2011
Your Benefits Connection

Eligible CCSD employees enjoy a comprehensive benefits package. This booklet contains valuable information about each of the benefits offered.

CCSD Benefits Office
Physical Location:
590 Commerce Park Drive
Marietta, GA 30060

Mailing Address:
P.O. Box 1088
Marietta, GA 30061

Phone: (770) 426-3537
Fax: (770) 429-5809
Email:
benefits@cobbk12.org

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Benefit Plan year is from January 1, 2011 – December 31, 2011

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 2011 for all carrier/vendor names and phone numbers (www.dch.georgia.gov/shbp)

DENTAL INSURANCE
MetLife
1-800-942-0854
United Concordia
1-866-851-7568

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

LIFE INSURANCE (BASIC, SUPPLEMENTAL, DEPENDENT)
MetLife
1-800-633-2360

CANCER INSURANCE
Kansas City Life Insurance Company
Agent: T.W. Lord 770-427-2461

LEGAL PLAN
Hyatt Legal Plans
1-800-821-6400

DISABILITY PLANS (SHORT TERM/LONG TERM)
MetLife
1-800-638-2242

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
T. W. Lord & Associates
(770) 427-2461

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.

Dental Insurance Plans

Cobb County School District is pleased to offer you two dental benefit plans :

- **The MetLife High Dental Plan Option**
- **The United Concordia Low Dental Plan Option**

Both plans 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 plan summary information so that you can make the most informed decision possible.

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

MetLife is not content to just provide you with great dental protection – they want you to have a great experience. That's what MetLife's superior service commitment is all about. If you have questions, simply call **1-800-942-0854** or log on to **www.metlife.com/mybenefits** to access all the tools and information you will need to be better informed about your dental plan options.

United Concordia's customer service representatives are available to assist you and may be contacted at the following toll free number to answer questions: 1-866-851-7568. You may also log on to the following website for assistance and detailed information: www.unitedconcordia.com

Like most group health insurance policies, MetLife group policies contain certain exclusions, limitations, waiting periods, and terms for keeping them in force. Please contact MetLife 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 and much more! See the section on Optional Spending for additional information.

MetLife

Cobb County School District Dental Plan Benefits

For the savings you need, the flexibility you want and service you can trust.

Benefit Summary

Coverage Type	**PDP In-Network:**	**Out-of-Network:**
Type A – (For example, cleanings, oral examinations and other maintenance type procedures)	100% of PDP Fee*	100% of R & C Fee**
Type B – (For example, fillings and other standard dental procedures)	75% of PDP Fee*	75% of R & C Fee**
Type C – (For example, bridges and dentures and other complex procedures)	50% of PDP Fee*	50% of R & C Fee**
Type D – orthodontia	40% of PDP Fee*	40% of R & C Fee**
Deductible*†:	**In-Network**	**Out-of-Network**
Individual	$50.00	$50.00
Family	$150.00	$150.00
Annual Maximum Benefit**:	**In-Network**	**Out-of-Network**
Per Person	$1,000	$750
Orthodontia Lifetime Maximum:	**In-Network**	**Out-of-Network**
Per Person	$1,000	$1,000

* PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing and benefits maximums.

** R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

*** Applies to type B & C Services.

**** Applies to type A, B & C Services.

MetLife

PDP Savings Example

This hypothetical example* shows how receiving services from a PDP (in-network) dentist can save you money.

Your Dentist says you need a Crown, a Type C service —

- PDP Fee: $375.00
- R&C Fee $500.00
- Dentist's Usual Fee: $600.00

IN-NETWORK When you receive care from a participating PDP dentist:		**OUT-OF-NETWORK** When you receive care from a non-participating dentist:	
Dentist's Usual Fee is:	$600.00	Dentist's Usual Fee is:	$600.00
The PDP Fee is:	$375.00		
Your Plan Pays:		***Your Plan Pays:***	
50% X $375 PDP Fee	- $187.50	50% X $500 R&C Fee	- $250.00
Your Out-of-Pocket Cost:	$187.50	Your Out-of-Pocket Cost:	$350.00

In this example, you save $162.50 ($350.00 minus $187.50)…
by using a participating PDP dentist.

*Please note: This example assumes that your annual deductible has been met.

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List of Primary Covered Services & Limitations

Type A – Preventive	How Many/How Often:
Prophylaxis (cleanings)	• Two per calendar year.
Oral Examinations	• Two exams per calendar year.
Topical Fluoride Applications	• One fluoride treatment per calendar year for dependent children up to 19th birthday.
X-rays	• Full mouth X-rays: one per 3 calendar years. • Panoramic X-Rays: one per 3 calendar years. • Bitewing X-rays: two sets per calendar year.
Space Maintainers	• Space Maintainers for dependent children up to 19th birthday.
Sealants	• One application of sealant material every 3 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 14th birthday.

Type B - Basic Restorative	How Many/How Often:
Fillings	
Simple Extractions	
Crown, Denture, and Bridge Repair	
Endodontics	
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Oral Surgery	
Periodontics	

Type C - Major Restorative	How Many/How Often:
Implants	• Initial placement to replace one or more natural teeth, which are lost while covered by the Plan.
Bridges and Dentures	• Dentures and bridgework replacement: one every 5 years. • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.
Crowns/Inlays/Onlays	• Replacement: once every 5 years.

Type D - Orthodontia	How Many/How Often:
	• You, Your Spouse, and Your Children, up to age 19, are covered while Dental Insurance is in effect. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • Benefit for initial placement of the appliance will be made representing 20% of the total benefit. • Orthodontic benefits end at cancellation of coverage.

MetLife

Common Questions… Important Answers

Who is a participating Preferred Dentist Program (PDP) dentist?

A participating dentist is a general dentist or specialist who has agreed to accept MetLife's negotiated fees as payment in-full for services provided to plan participants. PDP fees typically range from 10-35%‡ below the average fees charged in a dentist's community for the same or substantially similar services.

‡ Based on internal analysis by MetLife

How do I find a participating PDP dentist?

There are nearly 110,000 participating PDP dentist locations nationwide, including over 25,000 specialist locations. You can get a list of these participating PDP dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.

What services are covered by my plan?

All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

Does the Preferred Dentist Program (PDP) offer any discounts on non-covered services?

Yes. MetLife's negotiated fees with PDP (in-network) dentists extend to services not covered under your plan and services received after your plan maximum has been met. If you receive services from a PDP dentist that are not covered under your plan, you are only responsible for the PDP (in-network) fee.

May I choose a non-participating dentist?

Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment for the approved service. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP in-network fee for the service provided and your plan's payment for the approved service. Please note: any plan deductibles must be met before benefits are paid.

Can my dentist apply for PDP participation?

Yes. If your current dentist does not participate in the PDP and you'd like to encourage him or her to apply, tell your dentist to visit www.metdental.com, or call 1-877-MET-DDS9 for an application. The website and phone number are designed for use by dental professionals only.

How are claims processed?

Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, you can find one online at www.metlife.com/mybenefits or request one by calling 1-800-942-0854.

Can I find out what my out-of-pocket expenses will be before receiving a service?

Yes. With pre-treatment estimates, you never have to wonder what your out-of-pocket expense will be. MetLife recommends that you request a pre-treatment estimate for services in excess of $300 (This often applies to services such as crowns, bridges, inlays, and periodontics.) To receive a benefit estimate, simply have your dentist submit a request for pre-treatment estimate online at www.metdental.com or call 1-877-MET-DDS9 (638-3379). You and your dentist will receive a benefit estimate (online or by fax) for most procedures *while you're still in the office*, so you can discuss treatment and payment options, and have the procedure scheduled on the spot. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

How does MetLife coordinate benefits with other insurance plans?

Coordination of benefits provision in dental benefits plan is a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan.

MetLife

Exclusions

This plan does not cover the following services, treatments and supplies:

- Temporomandibular joint disorder (TMJ)
- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - Scaling and polishing of teeth; or
  - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the employer of the person receiving such services is not required to pay; or
  - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations or appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Precision attachments associated with fixed and removable prostheses
- Initial installation or replacement of a Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and

Alternate Benefits: Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be: the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the scheduled PDP fee or, if non PDP, the actual charge, for the service actually rendered and the scheduled PDP fee or R&C fee (if non PDP) for the service upon which the plan benefit is based. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plans reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service.

This dental benefits plan is made available through a self-funded arrangement. MetLife administers this dental benefits plan, but has not provided insurance to fund benefits.

UNITED CONCORDIA

Insuring America's Dental Health

DENTAL PLAN FOR
Cobb County School District

Dental coverage for both the known and the unknown

Let's face it, that's what dental insurance is all about. Providing you with coverage for both known expenses—such as cleanings, exams and x-rays—as well as potential unknown ones—fillings, crowns and possibly oral surgery.

Research increasingly suggests a link between a person's oral and overall health. In fact, poor oral care could result in gum disease, which has been linked to a variety of medical conditions, including:

- Heart disease and stroke
- Diabetes
- Complications with pregnancies
- Respiratory disease
- Certain cancers

United Concordia Dental cares about both your oral and overall health. That's why our plans are designed to provide you with the level of coverage you want at a price you can afford.

Why take a chance? For a relatively small investment, you can obtain the dental care you and your family need to help maintain good oral health.

1-866-851-7568
www.unitedconcordia.com

United Concordia® Low Option Dental Plan

Coverage Type	In-Network	Out-of-Network[1]
Type A—Preventive	See Copayment Schedule	85% of MAC[2]
Type B—Restorative	See Copayment Schedule	50% of MAC[2]
Type C—Major Restorative	See Copayment Schedule	40% of MAC[2]
Type D—Orthodontia (child only)	50% of MAC[2]	50% of MAC[2]

Deductible[3]	In-Network	Out-of-Network
Individual	None	$50
Family	None	$150

Annual Maximum	In-Network	Out-of-Network
Per Person	$750	$500

Orthodontia Lifetime Maximum	In-Network	Out-of-Network
Per Person	$750	$500

1. Out-of-network, United Concordia pays the coverage level shown. The member is responsible to pay the remainder of the maximum allowable charge (MAC), plus the difference between the MAC and the dentist's charge. See the *Member Savings Example* below for a hypothetical example.
2. The MAC is set by United Concordia as the highest amount to be paid to an Advantage *Plus* network dentist for a particular service.
3. Applies to Type A, Type B and Type C services.

Member Savings Example

SAVINGS FOR A MEMBER VS. INDIVIDUAL WITHOUT DENTAL INSURANCE[1]

Service	Average Dentist's Charge[2]	United Concordia's MAC[3]	Out-of-Network Coverage Level[4]	Out-of-Network United Concordia Pays[4]	Out-of-Network You Pay[4]	In-Network You Pay[5,6]	Savings for Member vs. Individual without Dental Insurance[6,7]
2 Cleanings	$145	$110	85%	$94	$51	$30	**$115**
2 Exams	$78	$52	85%	$44	$34	$0	**$78**
1 Set of X-rays	$48	$31	85%	$26	$22	$5	**$43**
1 "Silver" Filling	$154	$106	50%	$53	$101	$55	**$99**
1 Crown	$929	$700	30%	$210	$719	$480	**$449**
Total	$1,354	$999		$427	$927	$570	**$784**

1. For illustrative purposes only. Assumes that the deductible (if applicable) has already been met.
2. Average dentist's charge based on 2009 internal data for zip code 30044. Actual charges will vary by dentist, service and geographic region.
3. The maximum allowable charge (MAC) is set by United Concordia as the highest amount to be paid to an Advantage *Plus* network dentist for a particular service.
4. Assumes coverage levels of 85% for Type A, 50% for Type B and 30% for Type C services.
5. In-network copayment based on 2009 internal data for zip code 30044 (Area 2). Actual charges will vary by service and geographic region.
6. Assumes services received by an Advantage *Plus* network dentist.
7. Actual savings will be reduced by net premium costs.

UNITED CONCORDIA
Insuring America's Dental Health

United Concordia® Low Option Dental Plan

Best-in-Class Service

Whether you use our convenient online tools or contact our friendly, knowledgeable customer service experts, you have the information you need—when you need it—online or toll free.

Online Tools

Access the Cobb County School District's Clients' Corner page by visiting www.unitedconcordia.com, selecting **Clients' Corner** and searching for "Cobb County School District." There you can access online tools such as:

Find a Dentist—Search for a dentist near you, compare several dentists' attributes side by side, get driving directions to a dentist's office and more.

My Dental Benefits—Once enrolled, you can securely access your benefit information, including eligibility, claim status, procedure history and additional information about your plan.

> **Cost Estimator** is a new tool available in **My Dental Benefits** that allows you to obtain cost estimates for common dental procedures, enabling you to plan your out-of-pocket costs for dental care. You can even get cost estimates for several services and add them to a printable cost summary. To access this tool from **My Dental Benefits**, select the appropriate member and then click on **Cost Estimator.**

Dental Health Center—Explore our online library of dental health materials that includes information on the link between oral and overall health, details on proper dental care, a glossary of dental terms and links to helpful websites.

Customer Service Representatives

Call 1-866-851-7568 toll free Monday through Friday, 8 a.m. to 8 p.m., ET.

In-Network Copayment Schedules by Zip Code

To determine your out-of-pocket costs for covered services provided by an Advantage *Plus* network dentist, please follow Step 1 and Step 2 below.

Step 1—Find the zip code of your dentist's office in the chart below. Then use the corresponding schedule number to determine you out-of-pocket costs in Step 2.

Dentist's Office State	First 3 Digits of Dentist's Office Zip Code	Schedule
Alabama	350-352, 354-369	1
Alaska	995-999	4
Arizona	850,852-853,855-857,859-860,863-865	2
Arkansas	716-719	1
	720-729	2
California	917-922	2
	900-908,912-916, 923-928, 930-934, 936-938, 952-953, 955-961	3
	910-911, 935, 939-951, 954	4
Colorado	800-802, 804-815	2
	803	3
	816	4
Connecticut	060, 062-064, 066-067	3
	061, 065, 068-069	4
Delaware	197-199	4
District of Columbia	200-205, 207-209, 220-221	2
	222-223	3
Florida	335-338, 342, 344, 346	1
	320-334, 339, 341, 347, 349	2
Georgia	308-309, 312	1
	300-306, 310-311, 313-316, 318-319, 398	2
	317	3
Guam	969	2
Hawaii	967-968	2
Idaho	832-835, 838	2
	836-837	3
Illinois	609, 614-620, 622, 624-630, 633	1
	600-608, 610-611, 613, 623, 631	2

In-Network Copayment Schedules by Zip Code

Dentist's Office State	First 3 Digits of Dentist's Office Zip Code	Schedule
Indiana	464, 469, 471-475, 478	1
	460-463, 465-468, 470, 479	2
Iowa	504-510, 512-516, 520-528, 612	1
	500-503, 511	2
Kansas	667-669, 673-679	1
	660, 664-666, 670-672	2
Kentucky	400-418, 420-427, 476-477	1
	450	2
Louisiana	700-701, 703-704, 706-708, 710, 713-714	1
	705, 711-712	2
Maine	044, 046-047	3
	039-043, 045, 048-049	4
Maryland	206, 210-212, 214-219	1
Massachusetts	010, 012-013	2
	011, 014-027	3
Michigan	484-499	2
	480-483	3
Minnesota	561-562, 566-567	1
	550-551, 553-560, 563-565	2
Mississippi	386-388, 390-394, 396-397	1
	389, 395	2
Missouri	635-641, 644-658, 661	1
	634, 662	2
Montana	590-597, 599	2
	598	3
Nebraska	680-681, 683-693	1
Nevada	889-891, 893-895, 897-898	3
New Hampshire	030-038	4
New Jersey	071-072, 080-084	2
	070, 073-079, 085-089	3
New Mexico	870, 872-874, 877-884	2
	871, 875	3
New York	147-149	1
	103-104, 109-146	2
	100-102, 105-108	3

In-Network Copayment Schedules by Zip Code

Dentist's Office State	First 3 Digits of Dentist's Office Zip Code	Schedule
North Carolina	283-286	2
	270-282, 287-289	3
North Dakota	580-588	2
Ohio	430-431, 433-449, 453-457, 459	1
	432, 451-452, 458	2
Oklahoma	731, 734, 737-740, 743-749	1
	730, 735-736, 741	2
Oregon	970-979	3
Pennsylvania	150-167, 170-172, 185, 187	1
	168-169, 173-184, 186, 188-196	2
Puerto Rico	006, 007, 009	1
Rhode Island	028, 029	3
South Carolina	290-299	2
South Dakota	570-577	2
Tennessee	370-372, 374-375, 377-385	1
	373, 376	2
Texas	733, 755, 763-764, 766-769, 773, 776-777, 780-782, 786, 788-790, 792-796, 798-799	1
	750-754, 756-762, 765, 770-772, 774-775, 778-779, 783-785, 787, 791, 797, 885	2
Utah	840-847	1
Vermont	050-054, 056-059	3
Virginia	227, 230, 239-240, 242-244, 246	1
	224-226, 228-229, 231-238, 241, 245	2
Virgin Islands	008	2
Washington	985-986, 988, 990-994	3
	980-984, 989	4
West Virginia	247-253, 255-268	1
	254	3
Wisconsin	530, 534-535, 538-540, 546, 548	1
	531-532, 541-545, 547, 549	2
	537	3
Wyoming	820-831	2

Cobb County School District Copayment Schedules

Step 2—Use the schedule number from Step 1 to review your copayments for covered services in the chart below. This chart contains some of the most common dental procedures.

Service Category	Description	ADA Procedure Code	Schedule1	Schedule 2	Schedule 3	Schedule 4
Diagnostic	Periodic Exam	D0120	$0	$0	$0	$0
	Full Mouth and Bitewing X-Rays	D0210, D0270, D0272, D0274, D0277, D0330	$5	$5	$5	$10
	Fluoride	D1203, D1204, D1206	$5	$5	$5	$5
	Prophylaxis	D1110, D1120	$15	$15	$15	$15
Preventive	Exams	D0140, D0150, D0160, D0170, D0180	$5	$5	$5	$10
	Periapical first film and occlusal	D0220, D0240	$7	$8	$10	$10
	Extraoral X-Ray	D0250, D0260	$20	$25	$30	$30
	Additional Periapicals	D0230	$5	$5	$5	$5
	Sealants	D1351	$10	$15	$15	$20
	Space Maintainers—unilateral	D1510, D1520	$115	$135	$145	$160
	Space Maintainers—bilateral	D1515, D1525	$155	$175	$195	$220
Restorative	Amalgams—1 Surface	D2140	$30	$35	$40	$50
	Amalgams—2 Surfaces	D2150	$40	$45	$50	$60
	Amalgams—3 or More Surfaces	D2160, D2161	$50	$55	$60	$80
	Resin-based composite, anterior, 1 Surface	D2330	$35	$40	$45	$55
	Resin-based composite, anterior, 2 Surfaces	D2331	$45	$50	$55	$65
	Resin-based composite, anterior, more than 2 surfaces	D2332, D2335	$55	$60	$70	$85
	Inlays	D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D6602, D6603, D6604, D6605, D6606, D6607, D6624	$380	$435	$485	$540
	Crowns/Onlays, Metal/Porcelain	D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2810, D6544, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, D6610, D6611, D6612, D6613, D6614, D6615, D6634	$405	$480	$520	$590
	Additional procedures to new crown	D2971	$75	$85	$95	$105
	Recementation—Inlays/Onlays/ Crowns/Cast/Prefabricated post and core	D2910, D2915, D2920	$40	$40	$40	$50
	Prefabricated Crowns	D2930, D2931, D2932, D2934, D2970	$85	$95	$110	$130
	Resin Windows	D2933	$105	$120	$135	$170
	Post and Core	D2954, D6972	$105	$120	$135	$170
	Prefabricated Crowns/Post and Cores, each additional	D2957	$10	$15	$20	$25
	Sedative Filling	D2940	$20	$25	$25	$35
	Crown buildup, including any pins	D2950, D6973	$80	$85	$90	$120
	Cast post and core	D2952, D6970, D6971	$155	$180	$200	$220
	Crown repairs	D2980	$75	$85	$90	$115
Endodontics	Pulpal therapy	D3110, D3120, D3220, D3221	$35	$45	$50	$60
	Root canal, anterior	D3310	$265	$300	$335	$390
	Root canal, bicuspid	D3320	$310	$350	$395	$455
	Root canal, molar	D3330	$430	$490	$545	$605
	Root canal retreatment, anterior	D3346	$325	$370	$415	$470
	Root canal retreatment, bicuspid	D3347	$370	$420	$470	$545

Service Category	Description	ADA Procedure Code	Schedule1	Schedule 2	Schedule 3	Schedule 4
	Root canal retreatment, molar	D3348	$490	$555	$615	$700
	Apexification, initial	D3351	$110	$130	$145	$160
	Apexification, interim	D3352	$65	$70	$75	$90
	Apexification, final	D3353	$165	$185	$210	$245
	Apicoectomy	D3410, D3421, D3425	$245	$275	$315	$360
	Apicoectomy, additional post	D3426	$120	$135	$150	$195
	Root amputation/hemisection	D3450, D3920	$180	$200	$225	$250
Periodontics*	Soft tissue surgery—gingivectomy (per quadrant)	D4210	$200	$230	$260	$290
	Gingivectomy—up to 3 continuous teeth or bounded spaces	D4211 D4211	$110	$130	$155	$160
	Gingival Flap Procedure – more than 3 contiguous teeth or bounded teeth spaces/quad	D4240	$220	$245	$280	$315
	Gingival Flap Procedure—less than 3 contiguous teeth or bounded teeth spaces/quad	D4241	$130	$145	$165	$185
	Apically Positioned Flap	D4245	$115	$130	$145	$180
	Clinical crown lengthening	D4249	$330	$375	$425	$455
	Osseous surgery (more than 3 contiguous teeth or bounded teeth spaces/quad)	D4260	$450	$510	$575	$620
	Osseous surgery (up to 3 contiguous teeth or bounded teeth spaces/quad)	D4261	$270	$305	$345	$380
	Bone replacement graft—first site in quadrant	D4263, D4265, D7953	$105	$120	$140	$175
	Bone replacement graft—each additional site in quadrant	D4264	$65	$75	$80	$85
	Guided tissue regeneration	D4266, D4267	$165	$185	$220	$250
	Surgical revision per tooth	D4268	$55	$60	$65	$100
	Pedical soft tissue grafts	D4270	$245	$275	$305	$380
	Other soft tissue grafts	D4271, D4275	$320	$365	$410	$475
	Other soft tissue grafts per tooth	D4273, D4276	$395	$455	$510	$635
	Soft tissue surgery—distal or proximal wedge	D4274	$130	$150	$165	$200
	Scaling and root planing (4 or more teeth per quadrant)	D4341	$80	$90	$105	$115
	Scaling and root planing (1–3 teeth)	D4342	$65	$75	$75	$75
	Periodontal maintenance	D4910	$35	$40	$45	$50
Prosthodontics (Removable)	Complete dentures	D5110, D5120, D5130, D5140	$545	$620	$690	$790
	Partial dentures—resin base	D5211, D5212	$405	$465	$520	$585
	Partial dentures—flexible base	D5225, D5226	$405	$465	$520	$585
	Partial dentures—cast metal base	D5213, D5214	$635	$720	$805	$890
	Denture adjustments	D5410, D5411, D5421, D5422	$25	$35	$40	$50
	Denture repairs	D5510, D5520, D5610, D5620, D5630, D5640, D5650, D5660	$75	$95	$100	$130
	Rebase upper denture—complete	D5710	$200	$230	$260	$290
	Denture reline—chairside/office	D5730, D5731, D5740, D5741	$110	$130	$145	$165
	Denture reline—lab	D5750, D5751, D5760, D5761	$170	$195	$220	$240
	Tissue conditioning	D5850, D5851	$55	$65	$70	$100
Implant Services	Surgical placement of implant body; endosteal implant	D6010	$850	$970	$1,100	$1,185
	Surgical placement; eposteal implant	D6040	$1,660	$1,890	$2,115	$2,310
	Dental implant supported connecting bar	D6055	$375	$425	$480	$550
	Implant related prefabricated abutment	D6056	$305	$345	$370	$375
	Implant related custom abutment	D6057	$390	$445	$480	$485

Cobb County School District Copayment Schedules

United Concordia®

Service Category	Description	ADA Procedure Code	Schedule1	Schedule 2	Schedule 3	Schedule 4
	Implant maintenance procedures including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis	D6080	$35	$35	$40	$45
	Implant removal, by report	D6100	$120	$135	$145	$165
	Radiographic/surgical implant index, by report	D6190	$85	$95	$105	$115
Prosthodontics (fixed)*	Fixed partial denture pontics	D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252	$450	$485	$550	$605
	Retainer	D6545, D6548	$170	$195	$220	$245
	Recementation—bridges	D6930	$45	$50	$55	$75
	Fixed partial denture repair	D6980	$70	$80	$85	$110
Oral Surgery	Simple extractions	D7110, D7111, D7120, D7130, D7140	$50	$55	$60	$80
	Surgical removal of erupted tooth	D7210, D7250	$90	$100	$120	$145
	Removal of impacted tooth, soft tissue/partial bony	D7220, D7230	$125	$140	$155	$200
	Removal of impacted tooth, full bony	D7240, D7241	$175	$200	$225	$245
	Alveoplasty with an extraction (4 or more teeth per quadrant)	D7310	$80	$90	$100	$125
	Alveoplasty with an extraction (1–3 teeth per quadrant)	D7311	$45	$55	$60	$75
	Alveoplasty without an extraction (4 or more teeth per quadrant)	D7320	$125	$140	$155	$200
	Alveoplasty without an extraction (1–3 teeth per quadrant)	D7321	$75	$85	$95	$120
	Incision and drainage, intraoral	D7510, D7511	$70	$80	$90	$110
	Incision and drainage, extraoral	D7520, D7521	$100	$115	$130	$160
	Frenulectomy/Frenuloplasty	D7960, D7963	$125	$140	$170	$215
	Excision of hyperplastic tissue	D7970	$145	$165	$180	$225
	Operculectomy	D7971	$65	$70	$75	$90
Adjunctive General Services	Palliative treatment	D9110	$20	$25	$25	$40
	General anesthesia or intravenous sedation, first 30 minutes	D9220, D9240, D9241	$140	$165	$185	$200
	General anesthesia, each additional 15 minutes	D9221	$50	$55	$65	$75
	Intravenous sedation, each additional 15 minutes	D9242	$35	$35	$40	$45
	Consultation	D9310	$35	$45	$45	$50
	Occlusal adjustment—limited	D9951	$35	$45	$45	$50
	Occlusal adjustment—complete	D9952	$160	$180	$210	$255
Orthodontics	If your plan covers orthodontics, payments will be based on a percentage of the total benefit available. A lifetime orthodontic maximum applies. Please refer to your plan overview for more details					

Please note that the charges listed may not indicate the full extent of your out-of-pocket expense. Services marked with an * are typically subject to alternate benefit provisions. We strongly encourage you to request a predetermination before receiving services estimated to cost more than $500, so you will know up front what your out-of-pocket costs will be.

United Concordia dental policies contain exclusions, limitations and terms. For complete details, please refer to your benefit booklet or contact your Human Resources department.

Alternate Benefits

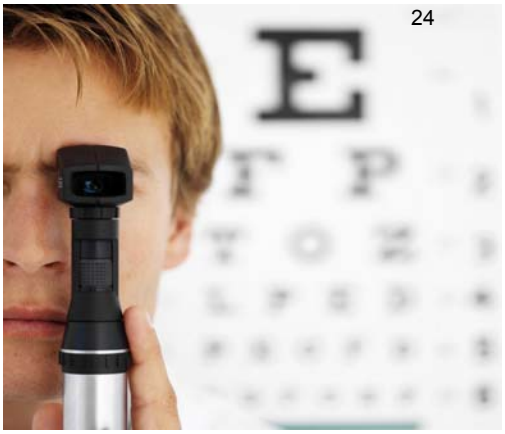
Under your dental plan, when two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement and the associated procedure charge on the least costly treatment alternative. If you and your participating Advantage Plus dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the maximum allowable charge (MAC) for the service received and the MAC for the service upon which the plan benefit is based. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before receiving services and request a predetermination prior to receiving certain high-cost services such as crowns, bridges or dentures. You and your dentist will each receive an explanation of benefits (EOB) that outlines the services provided, your plan's reimbursement for those services and your out-of-pocket costs. Procedure charge schedules are subject to change each plan year.

United Concordia® Low Option Dental Plan

List of Primary Covered Services and Limitations

The service categories and plan limitations shown below represent an overview of your dental benefit plan options. This document presents the majority of services within each category but is not a complete description of the plan. A summary plan description will be made available and will govern if any discrepancies exist between this overview and the actual summary plan description.

Type A—Preventive	**How Many/How Often**
Prophylaxis (Cleanings)	One cleaning in 6 consecutive months
Oral Examinations	One oral exam in 6 consecutive months
Topical Fluoride Applications	One fluoride treatment in 12 consecutive months, for dependent children up to age 14
X-rays	Bitewing X-rays; once per calendar year for adults; once in 6 consecutive months for dependent children
Type B—Restorative	**How Many/How Often**
Periodontal Maintenance	Periodontal maintenance is limited to 2 times in any year, less the number of teeth cleanings received during such 12-month period
Space Maintainers	Limitation of 1 space maintainer per lifetime per area for premature loss of primary teeth for dependent children up to age 14
Sealants	One application of sealant material every 60 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to age 14
Type C—Major Restorative	**How Many/How Often**
Bridges and Dentures	Initial installation of fixed bridgework
	Initial installation of partial and full removable dentures
	Dentures and bridgework replacement; one every 10 years
	Adjustment of dentures; no earlier than 6 months after initial installation
Crowns/Inlays/Onlays	Initial installation of crowns, inlays and onlays; once in 60 months
Endodontics	Root canal treatment limited to once per tooth per 24 months
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontics	Periodontal scaling and root planing; once per quadrant, every 24 months
	Periodontal surgery; once per quadrant, every 24 months
Consultations	Limited to twice in 12 consecutive months
Denture Relines/Rebases	Limited to one per 36 months
Type D—Orthodontia	
Dependent children are covered until the end of the month of their 19th birthday.	
All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.	
Initial payment due upon installation of the orthodontic appliance; repetitive payments for the orthodontic adjustments will be made quarterly at the end of the quarter based on the Orthodontic Lifetime Maximum.	
Orthodontic benefits end at cancellation of coverage.	



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.

Life Insurance

MetLife®

GETTING STARTED

Meeting your coverage needs is simple. Review your options by following these easy steps:

1. Determine how much life insurance coverage you may need by using the needs assessment tool on the CCSD Benefits web site **www.cobbk12.org** or on MetLife's web site at **www.metlife.com/mybenefits.**
2. Learn what options are available to you by reading the *Your Coverage Options* section.
3. If you have questions or need enrollment assistance, contact your benefits administrator.

Your Coverage Options — At a Glance

You have the opportunity to benefit from all that MetLife offers, including:

- Basic Life Insurance
- Personal Accidental Death and Dismemberment Coverage
- Supplemental Life Insurance (Employee Paid)
- Supplemental Accidental Death and Dismemberment Coverage (Employee Paid)
- Dependent Life Insurance (Employee Paid)

BASIC LIFE INSURANCE - WHAT BENEFITS ARE AVAILABLE?

Option 1 (Premium paid by CCSD):

CCSD has chosen to provide you with *Basic Life Insurance* coverage at no cost to you. If you are a non-smoker, you will receive coverage in the amount of $13,000. If you are a smoker, you will receive coverage in the amount of $10,000.

Option 2 (Premium cost-shared by CCSD and employee):

You can elect additional amounts based on your annual earnings (see Basic Life Insurance Table). If you elect Option 2 in place of Option 1, the first $10,000 (smokers) or $13,000 (nonsmokers) of Basic Life coverage will be paid for by your employer. You will be responsible for the additional coverage. See Table on page 26, and contact Benefits Office for assistance with actual rate calculation.

What are the Basic Life Insurance features and services?

- **Accelerated Benefits Option (ABO)**
- **Conversion**
- **Disability Provision**
- **Total Control Account® (TCA)**

For more information, please click on the following link for detailed information regarding Life Insurance.

Basic Life Insurance

CCSD has chosen to provide you with Basic Life Insurance coverage at no cost to you. If you are area non-smoker, you will receive coverage in the amount of $13,000. If you are a smoker, you will receive coverage in the amount of $10,000.

Example 1: Your salary is between $10,000 and $13,000 and you elect Option 2 and are a non-smoker: your total life insurance benefit equals $33,000; ($13,000 plus $20,000).

Example 2: Your salary is between $30,000 and $33,999 and you are a smoker, your total life insurance benefit equals $80,000 ($10,000 plus $70,000).

Employees with Annual Basic Earnings* of:	You may purchase the amount listed in addition to your $10K or $13K Basic Coverage	Basic and AD&D (coverage amount includes $10K Option 1)	Basic and AD&D (coverage amount includes $13K Option 1)
		TOTAL Smoker	TOTAL Non-Smoker
Less than $6,000		$10,000	$13,000
$ 6,000 to $9,999	$10,000	20,000	23,000
10,000 to 13,999	$20,000	30,000	33,000
14,000 to 17,999	$30,000	40,000	43,000
18,000 to 21,999	$40,000	50,000	53,000
22,000 to 25,999	$50,000	60,000	63,000
26,000 to 29,999	$60,000	70,000	73,000
30,000 to 33,999	$70,000	80,000	83,000
34,000 to 37,999	$80,000	90,000	93,000
38,000 to 41,999	$90,000	100,000	103,000
42,000 to 45,999	$100,000	110,000	113,000
46,000 or more	$110,000	120,000	123,000

***Basic Earnings** means your basic rate of pay, excluding any overtime pay, bonuses or other compensation.

PERSONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (Personal AD&D)

What benefits are available?

When enrolled in Basic Life Insurance coverage, you automatically receive Personal AD&D Insurance in an amount equal to your Basic Life Insurance coverage. This coverage, provided alongside your Basic Life Insurance coverage, is designed to safe-guard you and your family from a financial loss, due to an unexpected accidental death or injury.

What is covered under this plan?
Personal AD&D Insurance provides benefits for accidental loss of life or serious accidents based on a benefit schedule. For more information, please refer to the AD&D Benefit Schedule listed in the **Summary Plan Description.**

What are the Personal AD&D Insurance features and services?

- **Exposure Benefit**
- **Seat Belt Benefit**
- **Total Control Account® (TCA)**

For more information, please refer to your **Summary Plan Description**.

DEPENDENT LIFE INSURANCE

Nothing can lessen the emotional impact of losing a dependent. However, there are some steps you can take to ease the financial burden of such a loss. Dependent life insurance helps protect against the loss of your spouse's income and could be used to help cover domestic-related expenses, such as childcare or other household duties.

You may elect coverage for your dependent spouse and/or eligible children. Since this coverage is employee-paid, , premiums will be conveniently deducted from your paycheck.

What are my options?
You may elect to cover your eligible dependents by one of the following options*:

Spouse	**OPTION 1:** $10,000 **OPTION 2:** $25,000
Child	**OPTION 1:** $10,000 **OPTION 2:** $25,000

***To be eligible for Dependent Life Insurance, you must be enrolled in the Employee *Option 2 Basic Life insurance (Cost shared by District/Employee). Dependent Life Insurance* coverage may not exceed the employee coverage amount.**

What are the maximum amounts* for which my dependents can enroll?
The maximum amount of coverage that your dependent spouse can receive is $25,000.
The maximum amount of coverage that your dependent child can receive is $25,000.

Do my dependents need to provide a Statement of Health form?
You may enroll your dependent spouse or child for *Dependent Life Insurance* during this enrollment period without providing a Statement of Health form as long as your spouse and/or child are performing their normal activities and the following conditions are met:

- Your enrollment takes place within 31 days of becoming eligible for benefits
- Your dependent has not been hospitalized within 90 days of enrollment
- Your spouse is enrolling for coverage that does not exceed $10,000 or the current level of coverage
- Your child is enrolling for coverage that does not exceed $10,000 or the current level of coverage

Each dependent will need to submit a Statement of Health form if he/she does not meet the conditions stated above.

What are the Dependent Life Insurance features and services?

- **Accelerated Benefits Option (ABO) (Applicable to Dependent Spouse)**
- **Conversion**
- **Total Control Account® (TCA)**

For more information, please refer to the **Summary Plan Description (SPD)** section.

**For residents of Texas, dependent coverage cannot exceed the employee's coverage.*

Dependent Life Insurance coverage is provided under a group insurance policy (Policy Form GPNP99) issued to your employer by MetLife. Dependent Life coverage terminates when Dependent Life contributions cease, upon the death of the employee, when a dependent no longer qualifies as a dependent, or upon termination of the group contract by your employer upon prior written notice to MetLife. This coverage may also be discontinued by MetLife for nonpayment of premium or if participation requirements are not met.

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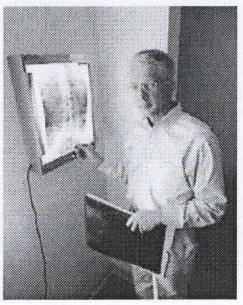
Issued through

KANSAS CITY LIFE INSURANCE COMPANY



Cancer Coverage

CCSD is pleased to offer three cancer coverage options provided through Kansas City Life Insurance Company. In an effort to select the plan option most suited for your needs, please review the plan options carefully.

OPTION I (LIFETIME MAXIMUM BENEFIT (IF ANY) PER INSURED

Hospital Expenses	Daily indemnity of $90/day for the first 7 days; $50/day for next 83 days. Extended benefits commence on the 91st day	UNLIMITED
Drugs and Medicine	Pays up to 10% of the total payable Hospital Confinement benefits for drugs and medicines administered by hospital	UNLIMITED
Surgical Benefits	Pays from $60 to $1,000 per operation as provided in the Surgical schedule	No limit on number of surgical procedures
Anesthetics	Pays up to $140 per operation ($60 for skin cancer) if administered by an anesthetist not employed by the hospital	UNLIMITED
Attending Physicians	Pays up to $20 per visit, not more than one visit per day while confided to the hospital	UNLIMITED
X-ray, Radium Therapy, Radio-Active Isotopes & Chemotherapy	UCR. This does not include diagnostic x-ray or other diagnostic procedures or laboratory tests related to treatment of Cancer	Up to $2,000 per insured person
Graduate Nursing	Payable for service of RN or LPN while hospitalized and when required and authorized by the attending physician not to exceed $48 per day	UNLIMITED
Blood & Plasma	UCR. No maximum limit for Leukemia	$600 per insured person
Ambulance	Not to exceed $100 per hospital confinement	UNLIMITED
Transportation Expense	Regular airplane or railroad fare when required and authorized by the attending physician for hospital confinement due to Cancer	$1,000

Extended Benefits:
Pays 100% of actual hospital charges for care and treatment on the ninety-first day of continuous confinement, not to exceed $10,000.00 per month.

Additional Supplemental Income Benefit:
The policy will pay directly to the insured an additional 20% of each claim paid to help cover expenses that are associated with Cancer claims.

Renewability:
The policy is issued to the insured as an employee of the Employer named in the policy application on a Group Plan. We cannot change premiums on this policy unless all policies of this form number on employees of the Employer have increased premiums.

If you discontinue your association with the Group Plan, you may continue this policy at the proper rate. Refer to your policy for additional information on the terms under which this policy may be nonrenewable and the terms under which dependent coverage will be terminated.

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Limitations and Exclusions:
This Cancer policy does not provide any benefits for: any loss except Cancer; any Cancer which is diagnosed for the first time before the effective date of coverage; or recurrence of Cancer which is pathologically related to previous Cancer, subject to Time Limit on Certain Defenses.

A claim for pre-existing conditions may be reduced or denied. This action may not be taken if covered loss begins more than two years from the effective date of the coverage. This action may be taken at any time for a pre-existing condition that was excluded by name or specific description before the date of loss.

This is not a contract but a brief description of the principal provisions available through this Cancer policy.

Employees who retained a policy offered in a previous benefit year may have a different plan document and less coverage.

Note: Kansas City Life Insurance Company requires a completed application for new participants. This application will be sent to the employee by T.W. Lord & Associates and must be completed and returned to their office within 30 days from the date of receipt. No coverage will be effective until the application has been submitted and approved.

CANCER – OPTION II		
Daily Hospital Confinement Policy	Pays a daily benefit of $100 for each day of hospitalization due to the treatment of a covered Cancer or specified dread disease (if diagnosed more than 30 days after policy effective date)	No Lifetime Maximum
Drugs and Medicine	Pays the actual charges, up to 15% of the daily benefit paid for drugs and medicine administered in the hospital for the treatment of a covered Cancer or specified dread disease	No Lifetime Maximum
Intensive Care	Pays a daily benefit of $200, in addition to any other policy benefits, for each day of confinement in a Hospital's Intensive Care Unit for the treatment of a covered Cancer or specified dread disease	No Lifetime Maximum $200 per day
First Occurrence Benefit	Pays a $500 initial benefit when a covered Cancer or specified dread disease other than skin cancer is first diagnosed, as well as a progressive benefit equal to 5% of the initial benefit for each month this rider is in force (maximum progressive amount of $1,000	$500-$1,500
X-Ray, Radium, Chemotherapy and Cobalt Treatment	Pays up to the Maximum Annual Benefit amount per calendar year for each insured person for the treatment of a covered Cancer and specified dread disease, which is first diagnosed more than 30 days after the rider is in force, not to exceed the actual charges for such treatments. Benefits include drugs and medicine administered to provide such treatments when received in a Hospital (on an inpatient or outpatient basis) or an Out-of-Hospital facility. Benefits do not include diagnostic x-ray or other diagnostic procedures or laboratory tests related to these treatments. Up to $3,000	No Lifetime Maximum Up to $3,000
Comprehensive Care	For Blood, Plasma, Platelets, pays actual charges when received in a hospital (on an inpatient or outpatient basis) or in an out-of-hospital facility as a result of a covered Cancer or specified dread disease	No Lifetime Maximum Actual Charge
	For Ambulance (to/from a Hospital as inpatient) pays up to $75 per trip when transported due to a covered Cancer or specified dread disease	No Lifetime Maximum Up to $75 trip
	For Initial Positive Testing (not payable for skin cancer) pays actual charges up to $250 if the diagnostic test results in an initial positive diagnosis of a covered Cancer or specified dread disease within 90 days of testing	No Lifetime Maximum Up to $250
	For Recurrence Testing (not payable for skin cancer) pays actual charges up to $500 a calendar year for all tests used to monitor for the recurrence of a covered Cancer or specified dread disease.	Up to $500 per year
	For Transportation, for treatment requiring hospital confinement	

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	that cannot be obtained within a 70 mile radius of Insured Person's hone, pays: (1) actual charges for round-trip coach air fare, rail or bus to the nearest treatment center (patient and one adult family member) or (2) $.30 per mile for an automobile for up to 700 miles round-trip	
	For Lodging, pays $50 per day for lodging one adult member of the immediate family accompanying the Insured Person requiring treatment for a covered Cancer or specified dread disease	
Hospice Care	Inpatient Services, pays a daily benefit for all services provided by Hospice when confined as an inpatient, but not to exceed a 50 day limited lifetime maximum	$25 daily benefit
	Outpatient Services, pays one-half (1/2) of the daily benefit for all services provided by Hospice (on an outpatient basis or in an Insured Person's home); but not to exceed an 80 day lifetime maximum	
	Counseling Services, pays the expense of counseling services provided by Hospice for a Terminally Ill Person and his/her immediate family, but not to exceed a lifetime total of $100 for all counseling services	
Physicians Attendance and Private Duty Nurse	Pays actual charges up to the daily benefit for each day for physician services in a Hospital, and will pay up to twice the daily benefit for a Private Duty Nurse (when medically necessary for at least 8 hours a day)	No Lifetime Maximum Up to $20
Surgical and Anesthesia Benefits	Surgical pays the actual charges up to the percentage of maximum listed on the schedule of operations for surgery performed in a Hospital (on an inpatient or outpatient basis) or in an Ambulatory Surgical Center due to a covered Cancer or specified dread disease. Limited benefits for skin cancer ($250 Lifetime Maximum)	No Lifetime Maximum
	Anesthesia pays the actual charges up to 25% of the Surgical benefits paid for anesthesia administered in connection with surgery performed due to a covered Cancer or specified dread disease	

CANCER – OPTION III		
Daily Hospital Confinement Policy	Pays a daily benefit of $150 for each day of hospitalization due to the treatment of a covered Cancer or specified dread disease (if diagnosed more than 30 days after policy effective date)	No Lifetime Maximum
Drugs and Medicine	Pays the actual charges, up to 15% of the daily benefit paid for drugs and medicine administered in the hospital for the treatment of a covered Cancer or specified dread disease	No Lifetime Maximum
Intensive Care	Pays a daily benefit of $400, in addition to any other policy benefits, for each day of confinement in a Hospital's Intensive Care Unit for the treatment of a covered Cancer or specified dread disease	No Lifetime Maximum $400 per day
First Occurrence Benefit	Pays a $500 initial benefit when a covered Cancer or specified dread disease other than skin cancer is first diagnosed, as well as a progressive benefit equal to 5% of the initial benefit for each month this rider is in force (maximum progressive amount of $1,000	$500-$1,500
X-Ray, Radium, Chemotherapy and Cobalt Treatment	Pays up to the Maximum Annual Benefit of $5,000 per calendar year for each insured person for the treatment of a covered Cancer and specified dread disease, which is first diagnosed more than 30 days after the rider is in force, not to exceed the actual charges for such treatments. Benefits include drugs and medicine administered to provide such treatments when received in a Hospital (on an inpatient or outpatient basis) or an Out-of-Hospital facility. Benefits do not include diagnostic x-ray or other diagnostic procedures or laboratory tests related to these	No Lifetime Maximum Up to $5,000

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	treatments	
Comprehensive Care	For Blood, Plasma, Platelets, pays actual charges when received in a hospital (on an inpatient or outpatient basis) or in an out-of-hospital facility as a result of a covered Cancer or specified dread disease	No Lifetime Maximum Actual Charge
	For Ambulance (to/from a Hospital as inpatient) pays up to $75 per trip when transported due to a covered Cancer or specified dread disease	No Lifetime Maximum Up to $75 trip
	For Initial Positive Testing (not payable for skin cancer) pays actual charges up to $250 if the diagnostic test results in an initial positive diagnosis of a covered Cancer or specified dread disease within 90 days of testing	No Lifetime Maximum Up to $250
	For Recurrence Testing (not payable for skin cancer) pays actual charges up to $500 a calendar year for all tests used to monitor for the recurrence of a covered Cancer or specified dread disease	Up to $500 per year
	For Transportation, for treatment requiring hospital confinement that cannot be obtained within a 70 mile radius of Insured Person's hone, pays: (1) actual charges for round-trip coach air fare, rail or bus to the nearest treatment center (patient and one adult family member) or (2) $.30 per mile for an automobile for up to 700 miles round-trip	
	For Lodging, pays $50 per day for lodging one adult member of the immediate family accompanying the Insured Person requiring treatment for a covered Cancer or specified dread disease	
Hospice Care	Inpatient Services, pays a daily benefit for all services provided by Hospice when confined as an inpatient, but not to exceed a 50 day limited lifetime maximum	$50 daily benefit
	Outpatient Services, pays one-half (1/2) of the daily benefit for all services provided by Hospice (on an outpatient basis or in an Insured Person's home); but not to exceed an 80 day lifetime maximum	
	Counseling Services, pays the expense of counseling services provided by Hospice for a Terminally Ill Person and his/her immediate family, but not to exceed a lifetime total of $100 for all counseling services.	
Physicians Attendance and Private Duty Nurse	Pays actual charges up to the daily benefit for each day for physician services in a Hospital, and will pay up to twice the daily benefit for a Private Duty Nurse (when medically necessary for at least 8 hours a day)	No Lifetime Maximum Up to $40
Surgical and Anesthesia Benefits	Surgical pays the actual charges up to the percentage of maximum listed on the schedule of operations for surgery performed in a Hospital (on an inpatient or outpatient basis) or in an Ambulatory Surgical Center due to a covered Cancer or specified dread disease. Limited benefits for skin cancer ($250 Lifetime Maximum)	No Lifetime Maximum Up to $1,500
	Anesthesia pays the actual charges up to 25% of the Surgical benefits paid for anesthesia administered in connection with surgery performed due to a covered Cancer or specified dread disease	
Disability Income	(available on employee only) pays $500 a month up to 6 months beginning with the 8th day you are Totally Disabled due to a covered Cancer or specified dread disease	$500

DEFINITIONS

Cancer – a sickness or disease which:
(1) has been pathologically diagnosed by a Physician to be a malignant neo-plastic growth or disorder; or if such a pathological diagnosis is medically inappropriate, has been clinically diagnosed; and
(2) has been defined and recognized as Cancer by the American Medical Association Nomenclature Index.
Dread Disease – any of the following:

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Addison's Disease, Bubonic Plague, Diptheria, Encephalitis, Hansen's Disease, Malaria, Meningitis, Muscular Dystrophy, Multiple Sclerosis, Osteomyelitis, Poliomyelitis, Rabies, Rocky Mountain Spotted Fever, Scarlet Fever, Sickle Cell Anemia, Smallpox, Tetanus, Tuberculosis, Tularemia, Typhoid Fever, Undulant Fever.

First Diagnosed – For Cancer, this is the day the tissue specimen, culture(s) and/or titer (s) is (are) taken and upon which the diagnosis of Cancer is based. For Dread Disease, this is the day the existence of the disease is conclusively established.

In South Carolina, First Diagnosed for Cancer means the day (s) the tissue specimen culture(s) and/or titer(s) is (are) taken and upon which the diagnosis of Cancer is based; or (b) if such a pathological diagnosis is medically inappropriate, has been clinically diagnosed. For a Dread Disease, this is a day the existence of the disease is conclusively established.

Hospital – A lawfully operating institution which:

(1) has resident facilities for sick or injured patients; and
(2) mainly provides diagnostic, medical and surgical treatment for a fee to sick or injured persons (or has such treatment facilities available on pre-arranged contractual basis). In Missouri, solely provides diagnostic, medical and surgical treatment for a fee to sick or injured persons (or has such treatment facilities available on a pre-arranged contractual basis); and in South Carolina: mainly provides diagnostic medical and surgical treatment to sick or injured persons (or has such treatment facilities available on a pre-arranged contractual basis).
(3) Has a 24-hour nursing service by or under the supervision of a graduate registered nurse; and
(4) Has at least one Physician on the staff who is on call at any time; or
(5) Is accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association, subject to the limitations in the paragraph below.

A Hospital is not an institution or part of an institution which mainly provides convalescent, nursing, or extended care.

In Utah, a Hospital is an institution which is licensed as such and is operating within the scope of such license.

Totally Disabled or Total Disability – You are Totally Disabled when unable, because of Cancer or a Dread Disease, to perform all the substantial and material duties of Your principal occupation at the time such disability commenced.

RENEWABILITY

This policy is a group renewable plan. You may renew and continue this policy in force by paying the correct premium when due or within the Grace Period. Plan coverage will continue as long as the master group contract remains in force.

LIMITATIONS AND EXCLUSIONS

We do not cover Hospital confinements or medical treatment:

for any loss that is not directly due to Cancer or a Dread Disease (In South Carolina: for any loss that is not directly due to or caused or aggravated by Cancer or a Dread Disease or the treatment thereof)

for Cancer or a Dread Disease covered under Workers' Compensation, an Employer's Liability Law or similar law;

which are adjudged experimental by the American Medical Association (A.M.A.) (In Illinois, no coverage shall be denied on the basis of the procedure being deemed experimental unless supported by a determination of the Office of Health Care Technology Assessment rather than the Office of Medical Application of Research of the National Institute of Health);

which is rendered outside the United States, its possessions, or Canada; nor

for which payment is not legally required, except for:

(a) Medicaid;
(b) Treatment of non-service connected disabilities in Veteran Administration hospitals; and
(c) Inpatient care rendered to armed services retirees and dependents in military facilities of the United States Government). (Does not apply in Missouri & South Carolina).

In New Mexico, for any loss due to Cancer or a Dread Disease that is First Diagnosed within 30 days after the Effective Date of Coverage.

PRE-EXISTING CONDITIONS

We do not cover pre-existing conditions for the first 2 years after the Effective Date of coverage.

By pre-existing conditions, We mean:

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(1) the existence of symptoms which would cause an ordinarily prudent person to seek medical diagnosis, care or treatment during the 2 years before or within the 30 days after the Effective Date of his/her coverage; or
(2) a condition for which medical advice or treatment was recommended by or received from a Physician within the two years before or within the 30 days after the Effective Date of his/her coverage.

In New Mexico, no claim for loss incurred or disability (as defined in the policy) shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description had existed prior to the effective date of coverage of this policy.
In South Carolina, by pre-existing conditions, We mean a condition: (a) misrepresented or not revealed in the application; and (b) for which symptoms existed within the 2 years before or within the 30 days after the Effective Date (1) that would cause an ordinarily prudent person to seek diagnosis, care or treatment: or (2) for w hich medical advice was recommended by or received from a Physician.
In Texas, for persons age 65 and over when their coverage becomes effective, We do not cover pre-existing conditions for the first 6 months after the Effective Date of their coverage.
In Virginia, by pre-existing conditions, We mean a condition:

(1) which manifests itself within the 6 months before or within the 30 days after the Effective Date of his/her coverage; or
(2) which was diagnosed by a Physician prior to or within the 30 days after the Effective Date of his/her coverage; or
(3) for which medical advice or treatment was recommended by or received from a Physician within 10 years before or within the 30 days after the Effective Date of his/her coverage.

This provision does not affect a newborn dependent child added after the Policy Date.
Pre-existing conditions specifically named or described as excluded in any part of this contract are never covered.

Product underwritten by Kansas City Life Insurance Company

This brochure is presented as a matter of general information and only applies after the Effective Date of the policy.
For specific details about benefits, including definitions, limitations and exclusions, refer to the group policy.

The Hyatt Legal Plan
for Cobb County School District Employees

Value, Convenience and More

The Hyatt Legal Plan offers you and your family value, convenience and comfort in knowing you can access legal services for almost all personal legal matters.

It gives you easy and low-cost access to a wide variety of personal legal services.

No one can predict your future, but we can help you prepare for legal needs that may lie ahead.

Telephone and Office Consultations on an Unlimited Number of Matters

If your legal problem is not covered by the legal plan, there is no charge for your initial consultation. You will be given a fixed, standard fee agreement by your plan attorney for the non-covered services. This procedure ensures that you know up front exactly what the service will cost.

The Hyatt Legal Plan provides personal legal services. Any business-related matters and those having to do with your employer are specifically excluded from coverage.

Access to Over 9,500 Attorneys

The Hyatt Legal Plan provides members with access to a national network of more than 9,500 attorneys. If you prefer, you may use your own attorney and be reimbursed according to a set fee schedule. If you find yourself in need of legal assistance while traveling within the U.S., call our Client Service Center. You will be referred to an attorney in the area.

smart. simple. affordable.®

Hyatt Legal Plans

A MetLife® Company

Fully Covered Services

The attorney fees for the following personal legal services are fully paid for by the plan when you use a plan attorney. There are no limits on the number of times you may use the plan, and there are no dollar limits on your use of a plan attorney for the following services:

Consumer Protection
- Consumer Protection Matters

Debt Matters
- Debt Collection Defense
- Identity Theft Defense
- Tax Audits

Defense of Civil Lawsuits
- Civil Litigation Defense
- Administrative Hearings

Document Preparation
- Affidavits
- Deeds
- Demand Letters
- Mortgages
- Notes
- Document Review

Immigration
- Immigration Assistance

Family Law
- Uncontested Divorce
- Uncontested Adoption
- Uncontested Guardianship
- Name Change

Real Estate Matters
- Sale or Purchase of Your Home
- Tenant Problems / Eviction Defense (where you are the Tenant)
- Boundary or Title Disputes

Traffic Matters / Criminal
- Traffic Ticket Defense (no D.U.I.)
- Restoration of Driving Privileges
- Misdemeanor Defense
- Juvenile Court Defense

Wills And Estate Planning
- Wills
- Codicils
- Living Wills
- Powers of Attorney

How Much Does the Hyatt Legal Plan Cost?

You may choose from two levels of coverage, each payable through a convenient payroll deduction. The Associate Only rate is $13.50 per month and the Associate plus family rate is $15.80 per month. Most covered services are also available to your spouse and dependents. Your enrollment will continue through the end of the plan year. You may not add or cancel coverage during the plan year.

Stop and Think About Your Future

You will have access to a wide array of frequently needed personal legal services, offering you and your family value and convenience. We cannot predict the future, but we can help you prepare for it.

Consider the Following:

If you owe money, would you like harassing calls from bill collectors to be stopped? Your plan attorney can help enforce your rights.

Have you ever had problems with a landlord? Having an attorney on your side will protect your rights.

If you were in a coma, would your family or doctor know your wishes regarding medical care? A living will allows your wishes to be known.

Do you want the courts to decide who will be the guardian of your children? If you do not have a will, the courts will choose a guardian for your children upon your passing.

Why Should I Choose the Hyatt Legal Plan?

The Hyatt Legal Plan gives you and your family access to professional legal representation at an affordable price. It's like having your own lawyer on retainer. The plan features:

In-Network

- All attorney fees for covered services are paid in full
- 9,500 attorneys to choose from
- No deductibles or co-payments
- No claim forms

Out-of-Network

- You may choose a non-plan attorney and be reimbursed according to a set fee schedule*

Visit our website at
www.legalplans.com
Your passwords are:
5160010 - Associate only
5170010 - Associate plus family

How Do I Use the Plan?

Once you are enrolled, call Hyatt Legal Plans toll-free at 1-800-821-6400, Monday through Thursday from 8 a.m. to 7 p.m. and Friday from 8 a.m. to 6 p.m. (Eastern Time). A Client Service Representative will confirm that you are eligible to use the plan, and will give you the address and telephone number of the attorney(s) located most conveniently to you, as well as a case number. Once you have this information, you may contact the attorney yourself to schedule an appointment.

What if I Have More Questions?

Call 1-800-821-6400 Monday through Thursday from 8 a.m. to 7 p.m. and Friday from 8 a.m. to 6 p.m. (Eastern Time). A Client Service Representative will help you understand coverage, find a plan attorney in the location most convenient to you, offer information about using an out-of-network attorney, and answer any other questions.

Non-Covered Items

What Are the Exclusions? Excluded services are those legal services that are not provided under the plan. Please see your plan description for complete details and exclusions. Excluded services include the following: (1) employment-related matters, including company or statutory benefits; (2) matters involving the employer, MetLife® and affiliates, and plan attorneys; (3) matters in which there is a conflict of interest between the associate and spouse or dependents, in which case services are excluded for the spouse and dependents; (4) appeals and class actions; (5) farm and business matters, including rental issues when the participant is the landlord; (6) patent, trademark and copyright matters; (7) costs or fines; (8) frivolous or unethical matters; and (9) matters for which an attorney-client relationship exists prior to the participant becoming eligible for plan benefits.

This brochure offers a brief summary of the Hyatt Legal Plan. If you have questions about coverage or use of the Legal Plan before you enroll, call Hyatt Legal Plansat 1-800-821-6400 Monday through Thursday from 8 a.m. to 7 p.m. and Friday from 8 a.m. to 6 p.m. (Eastern Time).

*You will be responsible to pay the difference, if any, between the plan's payment and the non-plan attorney's charge for services.

Group legal plans offered by Hyatt Legal Plans, Inc., Cleveland, Ohio. In certain states, the plans are provided through insurance coverage underwritten by Metropolitan Property and Casualty Company and Affiliates, Warwick, Rhode Island.

Short Term Disability Insurance

MetLife®

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.

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 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.

What if I am a late enrollee?

If you make a request to be covered for personal benefits during an annual enrollment period, but after your personal benefits eligibility date and electing no coverage at your initial eligibility date, evidence of your good health must be given to us. Your personal benefits eligibility date is the latter of July 1, 2002 and the first day of the calendar month after the date you complete 1 month of continuous service as an Employee of Cobb County School District.

The "Plan Highlights" provide only a brief overview of the STD plan. A more complete description of the benefits provisions, conditions, limitations, and exclusions will be included in the employee booklet. If any discrepancies exist between this information and the legal plan documents, the legal plan documents will govern.

Short Term Disability ("STD") coverage is provided under a group insurance policy (Policy Form G2130-S) issued to your employer by MetLife. This STD coverage terminates when your employment ceases, when you cease to be an eligible employee, when your STD contributions cease (if applicable) or upon termination of the group contract by your employer. The group policy and your coverage may be discontinued by MetLife for non-payment of premium or if participation requirements are not met or if the number of lives falls below ten. Like most group insurance policies, MetLife group policies contain certain exclusions, waiting periods, reductions, limitations and terms for keeping them in force.

Metropolitan Life Insurance Co., NY,NY
L02052CYH(exp1004)MLIC-LD

Short Term Disability Insurance Buy Up Plan

MetLife®

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

MetLife®

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.

**Not available in New York; In New Jersey, Family Care Expense reimbursement is only for child care.*

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.

***Reasonably prudent person limitation not part of pre-existing condition definition in Arizona, Minnesota, Missouri, Montana, New Jersey, North Carolina, North Dakota, Oregon, Pennsylvania, Texas, and Wyoming.*

The plan also has limited benefits for particular conditions, such as mental or nervous disorders, alcohol, drug, or substance abuse or dependency, neuromusculoskeletal and soft tissue disorders, and chronic fatigue syndrome. The "Plan Highlights" provide only a brief overview of the LTD plan. A more complete description of the benefits provisions, conditions, limitations, and exclusions will be included in the employee booklet. If any discrepancies exist between this information and the legal plan documents, the legal plan documents will govern. Long Term Disability ("LTD") coverage is provided under a group insurance policy (Policy Form G2130-S) issued to your employer by MetLife. This LTD coverage terminates when your employment ceases, when you cease to be an eligible employee, when your LTD contributions cease (if applicable) or upon termination of the group contract by your employer. The group policy and your coverage may be discontinued by MetLife for non-payment of premium or if participation requirements are not met or if the number of lives falls below ten. Like most group insurance policies, MetLife group policies contain certain exclusions, waiting periods, reductions, limitations and terms for keeping them in force.

Metropolitan Life Insurance Co., NY, NY
L04107VZU(exp1005)MLIC-LD

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 entities: 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. Employees hired during the school year are eligible to begin participation on the first day of the month following their hire dates.

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 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. A more extensive list is provided on the CCSD's Benefits website.

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. Appropriate receipts are required reflecting spending account payments for any reimbursements.

Dependent 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 a variety of ways to save for retirement; one of which is the availability of tax deferred savings plans or tax sheltered annuity plans as they are commonly referred to. The types of plans that are available to employees of The District 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 2011. 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 2011. 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 2011. 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

Employees of The District 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 his/her personally-selected vendor(s) in a manner that is consistent with his/her 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	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	
	Chad Kishel	ckishel26@hotmail.com	(404) 881-9697	(404) 881-8622	
	LaKiesha McGhee	lmcghee@lincolninvestment.com	(770) 909-0340	(404) 909-0339	
	Pam Middleton	pmiddleton@lincolninvestment.com	(770) 909-0340 (404) 202-9588	(770) 909-0339	
	Robert Moore	romoore@lincolninvestment.com	(770) 909-0340	(770) 909-0339	
Lincoln National	Jay Dover	jay.dover@lfg.com	(678) 949-9277		403(b) TSA 457(b) TSA
	Joe Morrison	joe.morrison@lfg.com	(770) 425-7887	(770) 426-8448	
MetLife	Ernest Foster *West Cobb*	efoster@metlife.com	(800) 492-3553, x 28193 (678) 938-2670		403(b) TSA 457(b) TSA
	Cindi Kreidell	ckreidell@metlife.com	(800) 492-3553 x 28568 (678) 521-5607	(770) 407-2428	
	Larry Logan *East Cobb*	llogan@metlife.com	(800) 492-3553 x 28339 (770) 715-0477		
SYMETRA	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 (770) 461-6903		
	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	Melinee McComas	www.usaa.com *(secure email)*	(800) 531-8292-Opt 2		403(b) TSA 403(b) with mutual funds
VALIC	Customer Service	*(for forms, general questions)*	(800) 448-2542		403(b) TSA 457(b) TSA
	Stephen Komisar	stephen.komisar@valic.com	(800) 892-5558, x88329	(770) 671-0499	
	Janis Sizemore Jones	janis.jones@valic.com	(770) 395-4706 (404) 210-8818	(770) 671-0499	

Note: Employees may contact one of these representatives to schedule an individual appointment.

The aforementioned Tax Deferred Savings Plan information briefly summarizes the plan. A more detailed description of provisions, conditions, limitations and exclusions is documented in the Summary Plan Description. If any discrepancies exist between the listed information and the legal plan document, the legal plan document or IRS regulations will govern.

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?

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus budget Reconciliation Act of 1985. COBRA continuation coverage can become available to you when you would otherwise lose your group coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group coverage.

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

EMPLOYEE

If you are an employee, you may be become 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 happens:

- 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 happen:

- Your spouse 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); or
- 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; or

- 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 – T. W. Lord & Associates 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 T. W. Lord & Associates
- Cancer Insurance – contact T.W. Lord & Associates
- Legal Services – contact Hyatt Legal Plans

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 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 short term leave at a rate of 1 ½ days for each month of service if salary is earned for at least half of the workdays in the service report period. Short term 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. Employees must have been employed with the District for at least 12 months in order to be eligible to apply for a Long Term Leave of Absence. Refer to Administrative Rule GCC for specific details and 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.

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. If additional details are desired, please contact the insurance company directly.

Thank you.