Sex and Race: 1970 to 1997, U.S. Census Bureau, Statistical Abstract of the United States, 1999, page 95.
Am I eligible?	You are eligible if you are an active full-time Employee, excluding Board Members and Superintendent, who works at least 20 hours per week on a regularly scheduled basis.
When can I enroll?	As an eligible Employee, you are automatically covered by Basic Life and AD&D Insurance; you do not have to enroll. You may enroll for an additional Basic Life and AD&D Insurance benefit based on your base annual Earnings from 10/11/2011-11/10/2011. If you have not already done so, you must designate a beneficiary as described below.
When is it effective?	Coverage goes into effect subject to the terms and conditions of the policy. Benefits will be effective 1/1/2012 or the first day of the calendar month, as defined in accordance with the current Georgia state definition, after the date you complete 1 month/30 days of continuous service as an Employee of the Employer, whichever is later. You must be Actively at Work with your employer on the day your coverage takes effect.
Does my coverage reduce as I get older?	Your coverage does not reduce. All coverage cancels at retirement.
AD&D Coverage	AD&D provides benefits due to certain injuries or death from an accident. The covered injuries or death can occur up to 365 days after that accident. The Insurance pays: • 100% of the amount of coverage you purchase in the event of accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears or quadriplegia. • 75% for paraplegia or triplegia (paralysis of three limbs). • One-half (50%) for accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia. • One-quarter (25%) for accidental loss of thumb and index finger of the same hand or uniplegia. Your total benefit for all losses due to the same accident will not be more than 100% of the amount of coverage provided to you.
What is a beneficiary?	Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are covered by the policy. You must select your beneficiary when you complete your enrollment application; your selection is legally binding.
Can I keep my Life coverage if I leave my employer?	Yes, subject to the contract, you have the option of: • Converting your group Life coverage to your own individual policy (policies).
What is the Living Benefits Option?	If you are diagnosed as terminally ill with a 12 month life expectancy, you may be eligible to receive payment of a portion of your Life Insurance. The remaining amount of your Life Insurance would be paid to your beneficiary when you die.

Do I still pay my Life Insurance premiums if I become disabled?	If you become totally disabled before age 60 and your disability lasts for at least 9 months, your Life Insurance premium may be waived.

Important Details

As is standard with most term life Insurance, this Insurance coverage includes certain limitations and exclusions:

AD&D Insurance does not cover losses caused by or contributed to by:

• Sickness; disease; or any treatment for either; • Any infection, except certain ones caused by an accidental cut or wound; • Intentionally self-inflicted injury, suicide or suicide attempt; • War or act of war, whether declared or not;	• Injury sustained while in the armed forces of any country or international authority; • Taking prescription or illegal drugs unless prescribed for or administered by a licensed physician; • Injury sustained while committing or attempting to commit a felony; • The injured person's intoxication.

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.

This Benefit Highlights Sheet is an overview of the Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the Insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your Insurance coverage. In the event of any difference between the Benefit Highlights Sheet and the Insurance policy, the terms of the Insurance policy apply.

GROUP BENEFITS

Supplemental Life and AD&D Insurance

Benefit Highlights

Cobb County School District

What is Supplemental Life and AD&D Insurance?	Supplemental Life and AD&D Insurance is coverage that you pay for. Supplemental Life and AD&D Insurance pays your *beneficiary* (please see below) a benefit if you die while you are covered. This highlight sheet is an overview of your Supplemental Life and AD&D Insurance. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.
Why do I need Supplemental Life and AD&D Insurance?	Supplemental Life and AD&D Insurance provides affordable financial security for your loved ones, although when it comes down to it, contemplating some pretty unpleasant things is hard to do. But when you consider the fact that between 1995 and 1997, almost 40% of all deaths that occurred were people between the ages of 25 and 64[1], it's harder to ignore. Especially when your family depends on your income. [1]Death Rates by Age, Sex and Race: 1970 to 1997, U.S. Census Bureau, Statistical Abstract of the United States, 1999, page 95.
Am I eligible?	You are eligible if you are an active full time Employee who works at least 20 hours per week on a regularly scheduled basis and has enrolled in the additional Basic Life and AD&D Insurance plan.
When can I enroll?	Enrollment in Supplemental Life and AD&D Insurance begins 10/11/2011 and ends 11/10/2011.
When is it effective?	Coverage goes into effect subject to the terms and conditions of the policy. Benefits will be effective 1/1/2012 or the first day of the calendar month, as defined in accordance with the current Georgia state definition, after the date you complete 1 month/30 days of continuous service as an Employee of the Employer, whichever is later. You must be Actively at Work with your employer on the day your coverage takes effect.
How much Supplemental Life and AD&D Insurance can I purchase?	If you are a Non-Smoker, you can purchase Supplemental Life and AD&D Insurance in increments of 1 times your annual Earnings up to 6 times your annual Earnings. The maximum amount you can purchase cannot be more than the lesser of 6 times your annual Earnings or $500,000. If you are Smoker, you can purchase Supplemental Life and AD&D Insurance in increments of 1 times your annual Earnings up to 5 times your annual Earnings. The maximum amount you can purchase cannot be more than the lesser of 5 times your annual Earnings or $500,000. Annual Earnings are defined in The Hartford's contract with your employer.

AD&D Coverage	AD&D provides benefits due to certain injuries or death from an accident. The covered injuries or death can occur up to 365 days after that accident. The Insurance pays: • 100% of the amount of coverage you purchase in the event of accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears or quadriplegia. • 75% for paraplegia or triplegia (paralysis of three limbs). • One-half (50%) for accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia. • One-quarter (25%) for accidental loss of thumb and index finger of the same hand or uniplegia. Your total benefit for all losses due to the same accident will not be more than 100% of the amount of coverage you purchase.
I already have Supplemental Life and AD&D Insurance coverage; do I have to do anything?	If you take no action, your coverage and coverage for your eligible dependents will automatically continue with The Hartford subject to the terms of the contract.
Am I guaranteed coverage?	If you are electing coverage for the first time, or electing to increase your current coverage, you will be required to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.
What is a beneficiary?	Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are covered by the policy. You must select your beneficiary when you complete your enrollment application; your selection is legally binding.
Are there other limitations to enrollment?	This coverage, like most group benefit Insurance, requires that a certain percentage of eligible employees participate. If that group participation minimum is not met, the Insurance coverage that you have elected may not be in effect.
Spouse Supplemental Life Insurance	If you elect additional Basic Life and AD&D Insurance for yourself, you may choose to purchase Spouse Supplemental Life Insurance in the amount(s) of $10,000 or $25,000. Coverage cannot exceed 100% of the total amount of your Employee Basic Life Insurance coverage. You may not elect coverage for your Spouse if they are an active member of the armed forces of any country or international authority, or is already covered as an Employee under this policy. If your Spouse is confined in a hospital or elsewhere because of disability on the date his or her Insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days. If you are electing coverage for the first time, or electing to increase your current coverage, your Spouse will be required to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.

Child(ren) Supplemental Life Insurance	If you elect additional Basic Life and AD&D Insurance for yourself, you may choose to purchase Child(ren) Supplemental Life Insurance coverage in the amount(s) of $10,000 or $25,000 for each Child– no medical information is required. You may not elect coverage for your Child if your Child is an active member of the armed forces of any country or international authority. • If your dependent Child is confined in a hospital or elsewhere because of disability on the date his or her Insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days. • Children must be unmarried and are covered from Live Birth to 19 years old or 25 years if they are a full-time student or meet certain other conditions. • Unmarried Children over age 19 may be covered if they are disabled and primarily dependent upon the Employee for financial support.
Does my coverage reduce as I get older?	Your coverage does not reduce. All coverage cancels at retirement.
Can I keep my Life coverage if I leave my employer?	Yes, subject to the contract, you have the option of: • Converting your group Life coverage to your own individual policy (policies). • If you leave your employer, Portability is an option that allows you to continue your Life Insurance coverage. To be eligible, you must terminate your employment prior to Social Security Normal Retirement Age. This option allows you to continue all or a portion of your Life Insurance coverage under a separate Portability term policy. Portability is subject to a minimum of $5,000 and a maximum of $250,000 and does include coverage for your Spouse and Child(ren). To elect Portability, you must apply and pay the premium within 31 days of the termination of your Life Insurance. Evidence of Insurability will not be required. Dependent Spouse Portability is subject to a maximum of $50,000. Dependent Child Portability is subject to a maximum of $10,000.
What is the Living Benefits Option?	If you are diagnosed as terminally ill with a 12 month life expectancy, you may be eligible to receive payment of a portion of your Life Insurance. The remaining amount of your Life Insurance would be paid to your beneficiary when you die.
Do I still pay my Life Insurance premiums if I become disabled?	If you become totally disabled before age 60 and your disability lasts for at least 9 months, your Life Insurance premium may be waived. The premium for your dependent's coverage will also be waived if you are disabled and approved for waiver of premium.

Important Details

As is standard with most term life Insurance, this Insurance coverage includes certain limitations and exclusions:

- Death by suicide (two years).

AD&D Insurance does not cover losses caused by or contributed by:

• Sickness; disease; or any treatment for either; • Any infection, except certain ones caused by an accidental cut or wound; • Intentionally self-inflicted injury, suicide or suicide attempt; • War or act of war, whether declared or not;	• Injury sustained while in the armed forces of any country or international authority; • Taking prescription or illegal drugs unless prescribed for or administered by a licensed physician; • Injury sustained while committing or attempting to commit a felony; • The injured person's intoxication.

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.

This Benefit Highlights Sheet is an overview of the Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the Insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your Insurance coverage. In the event of any difference between the Benefit Highlights Sheet and the Insurance policy, the terms of the Insurance policy apply.

Benefit coverage for

Cobb County School District

In the United States, about 1,529,560 new cancer cases were expected to be diagnosed in 2010.[1]

[1] *Cancer Facts & Figures,* American Cancer Society, 2010.

GVCP2

GROUP CANCER INSURANCE

Best in Benefit Series℠

Allstate Benefits

group voluntary cancer

If you suddenly become diagnosed with cancer, it can be difficult on your family's financial and emotional stability. Having the right coverage to help when you are sick and undergoing treatment or when you cannot work is important. Our cancer insurance can help provide security when you need it most.

meeting your needs

Our cancer coverage can help offer you and your family members financial support during a period of unexpected illness.

- Benefits will be paid directly to you unless otherwise assigned
- Coverage can be purchased for you or your entire family
- No evidence of insurability required at initial enrollment
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts*
- Includes coverage for 29 other specified diseases
- Convertible coverage

*Primary insured only

your benefit coverage

Allstate Benefits (AB) pays the following benefits for the necessary treatment of cancer or a specified disease, and for any other condition directly caused or aggravated by the cancer or specified disease.

Specified Diseases - Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis (bacterial), Brucellosis, Sickle Cell Anemia, Thallasemia, Rocky Mountain Spotted Fever, Legionnaire's Disease (confirmation by culture or sputum), Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or Chronic C with liver failure or hepatoma), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Liver Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis, and Primary Biliary Cirrhosis.

HOSPITAL AND RELATED BENEFITS

Continuous Hospital Confinement - **A $100 (Economy or Standard) or $200 (Deluxe) benefit will be paid** for you or each covered family member for each day of continuous hospital confinement for the treatment of cancer or specified diseases. The maximum number of days payable is 70 days for each period of continuous hospital confinement.

Extended Benefits - **Up to a $100 (Economy or Standard) or $200 (Deluxe) benefit will be paid** per day for you or each covered family member if confined in a hospital for the treatment of cancer or specified disease for more than 70 days of continuous hospital confinement for hospital room and board, medicine, laboratory tests and other hospital charges. This benefit begins on the 71st day of continuous hospital confinement. This benefit is paid in lieu of all other benefits payable during the continuous hospital confinement beginning on the 71st day under the Schedule of Benefits (except Waiver of Premium Benefit). This benefit continues as long as the covered person is continuously hospital confined.

Government or Charity Hospital - **A $100 (Economy or Standard) or $200 (Deluxe) benefit will be paid** for you or each covered family member for each day confined to: 1. a hospital operated by or for the U.S. Government (including the Veteran's Administration); or 2. a hospital that does not charge for the services it provides (charity). This benefit is paid in lieu of all other benefits in the policy (except Waiver of Premium Benefit).

In the U.S., men have slightly less than a 1 in 2 lifetime risk of developing cancer; for women, the risk is a little more than 1 in 3.[2]

[2] Cancer Facts & Figures, American Cancer Society, 2010.

Private Duty Nursing Services - **Up to a $100 (Economy or Standard) or $200 (Deluxe) benefit will be paid** per day for you or each covered family member while hospital confined, if a covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24 hour period. These services must be required and authorized by a physician and must be provided by a nurse.

Extended Care Facility - **Up to a $100 (Economy or Standard) or $200 (Deluxe) benefit will be paid** for each day you or each covered family member remain confined in an extended care facility for the treatment of cancer or specified disease. Confinement must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. Benefit is limited to the number of days of the previous continuous hospital confinement.

At Home Nursing - **Up to a $100 (Economy or Standard) or $200 (Deluxe) benefit will be paid** per day for you or each covered family member to receive private nursing care and attendance by a nurse at home. At home nursing services must be required and authorized by the attending physician and must begin within 14 days after a covered confinement as an inpatient in a hospital. Benefit is limited to the number of days of the previous continuous hospital confinement.

Hospice Care - **Up to a $100 (Economy or Standard) or $200 (Deluxe) benefit will be paid** for you or each covered family member for one of the following when diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live 6 months or less and the attending physician has approved services: **1.** Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center. Benefit is payable only if a covered person is admitted to a freestanding hospice care center within 14 days after a period of inpatient hospital confinement. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or **2.** Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if home care services begin within 14 days after a period of hospital confinement. Does not pay for: food services or meals other than dietary counseling; or services related to well-baby care; or services provided by volunteers; or support for the family after the death of the covered person.

RADIATION, CHEMOTHERAPY AND RELATED BENEFITS

Radiation/Chemotherapy - **Up to a $5,000 (Economy, Standard, or Deluxe) benefit will be paid** per 12 month period for you or each covered family member when radiation therapy and chemotherapy is received. • This benefit is limited to the amount shown per 12 month period beginning with the first day of benefit under this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period.

Blood, Plasma, and Platelets - **Up to a $5,000 (Economy, Standard, or Deluxe) benefit will be paid** per 12 month period, for you or each covered family member to receive blood, plasma and platelets (including transfusions and administration charges); processing and procurement costs; and cross-matching. Does not pay for blood replaced by donors.

SURGERY AND RELATED BENEFITS

Surgery - **Up to a $1,500** (Economy), $3,000** (Standard), or $4,500** (Deluxe) benefit will be paid for you or each covered family member** when a covered surgery is performed. This benefit pays the actual charges, up to the amount listed in the Schedule of Surgical Procedures for the specific procedure. Two or more procedures performed at the same time through one incision or entry point are considered one operation; AB pays the amount for the procedure with the greatest benefit. AB pays for a covered surgery performed on an outpatient basis at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in the Schedule of Benefits. **Amount per surgery depends on surgery.

Anesthesia - **Actual charges or up to 25% (Economy, Standard, or Deluxe) of the surgery benefit will be paid for** you or each covered family member if anesthesia is received.

Ambulatory Surgical Center - **Up to a $250 (Economy), $500 (Standard), or $750 (Deluxe) benefit will be paid** for you or each covered family member for the use of an Ambulatory Surgical Center, up to the amount shown each day for a surgical procedure covered under the Surgery Benefit that is performed at an Ambulatory Surgical Center.

Second Surgical Opinion - **Up to a $200 (Economy), $400 (Standard), or $600 (Deluxe) benefit will be paid** for you or each covered family member to receive a second surgical opinion, if physician recommends surgery for covered condition. This second opinion must be rendered prior to surgery being performed, and obtained from a physician not in practice with the physician rendering the original recommendation.

Bone Marrow or Stem Cell Transplant* - **Up to a 1. $500*, 2. $1,250*, 3. $2,500* (Economy), 1. $1,000*, 2. $2,500*, 3. $5,000* (Standard), or 1. $1,500*, 2. $3,750*, 3. $7,500* (Deluxe) benefit will be paid** for you or each covered family member to receive the following types of bone marrow or stem cell transplants. 1. A transplant which is other than non-autologous. 2. A transplant which is non-autologous for the treatment of cancer or specified disease, other than Leukemia. 3. A transplant which is non-autologous for the treatment of Leukemia. ***This benefit is payable only once per covered person per calendar year.**

MISCELLANEOUS BENEFITS

Inpatient Drugs and Medicine - **Actual charges up to a $25 (Economy, Standard, or Deluxe) benefit will be paid for** you or each covered family member for each day charges are made by the hospital for drugs and medicine, while continuously hospital confined. This benefit does not pay for drugs and/or medicine covered under the Radiation and Chemotherapy Benefit.

Physician's Attendance - **Up to a $50 (Economy, Standard, or Deluxe) benefit will be paid** per day for you or each covered family member to receive a visit by a physician during hospital confinement. Benefit is limited to one visit by one physician each day of hospital confinement. Admission to the hospital as an inpatient is required.

Ambulance - **Up to a $100 (Economy, Standard, or Deluxe) benefit will be paid** per continuous hospital confinement for you or each covered family member to receive transportation by a licensed ambulance service or a hospital owned ambulance to or from a hospital in which the covered person is confined.

Non-Local Transportation - **A $0.40 (Economy, Standard, or Deluxe) per mile or actual cost of round trip coach fare on a common carrier benefit will be paid** for you or each covered family member to receive treatment at a hospital (inpatient or outpatient); or radiation therapy center; or chemotherapy or oncology clinic; or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally. Benefit pays up to 700 miles for round trip in personal vehicle. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. Mileage is measured from the covered person's home to the nearest treatment facility as described above. Does not cover transportation for someone to accompany or visit the person receiving treatment; visits to a physician's office/clinic; or for services other than actual treatment.

Outpatient Lodging - **Up to a $50 (Economy, Standard, or Deluxe) benefit will be paid** for lodging per day when you or each covered family member receive radiation or chemotherapy treatment on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. Benefit is the actual cost of a single room in a motel, hotel, or other accommodations acceptable to us during treatment, **up to the maximum $2,000** per 12 months beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

Family Member Lodging and Transportation - **Up to a $50 (Economy, Standard, or Deluxe) benefit per day will be paid for lodging and a $0.40 per mile or the actual cost of round trip coach fare on a common carrier benefit will be paid** for one adult member of your family to be near you or each covered family member, when a covered person is confined in a non-local hospital for specialized treatment. **1.** Lodging - The actual cost of a single room in a motel, hotel, or other accommodations acceptable to AB. Benefit is limited to 60 days for each period of continuous hospital confinement. **2.** Transportation - Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

Physical or Speech Therapy - **Up to a $50 (Economy, Standard, or Deluxe) benefit will be paid** per day, for you or each covered family member to receive physical or speech therapy for restoration of normal body function.

New or Experimental Treatment - **Up to a $5,000 (Economy, Standard, or Deluxe) benefit will be paid** per 12-month period, for you or each covered family member to receive new or experimental treatments. New or Experimental Treatments are covered for cancer and specified disease when: • the treatment is judged necessary by the attending physician, and • no other generally accepted treatment produces superior results in the opinion of the attending physician. This benefit is limited to the maximum shown per 12-month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in the Schedule of Benefits.

Prosthesis - **Up to a $2,000 (Economy, Standard, or Deluxe) benefit will be paid** for you or each covered family member to receive prosthetic devices which are prescribed as a direct result of surgery and which require surgical implantation.

Comfort/Anti-Nausea Benefit - **Up to a $200 (Economy, Standard, or Deluxe) benefit** will be paid per calendar year for you or each covered family member if anti-nausea medication is prescribed by a physician in conjunction with cancer or specified disease treatment. This benefit does not pay for medication administered while the covered person is an inpatient.

Waiver of Premium (primary insured only) - If while coverage is in force, you become disabled due to cancer first diagnosed after the effective date of coverage and remain disabled for 90 days, AB pays premiums due after such 90 days for as long as you remain disabled.

ADDITIONAL BENEFITS

Intensive Care Unit - **A $200 (Standard) or $400 (Deluxe) benefit will be paid** for you or each covered family member for each day of confinement in a hospital intensive care unit. Begins with the first day of admission and pays up to 45 days. For time periods less than a day (24 hours), a pro-rata share of the daily benefit is paid. **Actual Charges** will be paid if you or each covered family member require ambulance transportation to a hospital for admission to an intensive care unit for a covered confinement; this benefit is not paid if paid under the Ambulance Benefit of the base coverage. This benefit is not disease specific and pays a benefit for covered confinement in a hospital intensive care unit for any covered illness or accident from the very first day of confinement.

Cancer Initial Diagnosis (First Occurrence) - **A $1,000 (Standard) or $2,000 (Deluxe) one-time benefit will be paid** when you or each covered family member is diagnosed for the first time as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. Benefit is payable only once per covered person.

premiums detailed

Your packaged premiums consist of:

Economy Option - 1 unit of Hospital and Related Benefits; 2 units of Radiation, Chemotherapy and Related Benefits; 1 unit of Surgery and Related Benefits; and 1 unit of Miscellaneous Benefits.

Standard Option - 1 unit of Hospital and Related Benefits; 2 units of Radiation, Chemotherapy and Related Benefits; 2 units of Surgery and Related Benefits; 1 unit of Miscellaneous Benefits; 1 unit of Additional Cancer Initial Diagnosis; and 2 units of Additional Intensive Care.

Deluxe Option - 2 units of Hospital and Related Benefits; 2 units of Radiation, Chemotherapy and Related Benefits; 3 units of Surgery and Related Benefits; 1 unit of Miscellaneous Benefits; 2 units of Additional Cancer Initial Diagnosis; and 4 units of Additional Intensive Care.

Bi-Weekly Premiums

Insureds	Economy	Standard	Deluxe
Employee	$3.26	$4.74	$6.70
Family	$5.38	$8.04	$11.48

Monthly Premiums

Insureds	Economy	Standard	Deluxe
Employee	$7.06	$10.26	$14.48
Family	$11.66	$17.42	$24.84

Issue Ages: 18 and older while actively at work.

Certificates

Certificates under this plan are issued on a guaranteed basis only at the time of the initial enrollment. A completed Evidence of Insurability form is required for late entrants into the group plan.

certificate specifications

Conversion Privilege - If coverage terminates for any reason other than non-payment of premiums, the covered person can convert to an individual policy without evidence of insurability. This also applies to a dependent whose coverage terminates due to divorce or your death, or a child whose coverage terminates due to the attainment of the limiting age for dependent eligibility.

Termination of Coverage - As long as you are insured, your coverage under the policy ends on the earliest of: 1. the date the policy is canceled; or 2. the last day of the period for which you made any required premium payments; or 3. the last day you were in active employment; or 4. the date you are no longer in an eligible class; or 5. the date your class is no longer eligible. • We will provide coverage for a payable claim that occurs while you are covered under the policy. If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or your death. Coverage for children ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent. • Dependent coverage continues as long as the coverage remains in force and the dependent remains in such condition. If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, then coverage continues during the period for which such premium was accepted. This does not apply where such acceptance was based on a misstatement of age.

Coverage Subject To Policy - The coverage described in the certificate is subject in every way to the terms of the policy that is issued to the policyholder (employer). It alone makes up the agreement by which the insurance is provided. The group policy may at any time be amended or discontinued by agreement between us and the policyholder. Your consent is not required for this. Neither are we required to give you prior notice.

Pre-Existing Condition - A pre-existing condition is a disease or physical condition for which medical advice or treatment was received by the covered person during the 12 month period prior to the effective date of the covered person's coverage. AB does not pay for any loss due to a pre-existing condition as defined during the 12 month period beginning on the date that person became a covered person.

Exclusions and Limitations - The policy does not pay for any loss except for losses due directly from cancer or specified disease and any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. Treatment must be received in the United States or its territories.

Intensive Care Exceptions and Limitations - The Hospital Intensive Care Unit Confinement benefit does not pay for intensive care if a covered person is admitted because of an attempted suicide; or intentional self-inflicted injury; or intoxication or being under the influence of drugs not prescribed or recommended by a physician; or alcoholism or drug addiction. We do not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step down units and any other lesser care treatment units do not qualify as hospital intensive care units. We do not pay this benefit for continuous hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage.

The policy is Limited Benefit Cancer and Specified Disease Insurance. This is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from American Heritage Life Insurance Company. Subject to COBRA continuation of coverage. Underwritten by American Heritage Life Insurance Company.

This material is valid as long as information remains current, but in no event later than September 15, 2014. Group Cancer and Specified Disease benefits provided by policy form GVCP2, or state variations thereof. This brochure highlights some features of the policy but is not the insurance contract. Only the actual certificate provisions control. The certificate itself sets forth, in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, contact your Insurance Agent, or call 1-800-521-3535. Underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). This is a brief overview of the benefits available under the Group Voluntary Policies issued by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificates issued.

This brochure is for use in the Cobb County School District enrollment which is situsedin Georgia.

Allstate Benefits

What's On Your To-Do List?

- ☐ SAVE MONEY
- ☐ REDUCE MY WORRIES
- ☐ CARE FOR MY FAMILY
- ☐ UNDERSTAND MY LEGAL RIGHTS
- ☐ ADDRESS MY LEGAL ISSUES
- ☐ CREATE MY WILL
- ☐ SAFEGUARD MY IDENTITY
- ☐ PROTECT MY ASSETS
- ☐ PLAN FOR MY FUTURE

☑ DO ALL THE ABOVE... ENROLL TODAY!

Your opportunity to enroll is limited – don't miss out.
For enrollment details, go to ARAGLegalCenter.com and enter Access Code 17840ccs or contact ARAG toll-free at 800-247-4184.

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ARAG®
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Des Moines, Iowa 50393-3180
800-247-4184
Service@ARAGgroup.com

ARAGLegalCenter.com
Access Code 17840ccs

[1] "Legal Needs of Today's Multi-Generational Workforce," a national study conducted by Russell Research and commissioned by ARAG, September 2008. [2] Average attorney rates in the United States of $294 per hour for attorneys with 11 to 15 years of experience, Survey of Law Firm Economics, The National Law Journal and ALM Legal Intelligence, July 2010. Average attorney rates for specific legal matters calculated by multiplying the average attorney rate of $294 multiplied by the number of hours per legal matter based on 2009 ARAG Claims Data.

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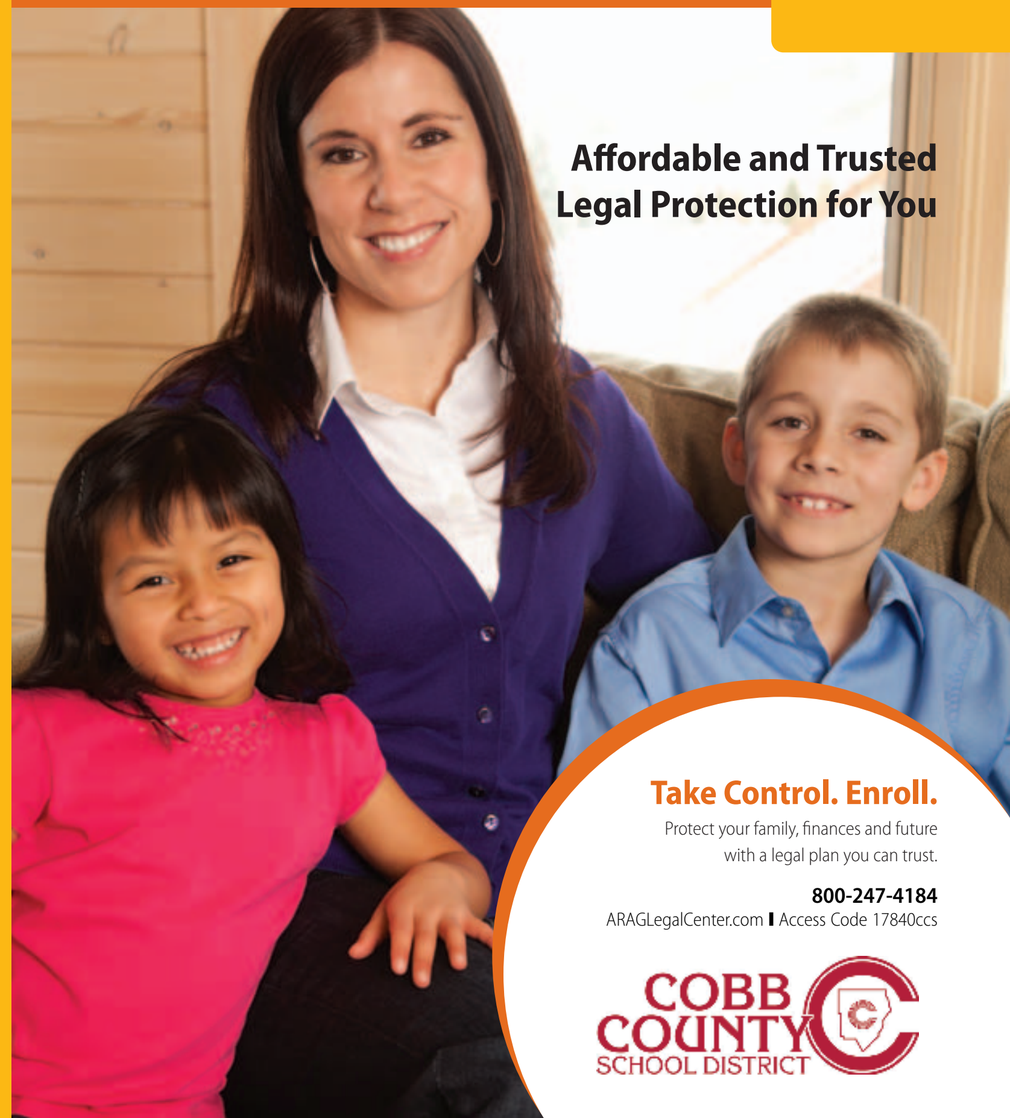

Affordable and Trusted Legal Protection for You

Take Control. Enroll.

Protect your family, finances and future with a legal plan you can trust.

800-247-4184
ARAGLegalCenter.com ❙ Access Code 17840ccs

COBB COUNTY SCHOOL DISTRICT

"It is pretty simple; having an ARAG legal plan has opened my eyes to the legal world and has taken away the stress of trying to figure things out."

– Gina Rupert, Member, Roseville, CA

Affordable Legal Protection for the Uncertainty in Life

As you go through life, chances are you'll experience a life event or unexpected occurrence that comes with personal challenges, legal implications or financial impact. **In fact, 7 out of 10 employees experience one or more legal events in a year.**[1] When life happens, where will you turn for help?

Look to an affordable legal plan from ARAG for answers – we'll help you plan for, prevent and resolve everyday and unexpected legal matters. Whether you're buying a home, getting married, preparing your Will or dealing with debt or consumer matters, we'll help you get through life's challenges with fewer worries.

Save Time and Money with Trusted Coverage

When you need legal help, don't waste time looking for the right attorney or paying high-cost attorney fees, which currently average $294 per hour.[2]

Turn to ARAG for help. We'll offer you the professional legal services and coverage you need to address your legal matters without worrying about the costs. Legal services include:

- Convenient access to ARAGLegalCenter.com with educational articles, legal resources and easy-to-use tools when you want to learn more about a specific legal issue.
- Professional legal advice and services from experienced attorneys to handle your legal issues – without the high costs.
- Helpful Customer Care Specialists you can always call for guidance. They will listen to your needs and help you identify the right path to resolution.

Enroll in a legal plan today and save valuable time and money.

How much do legal issues cost WITHOUT an ARAG legal plan?[2]

Average Attorney Rate	$294/hour
Debt Collection Issues	$2,499
Neighbor Dispute	$1,397
Purchase a Home	$2,352
Standard Will Preparation	$882

Save Money and Stay Protected!

Give Us a Call. We're Here to Help You.

When you have questions about the solutions available to you, call our award-winning Customer Care Center toll-free at 800-247-4184 or visit ARAGLegalCenter.com and enter Access Code 17840ccs. Our team of highly-trained and caring professionals can help answer your questions and walk you through your options.

800-247-4184
ARAGLegalCenter.com ▮ Access Code 17840ccs

Here's Your Opportunity to Get the Coverage You Need. Enroll Today!

Now is a great time to get the resources and guidance you need – at an affordable cost. Enroll in the group legal plan and take a proactive step toward protecting your family, finances and future.

UltimateAdvisor (A, B, & C)

This valuable, comprehensive legal plan provides quality coverage and services – without the high cost of attorney fees.

- Individual: $5.68 Bi-weekly
- Family: $7.04 Bi-weekly

A. Online Resources

The ARAG Legal Center provides online tools and useful information to help you learn more about your legal issues ***on your own***.

- **Education Center** helps you understand your legal situation and provides:
  - The Law Guide
  - Guidebooks and Videos
  - *LawExpresso*® (e-newsletter)
- **DIY Docs™** offers the convenience and control of creating state-specific, legally valid documents online on your own.
- **Online Financial Tools** help you map out a solid financial strategy with articles, calculators, a personalized financial plan and more.

B. Telephone Advice

Talk to a knowledgeable professional when you need information and direction to address your legal and financial matters.

- **Legal Hotline** offers you unlimited legal advice from Network Attorneys to help you address everyday legal issues. Additional services include:
  - Reviewing and preparing documents
  - Making follow-up calls and writing letters
  - Advice on immigration matters
  - Preparing a Standard Will
- **Identity Theft Services** provided by Certified Identity Theft Case Managers who can help you protect or recover your identity.
- **Financial Wellness Hotline** includes guidance and education on a wide range of financial topics from a Financial Counselor.

C. In-Office Services

Meet with an experienced attorney who can advise and represent you when you need ***an attorney on your side***.

- **Attorney Services** available include:
  - Reviewing and preparing documents
  - Making follow-up calls and writing letters
  - Providing legal advice and consultation
  - Representation in court
- **Comprehensive Coverage** protects you from costly legal fees. Most covered legal matters are **100% paid-in-full** when you work with a Network Attorney. *(See side panel for more details.)*
- **Reduced Fee Benefits** are available for non-covered personal legal matters. You can receive at least 25% off a Network Attorney's normal hourly rate.

Rely on the ARAG Attorney Network

You'll have a nationwide network of attorneys standing ready to assist you. Our attorneys average more than 20 years of experience – and must meet our rigorous licensing requirements and standards.

Comprehensive Coverage You Can Trust

When you enroll in UltimateAdvisor, you'll receive the ultimate protection that a legal plan can offer – and the peace of mind knowing that a wide range of covered legal matters are **100% paid-in-full** when you work with a Network Attorney.

- **Civil Damage Claims (Defense)**
  - Civil Damage
  - Pet-Related Matters
- **Consumer Protection Issues**
  - Auto Repair
  - Buying a New or Used Automobile
  - Consumer Fraud
  - Consumer Protection for Goods or Services
- **Criminal Matters**
  - Juvenile Matters
  - Misdemeanor Matters
  - Parental Responsibilities
- **Debt-Related Matters**
  - Debt Collection Matters
- **Family Law**
  - Adoption
  - Domestic Violence
  - Guardianship/Conservatorship
  - Incapacity
  - Name Change
  - Pre-marital Agreements
  - School Issues
- **Government Benefits**
  - Medicare/Medicaid Disputes
  - Social Security Disputes
  - Veterans Benefits Disputes
- **Landlord/Tenant Matters**
  - Contracts/Lease Agreements
  - Eviction
  - Security Deposit
  - Tenant Disputes with a Landlord
- **Real Estate Matters**
  - Building Codes/Zoning Variances
  - Buying/Selling a Home
  - Foreclosure
  - Home Improvement/Contractor Issues
  - Neighbor Disputes/Easements
  - Promissory Note
  - Refinancing
- **Small Claims Court**
  - Small Claims Court Issues
- **Tax Issues**
  - IRS Audit Protection
  - IRS Collection Defense
- **Traffic Matters**
  - Drivers License Suspension, Revocation and Restoration without DUI
  - Traffic Tickets (limited 1x per year)
- **Wills and Estate Planning**
  - Codicil (amendment to a Will)
  - Complex Will
  - Durable/Financial Power of Attorney
  - Estate Administration w/ Parents (limited)
  - Healthcare Power of Attorney
  - Irrevocable Trust
  - Living Will
  - Revocable Trust
  - Standard Will

Need more details? It's all online at...

ARAGLegalCenter.com ▮ Access Code 17840ccs

Short Term Disability Insurance

What is "Disability"?
"Disability" or "Disabled" means that, due to sickness, pregnancy or accidental injury, you are:

1. Receiving appropriate care and treatment from a doctor on a continuing basis; and

2. Unable to earn more than 80% of your pre-disability earnings at your own occupation for any employer in your local economy.

What is the benefit amount?
The Short Term Disability (STD) insurance benefit replaces up to 66 2/3% of your gross weekly earnings, less income you may receive from other sources. The basic core plan benefit is $50.00 per day OR $250.00 per week.

Core Plan
The core plan is based on having 15 or less accumulated short term leave days/work days. The benefit increases if you have more accumulated work days/short term leave days.

See chart below:

Accumulated short term leave days at time of disability	**Your Weekly Income Benefit**
Less than 15 work days	**$50.00**
15 to 24 work days	**$60.00**
25 to 34 work days	**$70.00**
35 to 44 work days	**$80.00**
45 to 59 work days	**$100.00**
60 to 89 work days	**$120.00**
90 or more work days	**$140.00**

When do benefits begin and how long do they continue?

- All short term leave days must be exhausted before disability payments begin.

- Benefits are payable following a waiting period of 5 days from your disability date.

- The waiting period begins on the day you become disabled and is the length of time you must wait after being disabled before you are eligible to receive a benefit.

- Benefits continue for as long as you are disabled up to a maximum duration of 180 days of continuous disability.

Can I return to work part-time and still receive a benefit?
Yes. The STD plan provides financial incentives for you to return to work, even on a part-time basis. You may receive up to 100% of your pre-disability earnings when combining benefits, rehabilitation incentives, and part-time earnings. If you are participating in an approved rehabilitation program, you may also be eligible to receive the rehabilitation incentive. The rehabilitation incentive provides a 5% increase in the weekly benefit.

Does the plan have limitations and exclusions?
Yes. For example, no benefits are payable for a disabling injury or sickness which happens in the course of any work performed by you for wage or profit, or for which you are eligible to receive benefits under any Workers' Compensation or any similar law.

Your disability begins after you have been covered under the plan for 12 consecutive months. A pre-existing condition is a condition for which you during the six months prior to your effective date, received medical treatment took prescription medication or had medication prescribed, or had symptoms which would cause a reasonably prudent person to seek diagnosis, care, or treatment. Disability is excluded from coverage if due to the commission of a felony.

Pre-Existing Condition Limitation – Maximum duration of benefits is 4 weeks if Pre-existing Condition applies. The Look-back Period/Treatment Free/Continuously Insured period is 6/6/12.

What if I am a late enrollee?
If you previously waived or declined coverage and are enrolling for the first time you must submit a Personal Health Application and be approved.

Short Term Disability Insurance Buy Up Plan

What is the benefit amount?
The basic Option 1 Core Plan offers a minimum weekly benefit. There is an enhancement to the plan, which allows you to purchase additional weekly benefits, if you do not feel the current STD plan covers you adequately. If you decide you would like this option, you may only insure yourself with an available amount not to exceed 66 2/3% of your earnings which is the plan maximum. As you are not eligible to receive more than 66 2/3% of your earnings, be sure not to elect an amount greater than that.

Short Term Disability Buy Up Plan

Option 1	**Core Plan**
Option 2	**Option 1 benefits plus an additional $115 per week**
Option 3	**Option 1 benefits plus an additional $231 per week**
Option 4	**Option 1 benefits plus an additional $346 per week**
Option 5	**Option 1 benefits plus an additional $462 per week**

Short Term Disability Buy Up Reference Chart

The Short Term Disability (STD) Core Plan benefit is tied to your available sick leave bank. The Reference Chart below indicates the maximum Short Term Disability coverage you may elect. This chart does not consider the number of days an employee is scheduled to work per year. Short Term Disability payments can never exceed 66 2/3% of your basic annual earnings (annual salary excluding overtime and any other pay).

Example: Your salary is $32,000 per year and you have 26 work days/short-term leave days. This qualifies you to elect Option 2 in the STD Buy Up Plan. Your core plan benefit is $350.00 per week. You are eligible to add an additional $115.00 per week based on Option 2 Buy Up. Total weekly benefit is $465.00 per week.

Consider your Option carefully; once your election is in effect you will not be able to change your Option until the next open enrollment.

Annual	***Number of Short Term Leave Days***						
Pre-disability Earnings	**less than 15**	**15 - 24**	**25 – 34**	**35 - 44**	**45 - 59**	**60 - 89**	**90 or more**
less than $20,000	Option 1	Option 1	Option 1	Option 1	Option 1	Option 1	Option 1
$22,000	Option 1	Option 1	Option 1	Option 1	Option 1	Option 1	Option 1
$24,000	Option 2	Option 1	Option 1	Option 1	Option 1	Option 1	Option 1
$26,000	Option 2	Option 1	Option 1	Option 1	Option 1	Option 1	Option 1
$28,000	Option 2	Option 2	Option 1	Option 1	Option 1	Option 1	Option 1
$30,000	Option 2	Option 2	Option 1	Option 1	Option 1	Option 1	Option 1
$32,000	Option 2	Option 2	Option 2	Option 1	Option 1	Option 1	Option 1
$34,000	Option 3	Option 2	Option 2	Option 1	Option 1	Option 1	Option 1
$36,000	Option 3	Option 2	Option 2	Option 2	Option 1	Option 1	Option 1
$38,000	Option 3	Option 3	Option 2	Option 2	Option 1	Option 1	Option 1
$40,000	Option 3	Option 3	Option 2	Option 2	Option 1	Option 1	Option 1
$42,000	Option 3	Option 3	Option 3	Option 2	Option 1	Option 1	Option 1
$44,000	Option 4	Option 3	Option 3	Option 2	Option 2	Option 1	Option 1
$46,000	Option 4	Option 4	Option 3	Option 3	Option 2	Option 1	Option 1
$48,000	Option 4	Option 4	Option 3	Option 3	Option 2	Option 1	Option 1
$50,000	Option 5	Option 4	Option 4	Option 3	Option 2	Option 1	Option 1
$52,000	Option 5	Option 4	Option 4	Option 3	Option 2	Option 2	Option 1
$54,000	Option 5	Option 4	Option 4	Option 4	Option 3	Option 2	Option 1
$56,000	Option 5	Option 5	Option 4	Option 4	Option 3	Option 2	Option 1
$58,000	Option 5	Option 5	Option 4	Option 4	Option 3	Option 2	Option 1
$60,000	Option 5	Option 5	Option 5	Option 4	Option 3	Option 2	Option 2
$65,000	Option 5	Option 5	Option 5	Option 5	Option 4	Option 3	Option 2
$70,000	Option 5	Option 5	Option 5	Option 5	Option 4	Option 4	Option 3
$75,000	Option 5	Option 5	Option 5	Option	Option 5	Option 4	Option 3
$80,000	Option 5	Option 5	Option 5	Option 5	Option 5	Option 5	Option 4

Long Term Disability Insurance

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What is "Disability"?

"Disability" is defined in two phases:

1. For the first 24 months, you must be unable to earn (at your own occupation) more than **80%** of your pre-disability earnings due to sickness, injury, or pregnancy.
2. After 24 months of disability benefit payments, you must be unable to earn more than **60%** of your pre-disability earnings at any occupation, considering prior education, training, experience, and earnings.

Throughout your disability you must be receiving appropriate care and treatment from a physician for the disabling condition.

What is the benefit amount?

- The Long Term Disability benefit replaces **60%** of your gross monthly earnings, less income you may receive from other sources (e.g., Social Security, Workers' Compensation, etc.).
- The maximum monthly benefit is **$4,000.**

When do benefits begin, and how long do they continue?

Benefits begin following a waiting period of 6 months and continue as long as you are disabled and up to the point specifically outlined in the certificate booklet (Summary Plan Description). The waiting period is the length of time you must wait after being disabled before you are eligible to receive a benefit.

Can I return to work part-time and still receive a benefit?

Yes. The LTD plan provides financial incentives for you to return to work, even on a part-time basis.
For the first 24 months of disability benefits, you may receive up to 100% of your pre-disability earnings when combining benefits, rehabilitation Incentives, family care expense reimbursements, and part-time earnings.

If you are participating in an approved rehabilitation program, you may also be eligible to receive the rehabilitation incentive and/or family care expense reimbursement. The rehabilitation incentive provides a 10% increase in the monthly benefit. The family care expense reimbursement* provides up to $250 per month reimbursement for eligible expenses, such as child care, during the first 24 months of disability.

Does the plan have limitations and exclusions?

The LTD plan does have limitations and exclusions. The plan does not cover **pre-existing conditions**, unless your disability begins after you have been covered under the plan for 12 consecutive months. A pre-existing condition is a condition for which you, during the 6 months prior to your effective date, received medical treatment, took prescription medication or had medication prescribed, or had symptoms which would cause a reasonably prudent person to seek diagnosis, care, or treatment.** Disability is excluded from coverage if due to: war, insurrection, or rebellion; active participation in a riot; intentionally self-inflicted injuries or attempted suicide; or the commission of a felony.

The Optional Spending Accounts

The second part of the Flexible Benefits Plan is the Optional Spending Accounts. The Optional Spending Account consists of two separate accounts: Medical (or Health Care) Spending Account and Dependent Care Spending Account.

The Flexible Benefits Plan simply changes the order in which your paycheck is calculated. By deducting eligible expenses before taxes are calculated, you reduce your taxable income. Payment with pretax dollars means increased take home pay.

Who is Eligible to Participate?
All regular employees working 20 hours per week are eligible to participate in the Optional Spending Accounts portion of the Flexible Benefits Plan.

Elections under the Plan:
Elections **may not be changed outside the Open Enrollment period** unless you have a change in family status. A change in family status includes: marriage, divorce, legal separation, death of a spouse or child, birth or adoption of a child, change in legal custody, significant change in dependent care provider plan, spouse's employment or termination of employment, switching from full-time to part-time or vice versa, significant increase in cost or a curtailment of benefits that amount to a loss of coverage, or taking an unpaid leave of absence by the employee or spouse. If you change your election because of a change in family status, the change will be effective on the first day of the month following your election.

Changes must be requested in writing on a family status change form and submitted within 31 days of the eligible change in family status.

Taxes Saved:
You will not have to pay federal or state income tax on the amount you put into your Optional Spending Account every payday. Additionally, you will not have to pay Social Security tax on the amounts you put into your Optional Spending Accounts. This means you will have paid a smaller total to Social Security over your working lifetime, and your Social Security benefit could be less than it would be if you do not sign up for this plan. For most people, the difference is negligible, but you should be aware of it.

Medical Spending Account:
Your Medical Spending Account allows you to pay for health-related treatments and expenses for you and your dependents not paid for by your insurance programs. The maximum contributions to the Medical Spending Account cannot exceed $5,000 during the plan year. Expenses that are eligible for reimbursement from the Medical Spending Account include, but are not limited to, the following:

- Deductibles and co-payments not paid by the health insurance option or dental insurance option in which you or any family members participate
- Cost of eligible procedures not covered by health or dental plans
- Vision examinations, glasses, contact lenses and supplies
- Hearing exams and hearing aids
- Alcoholism treatment, birth control, braces, chiropractor fees, prescription drug and medical supplies (used to alleviate or treat injury or illness), orthopedic shoes, psychiatric care, transportation expenses (related to the rendering of medical services), weight loss programs (if prescribed by a physician), wheelchair.

Premiums for other accident and health insurance coverage, including premiums for coverage under a plan maintained by the employer of your spouse or dependent are not reimbursable by the Medical Spending

Account. Long Term Care insurance premiums and any expenses incurred for long-term care services are NOT reimbursable from the Medical Spending Account as described in IRS Publication 502 – Medical and Dental Expenses. Appropriate receipts are required reflecting spending account payments for any reimbursements.

Dependent Child Care Spending Account:

The Dependent Care Spending Account allows you to use the expenses incurred (not to exceed $5,000 if married and filing joint income tax returns or $2,500 if unmarried or married and filing separate income tax returns in the plan year) to care for your children or other dependents while you and your spouse work or go to school full-time.

Expenses can be for the care of a child up to thirteen (13) years old or for care of a dependent who is disabled or elderly and frail who is living with you. Your child care expenses can be for a sitter or housekeeper in your home, a family day care home, or a day care center. You can include the full amount you pay to a nursery school, even though part of it is for lunch and education expenses. Only the portion of the cost of summer camp that is attributable to day care can be included, and camp deposits made in the winter or spring cannot be reimbursed until the full bill is due.

To use your Dependent Care Spending Account for expenses for a disabled or elderly person, that person must be physically or mentally unable to care to himself/herself. The person must be your dependent for tax purposes, and you must provide more than half of his/her living expenses. He/she must reside in your home at least eight hours a day. Thus, you can pay out of your Dependent Care Spending Account for adult day care for your frail elderly parent who lives with you and is a dependent on your tax return. You cannot use this account, however, to pay part of the cost of a nursing home for a parent in another city. You cannot claim payments if you are married and your spouse does not work. You can claim payments to a relative for dependent care if:

- the relative is not your dependent for the tax year –and-
- the relative is providing child care as an employee of another organization, or as a self-employed person in his/her own home, or as your employee for whom you are withholding social security taxes

Terms and Conditions:

The Internal Revenue Code, Section 125, governs the Flexible Benefits Plan, and Section 129 governs the Dependent Care Spending Account.

By choosing to contribute money to one or both of the Optional Spending Accounts, you are agreeing to abide by the regulations of the Flexible Benefits Plan, the Medical Reimbursement Plan and the Dependent Care Assistance Plan. Specifically, you are agreeing to the following provisions:

- Money contributed for one type of Optional Spending Account cannot be used to pay claims payable to the other Optional Spending Account
- The maximum on the Medical Spending Account cannot exceed $5,000 per plan year
- The amount contributed to a Dependent Care Spending Account cannot be greater than $5,000.00 if married and filing joint income tax returns or $2,500 if unmarried or married and filing separate income tax returns in the plan year
- The validity of a claim against either Optional Spending Account is determined in accordance with the Plan, IRS Code, and IRS regulations as interpreted by the Administrator subject to the appeal provisions of the Plan
- Any money contributed to either Optional Spending Account during the Plan year must be used for reimbursable expense incurred during the Plan year, otherwise, the contributed money will be forfeited as required by law.

Miscellaneous Information:

The IRS states that a person "incurs" an expense on the day the service is rendered, not when it is billed or not when it is paid, but only on the date the service is actually performed.

Any portion of your medical spending account or your dependent care spending account which you do not use during the plan year (January 1 – December 31) is forfeited as required by law and will not be carried over for use in later years.

You will not pay income taxes or Social Security (FICA) taxes on any amount included in the Flexible Benefits Plan. If you are within five years of Social Security retirement and choose to have FICA withheld, contact the Benefits Department to waive Flexible Benefits.

FLEXIBLE BENEFITS PLAN
STATEMENT OF RIGHTS

If you are a Participant in the Flexible Benefits Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Participants are entitled to:

- Examine without charge, at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Employer with the U.S. Department of Labor.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a statement of the amount of benefits you received from the Plan during the prior Plan year.
- File a suit in federal court, if materials requested are not received within thirty (30) days of your request, unless the materials were not sent because of matters beyond the control of the Plan Administrator. The court may require the Plan Administrator to pay up to $100 for each day's delay until you receive your materials.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the persons who are responsible for operating the Plan. These persons are referred to as "fiduciaries". Fiduciaries must act solely in the interest of the Plan Participants and must exercise prudence in the performance of their Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused to the Flexible Benefits Plan.

Your employer may not terminate you or discriminate against you to prevent you from obtaining a benefit or exercising your rights under ERISA. If you are improperly denied a benefit in-full or in-part, you have a right to file suit in a federal or state court. If Plan fiduciaries are misusing Plan assets, you have the right to file suit in a federal court or request assistance from the U.S. Department of Labor. If you are successful in your lawsuit, the court may, if it so decides, require the other party to pay your legal cost, including attorney fees. Likewise, if you are unsuccessful, the court, in its sole discretion, may order you to pay the legal costs, including attorney fees, of the defendants.

If you have any questions about this statement or your rights under ERISA, you should contact the Plan Administrator or the nearest office of the U.S. Department of Labor.

This is a summary of the CCSD's Flexible Benefits Plan. A complete description of the Plan is contained in the CCSD's Benefit Department. Every attempt has been made to ensure that the information contained herein is accurate. The official legal Plan document will govern.

Credit Union

Credit Union of Georgia

All Cobb County School District employees and students are eligible to join Credit Union of Georgia (formerly MACO). Credit Union of Georgia is a not-for-profit financial institution that has served the financial needs of the educational community for 45 years. To join, apply online at **www.cuofga.org** or call us at **678-486-1111** for more information.

Checking Accounts
Checking options to Fit Your Needs featuring:
FREE Direct Deposit, FREE Internet Banking, FREE Electronic Bill Payment,
FREE Electronic Statements, FREE Telephone Banking,
Free VISA Debit Card and unlimited use of Credit Union of Georgia ATMs

Savings Accounts
Regular Savings, Money Market Accounts, Traditional and Roth IRAs,
Certificates of Deposit, Children's Savings Program

Lending Options
Apply for loans ONLINE and receive an Instant Decision,
Auto Loans with Low Rates, Home Equity Lines of Credit, Personal Loans and Lines of Credit,
Competitive VISA Credit Cards and Recreational Vehicle Loans

Investments and Insurance
Complimentary Financial Planner, Mutual Funds,
Stocks, Bonds, 403B and 401K Rollover, Life Insurance

529 College Savings Plans
A tax-advantaged way of saving for a higher education. For more information, visit
www.cuofga.org/collegesavings.htm

Mortgage Solutions
First Mortgages, Home Equity Loans, Fixed and Adjustable Rate Mortgages,
Jumbo Mortgages, Construction Loans, Combination Programs and Residential Land Loans

LOCATIONS

Marietta Branch	KSU Branch	Paulding Branch	Towne Lake Branch
69 South Avenue	3333 George Busbee Drive	4075 Marietta Highway	3048 Eagle Drive
Marietta	Kennesaw	Dallas	Woodstock

Conduct basic transactions nationwide at credit union shared service centers.
To find out more about the shared service centers visit us at **www.cuofga.org**.

This Credit Union is federally-insured by the National Credit Union Administration.
We Do Business in Accordance with the Federal Fair Housing Law and the Equal Credit Opportunity Act.

Credit Union of Georgia
529 College Savings Programs

Quality Planning is Essential
Part of good parenting (grandparenting) is preparing your children for the future. Statistics show that higher education can increase your child's chances of receiving a better paying job later on in life. Given the rising costs of a college education, it benefits you to start a higher education funding plan now, instead of later. Planning early has added advantages for both you and your child.

Good parenting is also making sure that your children or loved ones can still have their dreams realized even if something happens to you. As with planning for a child's education, *now*—rather than later—is the best time to make sure you have adequate life and disability insurance protection.

All states now sponsor tax-advantaged college savings programs to help families save for future college costs. There are two main types of 529 programs (*prepaid tuition plans* and *college savings plans)* and each state plan has its own terms and features. The specifics of each plan vary greatly. So, before you sign on, get the details about the investments, fees, and restrictions, and consider all of your other college funding options.

What is a 529 College Savings Plan?
A 529 College Savings Plan is a tax-advantaged way of saving for a higher education. Anyone (a parent, spouse, grandparent, other family member, friend, or *you*) can contribute to the Plan. The student uses the 529 account for qualified education expenses, such as tuition and room and board. The contributor (or account owner) has complete control over the account and can contribute no matter his/her income level. The contributor selects from a variety of investment options with varying rates of return.

Who can contribute to a 529 plan?
In general, 529 plans don't have any eligibility income limitations. Any adult (parents, grandparents, other relatives, and friends) can open an account. The beneficiary qualifications depend on the type of 529 program. Most college savings plans allow anyone of any age to be the beneficiary of an account. But most prepaid plans impose limits on the age of the beneficiary.

What are the tax benefits?
When you make qualified withdrawals from a 529 plan your earnings are free from federal income tax. State rules governing 529 programs vary. Some allow state residents to deduct the full or a partial amount of their contribution from state income taxes. And most states allow residents to exempt earnings from state income tax. Some plans are open to residents of all states, although out-of-state participants may not get the state tax breaks. For example, you may not qualify for the state tax deduction if you contribute to an out-of state plan. And some states tax earnings withdrawn from out-of-state plans, generally at the student's state tax rate.

Along with the rest of the Tax Act of 2001, the provision that made 529 earnings free from federal tax is set to expire at the end of 2010. That means that earnings will revert to being taxed at the student's federal income tax rate, unless Congress extends the tax break or passes new legislation.

What are prepaid tuition plans?
Prepaid tuition plans allow you to pay tuition in advance and lock in the cost based on today's tuition prices. These plans pool investments and aim to keep pace with tuition increases in the state. You can use savings in these plans for tuition at any eligible public university or private college in the country. The amount, however, is based on tuition costs at a state's public universities. Therefore, if your child doesn't attend an in-state school and there's a difference between the prepaid tuition plan price and the current out-of-state tuition cost, you'll have to pay the difference.

Some states back their prepaid tuition plans with a full faith-and-credit obligation or statutory guarantee. Therefore, the state's Treasury is obligated to make up any difference in investment returns and future tuition bills. Some states, however, don't provide this guarantee.

What are college savings plans?
College savings plans allow you to save money in a special college savings account for a student's *qualified higher education expenses* at any *eligible educational institution.*
Qualified higher education expenses include tuition and fees, books and supplies, and room and board for students enrolled at least half time.

According to the IRS, the definition of *eligible educational institution* includes virtually all U.S. accredited public, nonprofit, and privately owned profit colleges, universities, and vocational schools.

Each state sets its own lifetime contribution limit per beneficiary, with limits generally ranging from about $180,000 to $300,000.

How do college savings plans work?
College savings plans provide variable rates of return based on the types of investments you choose from the available options. Therefore, your account value may increase or decrease based on the performance of your selected investments. Investments generally include stock, bond, and money market mutual fund options, as well as age-based portfolios of mutual funds.

These investments provide no return guarantees and account values may be more or less than the amount you contribute. Investments are not insured or guaranteed by the state, any investment company, or any government agency. Some plans also provide investment options designed to preserve your principal and provide a fixed minimum rate of return.

Importantly, you can only change investment options within the same plan once in a calendar year (assuming the plan permits this change). If you already made this annual change and you want to change your investments again, you can direct future contributions to different investments if you open a separate account for the same beneficiary (subject to the plan's lifetime contribution limits).

Another way to change investments is to roll over your plan assets to another college savings plan for the benefit of the same beneficiary. You can make this rollover free from federal income taxes and penalties as long as you limit transfers to one within any 12-month period. Before you make this move, however, check into any state tax consequences.

How do 529 College Savings Plans Compare To Other Tax-Favored options?
Click on the link above and see—from a comparison chart—how 529 College Savings Plans stack up against these other tax-favored college savings options: 529 Prepaid Tuition Plans, Education Savings Accounts, U.S. Savings Bonds, and custodial accounts.

What if my child or grandchild doesn't attend college or I withdraw my money for non-college use?
If the beneficiary of your account doesn't attend college, you may defer the account for later use or transfer it to another member of your family, which is defined broadly. You can withdraw your savings for non-qualified higher education expenses, subject to each plan's rules, but you'll owe federal income taxes on the earnings, generally at your income tax rate. Plus, you'll incur a 10% federal penalty tax on earnings, unless an exception applies. The exceptions include a student's disability, death, or receipt of a scholarship.

How do contributions to a 529 plan affect a student's financial aid eligibility?
Assets in a 529 plan may reduce a child's future eligibility for needs-based financial aid. The specific impact depends on your financial situation, the type of plan - prepaid or college savings, the type of aid, and the plan owner. Remember, though, most financial aid is awarded in the form of loans, and non-needs based aid is available if you don't qualify for needs-based aid.

For more information
A Guide to Understanding 529 Plans, The College Savings Plan Network, **www.collegesavings.org**

Other Options for Paying for College

Here's a brief rundown of some other ways to pay for college, including borrowing from your retirement accounts, taking a loan against your cash value insurance policy, or borrowing against your home equity.

Before you tap into these sources, however, evaluate them alongside all your other options, including federal, state, and college financial aid programs.

Loans from Employer-Sponsored Retirement Plans
Some 401(k) and 403(b) plans allow you to borrow a portion of your vested balance for your child's college education. Each plan has its own repayment terms, loan limits, and other restrictions, so check with your employer for specifics.

Note that if you quit or get laid off with a loan outstanding, you'll generally have to repay it quickly. Otherwise, the IRS will consider it a withdrawal and you'll owe regular income taxes, and if you're under age 59½, a 10% early withdrawal penalty.

Before dipping into your retirement nest egg, however, consider that your child has his or her entire working life to repay college loans. In contrast, you can't replace your savings once you withdraw them from your retirement plan.

Home Equity Loans
If you're a homeowner, another option may be a home equity loan, which allows you to use the equity in your home as collateral to borrow money. You can borrow a lump sum, which you repay in monthly installments over a set period, or you can borrow as you need it from an established line of credit, paying interest only on the money you actually use.

Interest on home-equity loans is either fixed or variable, and is generally tax deductible up to $100,000. However, since you're putting your home on the line, only borrow an amount you're certain you can repay, and get serious about repaying the loan as soon as possible.

Loans from Cash Value Life Insurance Policies
Cash value life insurance, including whole life, universal life, and variable universal life, allows you to borrow against your built-up cash value, generally at favorable rates.

Bear in mind though, while your loan is outstanding the policy's death benefit remains in effect, but it's reduced by the unpaid loan balance. So in the event of your death, your beneficiary will receive a reduced death benefit.

Retirement IRAs
When you make early withdrawals for qualified higher education expenses from either a traditional IRA or Roth IRA, the 10% penalty that is usually imposed when you make withdrawals before age 59½ is waived.

Qualified higher education expenses include tuition, fees, books, supplies, and equipment required for attendance at an eligible educational institution. Room and board also qualifies if a student is enrolled in college at least half time.

Before you consider your IRA as a source of college funds, though, make sure you understand all the consequences. For traditional IRAs, early withdrawals will escape the 10% tax penalty when you use the money for qualified higher education expenses. But you'll still owe regular income taxes on any deductible contributions you made and on your accumulated earnings. Plus, you'll be siphoning off money from your retirement nest egg that you can't replace.

For Roth IRAs, you can make withdrawals for any reason up to the amount of your original *contributions* without owing federal income taxes or penalties. And the 10% penalty is waived if you withdraw any *earnings* for qualified education expenses before the account has been open for at least five years and before you're age 59½. However, you'll owe income taxes on money that would have eventually been free from federal taxes had you left it invested.

Learn More About Paying For College

Check out comprehensive articles about college planning, 529 College Savings Programs, Education Savings Accounts, college tax credits and deductions, and financial aid.

For More Information and Assistance
Contact a **MEMBERS Financial Services** Representative at Credit Union of Georgia or contact James M. (Sam) Davis at (678) 322-2241, (800) 798-1660, (678) 797-0331 Fax, sam.davis@cunamutual.com, Marietta Branch, 69 South Avenue, Marietta, Georgia 30060-2357.

Tax Deferred Savings Plans

Cobb County School District offers employees the opportunity to participate in tax deferred savings plans. The types of plans that are available to CCSD employees include 403b, Roth 403b and 457b. Please take a moment to read about each plan type and decide which is the more appropriate option for you, as there are similarities and differences in each plan type.

403(b) Plan

A 403(b) is a tax-sheltered retirement savings plan that is available only to employees of educational organizations, hospitals, churches, and certain non-profit organizations. Though an employer may also make contributions to the plan, typically employees voluntarily contribute on a pre-tax basis through a salary reduction agreement with the employer. Employees are eligible to contribute 100% of their includable compensation to a maximum of $16,500 for the current year. For employees who are age 50 or greater, an additional $5,500 may be contributed. The plan is intended for retirement purposes, and assets are subject to a premature excise tax if withdrawn before age 59 ½. Most Tax Shelter Annuity (TSA) accounts have loan provisions. Distributions from a TSA must begin no later than age 70 ½ or the year of separation, if later.

Roth 403b Plan

A Roth 403b plan combines the features of a 403b plan with the tax free growth advantage of a Roth IRA. Under the Roth 403b plan guidelines, employees do not have to pay federal income taxes on the growth portion of the Roth 403b account, on the contributions of when the money is withdrawn, because deductions are taken on an after-tax basis. Employees are eligible to contribute 100% of their includable compensation to a maximum of $16,500 for the current year. For employees who are age 50 or greater, an additional $5,500 may be contributed.

Section 457(b) Plan

A Section 457(b) Plan is a tax-sheltered retirement plan that is available to employees of government and non-profit organizations. Typically, employee contributions are made on a pre-tax basis through a salary reduction agreement with the employer. Employees are eligible to contribute 100% of includable compensation up to a maximum of $16,500 for the current year. For employees who are age 50 or greater, an additional $5,500 may be contributed. Section 457(b) plans do not have an excise tax for premature distribution, but withdrawals are typically not allowed before employment severance. Section 457(b) plans may provide a loan provision at the Plan's discretion. Distributions from a 457(b) plan must begin no later than age 70 ½ or the year of separation, if later. If employees are considering retiring before age 60 and anticipate an income need, 457(b) plans allow for distribution prior to age 59 ½ and are not subject to a 10-percent federal tax penalty as are distributions from a 403(b) or IRA plan.

Investment Offerings

Fixed and variable annuity investment and mutual fund options are offered under the 403(b). The Section 457(b) plans currently offer only fixed and variable annuity investment options. To obtain more detailed information on each investment option, you may contact the vendor directly. ***All variable annuities and mutual funds are subject to market risk, including loss of principal.***

How are the plans different?

403(b) and Section 457(b) plans afford similar tax benefits in that contributions are made on a pre-tax basis and are sheltered from taxation until such time as they are withdrawn. With recent legislation, the two plans are more similar with the following exceptions:

403(b)
- Allows for additional catch-up opportunity for employees with 15 or more years of service
- Subject to a 10% excise tax for premature distribution prior to age 59 ½
- Exemption from the premature excise tax if employee works to age 55 or greater and retires
- Plan assets controlled by the employee
- Loan provisions
- Hardship withdrawals

Section 457(b)
- Contributions and earnings are not subject to a premature distribution excise tax
- Plan assets are controlled by the employer
- Loan provisions
- Hardship withdrawals are more restrictive

Double the Deferral Potential

CCSD employees may contribute to both the 403b and the 457b. The maximum you may contribute is a total of 100% of your includable compensation up to the effective deferral limit of each plan. This may allow you to double your contributions!

How do I enroll?

Cobb County School District has partnered with a third party administrator to provide a web-based tool for enrollment called the Cobb County Schools Retirement Manager.

Retirement manager is a comprehensive selection of retirement plan information and services which will provide valuable support and educational opportunities for all District employees. In a secure, Web-based environment, District employees will be able to enroll in the workplace tax deferred plans, retrieve financial planning information, manage retirement account(s) and evaluate retirement plan options to see if they are on track with contributions for the future – 24 hours a day, seven days a week.

Retirement Manager is vendor-neutral, so employees will always be able to interact with their personally-selected vendor(s) in a manner that is consistent with their preferences. Retirement Manager is also modular, so employees may use only the tools needed and add additional services when ready to do so.

Employees may access Retirement Manager by visiting the Benefits Home Page on the Human Resources Website at www.cobbk12.org. There is also an Employee User Guide and Retirement Manager Brochure available on the website that introduces District employees to all the features and functionalities of the tool. It is necessary to have the CCSD e-number available to establish user identify and log in to the site. The employee e-number may be found on the CCSD paystub.

Employees may participate in both a 403(b) plan and a Section 457(b) plan and may contribute the maximum to both plans. Investment options in both plans include fixed annuities, variable annuities and mutual fund programs. Assets in both plans may be rolled to another qualified plan or IRA at separation from employment.

Tax Deferred Savings Plans Vendors

Vendor	Representative	Email Address	Telephone #	Fax #	Investment Product
ING Reliastar http://ingretirementplans.com	Derrick Friedman	dfriedman@lincolninvestment.com	(770) 909-0340	(770) 909-0339	403(b) TSA 457(b) TSA
	April Jackson	ajackson@lincolninvestment.com	(770) 909-0340	(770) 909-0339	
	Charles Jones	cjones@jhnetwork.com	(770) 909-0340	(770) 909-0339	
	Chad Kishel	ckishel26@hotmail.com	(404) 881-9697	(404) 881-8622	
	Pam Middleton	pmiddleton@lincolninvestment.com	(770) 909-0340 (404) 202-9588	(404) 909-0339	
	Robert Moore	romoore@lincolninvestment.com	(770) 909-0340	(770) 909-0339	
	Barry Rawls	brawls@lincolninvestment.com	(770) 909-0340	(770) 909-0339	
	Virgil Lee Dortch	virgildortchiii@gmail.com	(678) 523-2908		403(b) TSA
Lincoln Financial http://www.lfg.com	Christie Cook	crystal.cook@lfg.com	(770) 910-2317		403(b) TSA 457(b) TSA
	Jay Dover	jay.dover@lfg.com	(678) 949-9277		
	Joe Morrison	joe.morrison@lfg.com	(770) 425-7887	(770) 426-8448	
	Clinton Ward	clinton.ward@lfg.com	(404) 683-7419		
MetLife http://www.ccga.metlife.com	Cindi Kreidell *West Cobb*	ckreidell@metlife.com	(678) 521-5607	(770) 407-2428	403(b) TSA 457(b) TSA
	Gabriela Cameron *East Cobb*	gcameron@metlife.com	(770) 596-9151	(770) 407-2428	
SYMETRA http://www.symetra.com	Henry L. Bailey, Jr.	lbailey@valuteachers.com	(770) 778-5848		403(b) TSA 457(b) TSA 403(b) with mutual funds
	Stephen Blackmore	nase009@yahoo.com	(678) 467-4448		
	Gene Griffin	genogriffin@gmail.com	(770) 565-9881	(770) 565-1591	
	Ivan Hammond	ivanhtg@hotmail.com	(678) 270-6333		
	Earnestine Howard	earniet956@yahoo.com	(706) 664-6692		
	Mary Johnson	maryjohnson@valuteachers.com	(770) 815-0511		
	Rodney Keyes	rodneykeyes@valuteachers.com	(404) 944-7424		
	Velda Lory	vlory8@yahoo.com	(404) 819-1963		
	Joanne Mazell	jomzell@bellsouth.net	(770) 623-0321		
	Henley Odom	henleyodom@valuteachers.com	(706) 540-6565		
	Tracy Smith	tracysmith@valuteachers.com	(404) 273-6214		
	Randy Southerland	rsoutherland@valuteachers.com	(404) 376-1648		
USAA http://www.usaa.com	Melinee McComas	www.usaa.com *(secure email)*	(800) 531-8292- Opt 2		403(b) TSA 403(b) with mutual funds
VALIC http://www.valic.com	Customer Service	*(for forms, general questions)*	(800) 448-2542		403(b) TSA 457(b) TSA
	Victor Banks	victor.banks@valic.com	(770) 298-5344	(770) 671-0499	
	Janis Sizemore Jones	janis.jones@valic.com	(770) 395-4706 (404) 310-8818	(770) 671-0499	
	Stephen Komisar	stephen.komisar@valic.com	(404) 964-9890	(770) 671-0499	

Retirement Plans

Teachers Retirement System of Georgia

All employees who are employed one-half time or more in a covered position are required to be members of the Teachers Retirement System of Georgia (TRSGA) or equivalent as a condition of hire. Covered positions include teachers, administrators, supervisors, clerical workers, paraprofessionals, nurses, and campus police officers. Refer to the TRS Facts book or **www.trsga.com**.

Public School Employees Retirement System

Employees of the CCSD who are not eligible for membership in the Teachers Retirement System of Georgia must establish membership in the Public School Employees Retirement System (PSERS) as a condition of employment. This **does not** include substitute employees who work less than 60% of the time during a monthly period. Specifically, this **does** include all school bus drivers, food service employees, maintenance and custodial personnel. No employee can be a member of both PSERS and TRS at the same time. Refer to the PSERS explanation of benefits brochure or **www.ersga.org**.

CCSD Supplemental Retirement Benefit Program for PSERS Employees

Employees who are in the Public School Employees Retirement System and work at least 20 hours per week can receive the Supplemental Retirement Benefits. Cobb County School District will contribute two percent (2%) of the employee's regular annual salary if the employee will contribute at least one percent (1%) of his/her regular annual salary. The employee will not receive any of the Cobb County School District contribution without the one percent (1%) employee contribution. Employer and employee contributions will be on a tax-deferred basis. The CCSD contributions are invested in fixed, interest earning accounts. Employee contributions may be invested in either fixed or variable annuities at the employee's option.

Note: This brief description does not serve as the plan document. More details will be provided to employees participating in this benefit program.

How Do I Pay for My Insurance Benefits?

Benefit Payroll Deductions

Benefit premiums are prepaid. Deductions are taken each month for the following month's coverage. Employees have 31 days to enroll and to make to their initial elections. This is known as the benefits grace period. If a deduction(s) is taken, and the benefit grace period is not satisfied or the employee ends his/her employment, the deduction(s) will be reimbursed, and coverage will end retroactively.

Employees Paid Monthly: Benefit deductions for the full amount of your insurance premiums are taken once a month, in advance, for insurance coverage the next month. A new employee's first deductions are taken from the paycheck he/she will receive in the month before his/her eligibility date (effective date of insurance coverage). If you are a new employee and your first insurance deductions are not taken from the paycheck before your eligibility date, premiums for two months will be deducted from your next paycheck.

Employees Paid Bi-Weekly (Two Times a Month): Benefit deductions for your insurance premiums are taken twice a month, in advance, for insurance coverage the next month. One-half of the insurance premium is taken from the first paycheck of the month, and the other half of the insurance premium is taken from the second paycheck of the month. A new employee's first deductions are taken from the two checks received before the coverage eligibility date (effective date of insurance coverage). If you receive your first paycheck during the second pay cycle of the month, the total premium for the month will be deducted from this check. If benefit deductions are not taken from either check before the eligibility date, the total back premiums will be taken from the first check of the following month, as well as one-half of the premiums for the next month.

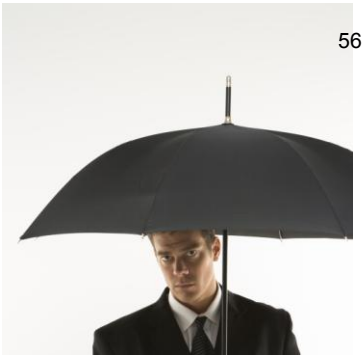
Benefits Effective Dates

Coverage Beginning Date

A new employee's coverage shall become effective on the first of the month following employment for the full preceding calendar month, if the employee is at work on that date. "At work" means the employee is at his/her customary place of employment, on paid leave, or performing his/her normal duties at a place other than the customary place of employment. A full calendar month means the first day of the month, unless the first day of the month falls on a weekend or Official State Holiday, then the first workday of the month is extended by the weekend and/or holiday.

Coverage Ending Date

Benefit premiums are deducted each month for the following month's coverage (one month in advance). Your coverage will end at the end of the month following the month in which your last **FULL** premiums are deducted. If a partial deduction is taken from your last paycheck, you will be refunded the premiums taken, and your coverage will end the following month after your last **FULL** premiums are deducted.



What is COBRA?

COBRA is the continuation of coverage under a plan (i.e., health, dental, vision) when coverage would otherwise end because of a life event is known as a "qualifying event". After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse and your dependent children could become qualified beneficiaries if coverage under your plan is lost because of the qualifying event.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus budget Reconciliation Act of 1985.

EMPLOYEE

If you are an employee, you may be a qualified beneficiary entitled to elect COBRA continuation coverage if you lose your coverage under the Plan because either one of the following qualifying events occurs:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

YOUR SPOUSE

If you are the spouse of an employee, you may become a qualified beneficiary entitled to elect COBRA continuation coverage if you lose your coverage under the Plan because any of the following qualifying events occur:

- Your spouse (the employee) dies
- Your spouse's hours of employment are reduced
- Your spouse's employment ends for any reasons other than his/her gross misconduct
- Your spouse becomes eligible for Medicare benefits (Under Part A, Part B, or both)
- You become divorced from your spouse

DEPENDENT CHILDREN

Your dependent children may become qualified beneficiaries entitled to elect COBRA continuation coverage if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies
- The parent-employee's hours of employment are reduced
- The parent-employee's employment ends for any reason other than his/her gross misconduct
- The parent-employee becomes eligible for Medicare benefits (Part A, Part or both)
- The parents become divorced
- The dependent child stops being eligible for coverage under the plan as a "dependent"

How is COBRA Coverage Provided?
Once the Benefits Office receives notice that a "qualifying event" has happened, COBRA continuation coverage will be offered the qualified beneficiaries.

HEALTH – State Health Benefit Plan (SHBP) will send information explaining how health benefits may be continued through COBRA

DENTAL – The Benefits Office will send information explaining how dental benefits may be continued through COBRA.

VISION – The Benefits Office will send information explaining how vision benefits may be continued through COBRA.

CONTINUATION OF OTHER BENEFITS

The following benefit plans are not eligible for COBRA coverage but may be converted to individual policies if there is a loss in coverage:

- Life Insurance – contact The Hartford (800) 523-2233
- Cancer Insurance – contact Allstate Benefits (800) 521-3535
- Legal Services – contact ARAG 1-800-247-4184, access code 17840ccs

Health Insurance Portability And Accountability Act (HIPAA)

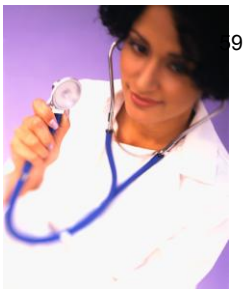
The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that regulates most employer group health plans, health insurance companies, and health care providers.

The law protects your privacy right as it relates to healthcare from your providers/doctors/hospitals. As a patient, you will see the effect of this legislation when you obtain medical care from a health care provider or require access to your personal medical records maintained by that provider. The legislation still allows health care providers and health plans to use and disclose information as needed in the course of providing treatment, payment, or other health care operations.

The other aspect of HIPAA is how it has changed pre-existing condition limitations when you leave CCSD and obtain coverage through a new employer's plan. Many health plans have a pre-existing condition clause that limits or excludes coverage for a condition or diagnosis you had before joining that plan. However, if your new employer's plan is subject to this area of HIPAA, the new employer may reduce or remove the limitation on pre-existing conditions. If you have had coverage under a previous health plan(s) for 18 months or longer, without a break in coverage of more than 63 days, then this may be available to you.

A 63-day break in health insurance coverage (not counting time spent in any waiting periods) is very significant as it will disqualify any previous coverage (before that break) from being considered as "creditable coverage". So, if you experience a COBRA Qualifying Event and lose health insurance coverage, you may need to elect COBRA coverage for the interim.

Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." If your new health plan's waiting period will not begin until more than 63 days later after your previous loss of coverage, you may be subject to pre-existing condition exclusions**.** A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.



Leaves of Absence

Short Term/Sick Leave and Absences
Short Term Leave is defined as time granted to an employee to be absent from his/her work assignment according to specific terms. All benefit eligible employees will be entitled to earn and use leave with full pay for short term absences as defined in Administrative Rule GCC. Employees will earn sick leave at a rate of 1 1/4 days for each month of service if salary is earned for at least half of the workdays in the service report period. Sick leave can be granted for personal illness, family illness, bereavement, and personal/professional reasons.

Long Term Leave of Absence
Eligible employees may be granted a leave of absence without salary for a period of one year for personal illness, family illness, birth, adoption, educational, or military purposes. Refer to Administrative Rule GCC for specific details and eligibility requirements.

Family and Medical Leave
All eligible employees are entitled to a combined total of 12 workweeks of unpaid leave during a 12 month period for certain family and medical reasons. Employees who have been employed with the District for at least 12 months are eligible to apply for Family Medical Leave. Refer to Administrative Rule GCCAC for specific details and requirements.

Military Family Leave
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week entitlement to address certain qualifying exigencies. The Family and Medical Leave Act also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12 month period.

Maternity Leave, Military Leave, and Jury Duty
In most cases, eligible employees are allowed 6 weeks disability for a vaginal normal delivery and 8 weeks disability for a Cesarean section. Rules regarding the Family and Medical Leave Act (see above) also apply. Eligible employees will use accrued short tern leave days as applicable. Please contact the Human Resources/Benefits Office for specific information regarding your personal situation.

Military Leave (Employee)
District employees are extended the right to short term military leave of absence. This leave is for National Guard or Reserve duty which the employee is required to attend. When given a choice by the military, the employee will select the duty which will have the least detrimental effect on the employee's job responsibilities. The employee will be granted the leave, withpay, for up to eighteen (18) days. The employee will provide written documentation as to the duty being required and the required dates of duty.

Jury Duty
Employees who are called to jury duty serve with no loss of pay. Employees who are subpoenaed as witnesses in cases where they have no direct personal interest are allowed the absence with no loss of pay. Absences due to jury duty are not charged against the employee's accumulated leave. Employees who have a direct personal interest in the lawsuit or legal proceeding should take personal leave. See Administrative rule reference GCC.

Catastrophic Illness Leave Bank (CILB)

A catastrophic or terminal illness can create a financial hardship for a family. To provide assistance with such situations, the District offers a Catastrophic Illness Leave Bank (CILB) enrollment opportunity for all eligible employees. The CILB is a supplemental financial benefit available to all eligible employees who enroll. In order to be eligible to participate in the CILB, employees must be entitled to accumulate sick leave days and be employed for 120 consecutive days. Upon completing this eligibility requirement, the employee may make a **one time** donation of one day of accumulated sick leave during the next open enrollment.

Members of the CILB may receive the value of up to twenty (20) workdays' salary when they have a catastrophic illness or injury, have exhausted their sick leave, and have made application to and received approval from the CILB Committee. Applications are approved on the criteria set forth in Administrative Rule GBRIG.

In order to qualify and/or be considered for this benefit, the employee must be examined by a physician who must certify in writing that the employee's medical condition meets the following conditions:

- There is no reasonable expectation that the employee may be able to work within the following six (6) months; or
- Death would likely occur as a result of the disease, illness, or injury within one year without the application of life-sustaining procedures.

Exclusions and Limitations

Every insurance company has exclusions and limitations. Please read any and all exclusions in this booklet. Remember that this is only a brief summary of all of the plans offered by CCSD, and does not take the place of each plan's Summary Plan Description. The Summary Plan Descriptions will provide the exclusions and limitations for the specific plan. You may find Summary Plan Descriptions on the CCSD website, Benefits weg page, beginning, January 1, 2012. If additional details are desired, please contact the insurance company directly.

Thank you.