



**YOUR EMPLOYEE
BENEFIT PLAN**

COBB COUNTY SCHOOL DISTRICT



STD Benefits



Cobb County School District
514 Glover Street
Marietta, GA 30060

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Benefits are provided through a group policy issued to Cobb County School District by Metropolitan Life Insurance Company.

Cobb County School District

MetLife®

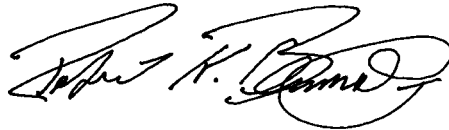
Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

The date when an Employee is eligible for coverage is set forth in the form with the title Eligibility for Benefits.

The date when an Employee's Personal Benefits become effective is set forth in the form with the title Effective Dates of Personal Benefits.

The amounts of coverage are determined by the form with the title Schedule of Benefits.



Robert H. Benmosche
Chairman, President and Chief Executive Officer

Employer: **Cobb County School District**

Group Policy No.: **1665648-G**

Florida Residents: The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

For Maryland residents: The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

For West Virginia Residents: You have the right to return this certificate within ten days of its receipt and to have your premium refunded if, after examination of the certificate, you are not satisfied for any reason.

If any prior certificate relating to the coverage set forth herein has been given to the Employee, such certificate is void.

Form G.23000-Cert.-1

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll-free telephone number for information or to make a complaint at

1-800-638-5433

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-5433

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concierne a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:

1-800-638-5433

IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:

**ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
1200 WEST THIRD
LITTLE ROCK, ARKANSAS 72201-1904**

California residents please be advised of the following:

IMPORTANT NOTICE

**TO OBTAIN ADDITIONAL INFORMATION, OR
TO MAKE A COMPLAINT, CONTACT METLIFE
AT:**

**METROPOLITAN LIFE INSURANCE
COMPANY
1 MADISON AVENUE
NEW YORK, NY 10010
ATTN: CORPORATE CONSUMER RELATIONS
DEPARTMENT
1-800-638-5433**

**IF, AFTER CONTACTING METLIFE
REGARDING A COMPLAINT, YOU FEEL THAT
A SATISFACTORY RESOLUTION HAS NOT
BEEN REACHED, YOU MAY FILE A
COMPLAINT WITH THE CALIFORNIA
INSURANCE DEPARTMENT AT:**

**CALIFORNIA DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1-800-927-4357 (within California)
1-213-897-8921 (outside California)**

Georgia residents please be advised of the following:

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

Utah residents please be advised of the following:

NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

PEOPLE ENTITLED TO COVERAGE

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

POLICIES COVERED

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

EXCLUSIONS AND LIMITATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.

- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or \$500,000 — whichever is lower. Other caps also apply:

- \$100,000 in net cash surrender values.
- \$500,000 in life insurance death benefits (including cash surrender values).
- \$500,000 in health insurance benefits.
- \$200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- \$5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

DISCLAIMER

PLEASE READ CAREFULLY:

. COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.

. COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.

. THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.

. INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.

. THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.

Utah Life and Health Insurance
Guaranty Association
955 E. Pioneer Rd.
Draper, Utah 84114

Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

Virginia residents please be advised of the following:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

Metropolitan Life Insurance Company
1 Madison Avenue
New York, New York 10010
Attn: Corporate Customer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:

1-800-638-5433

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

1-800-552-7945 - In-state toll-free
1-804-786-3741 - Out-of-state

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Wisconsin residents please be advised of the following:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Metropolitan Life Insurance Company
Corporate Consumer Relations Department
1 Madison Avenue
New York, NY 10010
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 266-0103 in Madison.

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SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

BENEFITS (EMPLOYEE ONLY)

SHORT TERM DISABILITY

All Employees who elect:

Option 1 Weekly Benefit.....See Chart Below

The Weekly Income Benefit will depend on the number of days available to you under the Employer's sick leave plan.

CHART

<u>If when disability starts your available sick leave is</u>	<u>Your Weekly Income Benefit is 5x a daily benefit of</u>
Less than 15 work days	\$ 50
15 work days but less than 25 work days	\$ 60
25 work days but less than 35 work days	\$ 70
35 work days but less than 45 work days	\$ 80
45 work days but less than 60 work days	\$100
60 work days but less than 90 work days	\$120
90 work days or more	\$140

Option 2 Weekly Benefit.....Option 1 plus \$115 per week

Option 3 Weekly Benefit.....Option 1 plus \$231 per week

Option 4 Weekly Benefit.....Option 1 plus \$346 per week

Option 5 Weekly Benefit.....Option 1 plus \$462 per week

However, your Weekly Benefit will not exceed 66 2/3% of your Basic Weekly Earnings for Options 1, 2, 3, 4 and 5.

Maximum Benefit Duration..... 180 days

Waiting Period..... 5 days

When you work while Partially Disabled, you will receive the sum of the following amounts:

1. Your Weekly Benefit;
2. The amount of your earnings for working while Partially Disabled.

During any period of Partial Disability, the total of the Weekly Benefit plus income earned while Partially Disabled cannot exceed 100% of your Basic Weekly Earnings.

Rehabilitation Incentive:

While Partially Disabled, when you participate in a rehabilitation program approved by us, your Weekly Benefit percentage is increased by 5%.

Increases and Decreases in Amount of Short Term Disability Benefits

The amount of your Weekly Benefit may change as a result of a change in your earnings or class. The new Weekly Benefit amount:

1. will take effect on the date of the change; and
2. will apply only to Full Disabilities commencing thereafter.

There is an exception if you are not Actively at Work on the above date. In this case the new Weekly Benefit amount will take effect on the date of return to Active Work.

Form G.23000-B

SCHEDULE SUPPLEMENT

A. Statements Made by You Which Relate to Insurability

Any statement made by you will be deemed a representation and not a warranty.

No such statement made by you which relates to insurability will be used:

1. in contesting the validity of the benefits with respect to which such statement was made; or
2. to reduce the benefits;

unless the conditions listed in items (a) and (b) below have been met:

- a. The statement must be contained in a written application which has been signed by you.
- b. A copy of the application has been furnished to you.

No such statement made by you will be used at all after such benefits have been in force prior to the contest for a period of two years during the lifetime of the person to whom the statement applies.

B. Assignment

This certificate may not be assigned by you. Your benefits may not be assigned prior to a loss.

C. Refund to Us for Overpayment of Benefits

If at any time we determine that the total amount paid on a claim is more than the total amount due, including any overpayment resulting from retroactive awards received from sources listed in Other Income Benefits, we have the right to recover the excess amount from the person to whom such payment was made. However, we, at our option, may recover the excess amount by reducing or offsetting against any future benefits payable to such person.

D. Additional Provisions

1. The benefits under This Plan do not at any time provide paid-up insurance, or loan or cash values.
2. No agent has the authority:
 - a. to accept or to waive the required notice or proof of a claim; nor
 - b. to extend the time within which a notice or a proof must be given to us.

Form G.23000-B1

DEFINITIONS OF CERTAIN TERMS USED HEREIN

"Actively at Work" or **"Active Work"** means that you are performing all of the material duties of your job with the Employer where these duties are normally carried out. If you were Actively at Work on your last scheduled working day, you will be deemed Actively at Work:

1. on a scheduled non-working day;
2. provided you are not disabled.

"Covered Person" means an Employee on whose account benefits are in effect under This Plan.

"Doctor" means a person who is legally licensed to practice medicine. A licensed practitioner will be considered a Doctor if:

1. there is a law which applies to This Plan and that law requires that any service performed by such a practitioner must be considered for benefits on the same basis as if the service were performed by a Doctor; and
2. the service performed by the practitioner is within the scope of his or her license.

"Employee" means a person who is employed and paid for services by the Employer on a Full-time basis. "Full-time" means:

1. Permanent Hourly Employees who are scheduled to work at least 20 hours per week for the Employer; or
2. Monthly and Annual Employees consistently working one-half or more of a normal full-time workday.

"Personal Benefits" mean the benefits which are provided on account of an Employee under This Plan.

"This Plan" means the Group Policy which is issued by us to provide Personal Benefits.

"We", **"us"** and **"our"** mean Metropolitan.

"You" and **"your"** mean the Employee who is a Covered Person for Personal Benefits.

Form G.23000-A

ELIGIBILITY FOR BENEFITS

Personal Benefits Eligibility Date

Your Personal Benefits Eligibility Date is the later of:

1. July 1, 2002; and
2. the first day of the calendar month after the date you complete 1 month of continuous service as an Employee of the Employer.

Form G.23000-C

EFFECTIVE DATES OF PERSONAL BENEFITS

A. Making a Request for Benefits

1. In order to become covered for Personal Benefits under This Plan, you must make a written request to the Employer on the benefits enrollment form furnished by the Employer.

In general, you can make choices for coverage for Personal Benefits:

- a. when you are first eligible for Personal Benefits; and
- b. during the annual enrollment period as designated by the Employer and reported to you.

Requests to be covered for Personal Benefits may only be made:

- a. during the first and any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Personal Benefits Eligibility Date; or
- b. during the thirty-one day period following your Personal Benefits Eligibility Date.

If you are already covered for Personal Benefits, requests for changes in Personal Benefits may only be made during the annual enrollment period, as designated by the Employer and reported to you.

2. If you make a request to be covered for Personal Benefits within thirty-one days of your Personal Benefits Eligibility Date, your Personal Benefits will become effective on your Personal Benefits Eligibility Date, subject to the Active Work Requirement.

3. If you make a request to be covered for Personal Benefits during an annual enrollment period, but after:

- a. your Personal Benefits Eligibility Date; or
- b. electing no coverage at your initial eligibility date;

evidence of your good health must be given to us.

4. If you make a request, during an annual enrollment period, to increase your Personal Benefits to an option of the Plan providing a higher level of benefits, the increased amount will become effective on the first day of July following the annual enrollment period, subject to the Active Work Requirement.

However, no increase in your benefit level will take effect with respect to a Disability caused by sickness or injury for which you received Medical Advice or Treatment during the 6 month period immediately prior to the effective date of your increase.

This limitation will not apply if your Elimination Period for a Disability starts after you have been an Active Employee under the This Plan for 12 consecutive months from the effective date of the increase.

B. Evidence of Good Health

The evidence of good health is to be given at your expense. Your Personal Benefits will become effective on the first day of the month following the date such evidence of good health is accepted by us as satisfactory, subject to the Active Work Requirement.

If the evidence of your good health is not accepted by us as satisfactory, you will not be covered for the requested Personal Benefits.

C. Active Work Requirement

You must be Actively at Work in order for your Personal Benefits to become effective. If you are not Actively at Work on the date when your Personal Benefits would otherwise become effective, your Personal Benefits will become effective on the first day after you return to Active Work.

D. Reinstatement of Benefits

If your Personal Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

Form G.23000-D3

SHORT TERM DISABILITY BENEFITS

A. Definitions

"Base Daily Rate of Pay" means for

1. Hourly Paid Employees: Your hourly rate of pay times the number of hours you are normally on duty per day, up to 8 hours; and for
2. Monthly or Annual Salaried Employees: Your monthly or annual salary divided by the number of work days in your contract with the Employer.

"Basic Annual Earnings" means your annual rate of pay from the Employer, excluding overtime and other extra pay. Basic Annual Earnings in effect as of the date of Full Disability will be used to compute your Weekly Benefit.

Basic Annual Earnings if you are a principal of a partnership or proprietorship, (a) means salary, advance, or "draw", excluding profits, dividends or return on capital; and (b) is based on the twelve month period preceding the date Full Disability started or annualized from the date of becoming a principal if less than twelve months.

"Basic Weekly Earnings" means 1/52 of your Basic Annual Earnings.

"Full Disability" or **"Fully Disabled"** means that, due to an Injury or Sickness, you:

1. are under the regular care and attendance of a Doctor; and
2. are unable to perform any of the material duties of your regular job.

"Partial Disability" or **"Partially Disabled"** means that, due to an Injury or Sickness, you:

1. are under the regular care and attendance of a Doctor; and
2. while unable to perform each of the material duties of your regular job on a full-time basis, are performing at least one of the material duties of your regular job or any other gainful work or service on a part-time or full-time basis; and
3. are earning at least 20% less per week than your Basic Weekly Earnings due to that same Injury or Sickness.

"Period of Disability" means any one continuous period of Full Disability and/or Partial Disability.

"Occupational Injury" means an Injury which happens in the course of any work performed by you for wage or profit and which entitles you to benefits under a Workers' or Workmen's Compensation or occupational disease law.

"Occupational Sickness" means a Sickness which entitles you to benefits under a Workers' or Workmen's Compensation or occupational disease law.

"Waiting Period" means the number of consecutive days of Full Disability before Short Term Disability Benefits become payable under This Plan.

"Injury" means accidental bodily injury resulting independently of all other causes. The Injury must occur and Full Disability must begin while you are covered under This Plan.

"Sickness" means illness, disease or pregnancy.

"Pre-Existing Condition" means a Sickness or Injury for which you received Medical Advice or Treatment during the 6 month period immediately prior to your effective date of Personal Benefits.

"Medical Advice or Treatment" means:

1. medical treatment;
2. medical care or services;
3. diagnostic tests; or
4. taking of prescribed drugs or medicines.

B. Benefits

If Full Disability or Partial Disability Benefits are due for a period of less than a week, they will be paid at a daily rate of 1/7th of the Weekly Benefit.

1. Full Disability Benefit

When we receive proof that you are Fully Disabled, we will pay a Weekly Benefit in accordance with the SCHEDULE OF BENEFITS.

The Weekly Benefit will be paid to you after completion of the Waiting Period up to the Maximum Benefit Duration, shown in the Schedule of Benefits, provided you remain Fully Disabled and proof of continued Full Disability is submitted, at your expense, to us upon request.

2. Partial Disability Benefit

If you become Partially Disabled immediately following a Period of Disability during which you were Fully Disabled for at least the Waiting Period, we will continue to pay the Weekly Benefit for the remainder of the Maximum Benefit Duration, provided you remain Partially Disabled and proof of continued Partial Disability is submitted, at your expense, to us upon request. However, the amount of the Weekly Benefit when added to any compensation you may earn while Partially Disabled cannot exceed 100% of your Basic Weekly Earnings.

C. Reduction of Benefits

The Weekly Benefit, as reduced by Other Income Benefits, will be subject to the following:

1. Cost of Living Freeze

The Weekly Benefit will not be further reduced due to cost of living increases:

- a. that are payable under Other Income Benefits; and
- b. that occur after the initial reduction for these Other Income Benefits has been determined.

2. Lump Sum Payments

If Other Income Benefits are paid in a lump sum, the sum shall be spread on a weekly basis over the period stated in the calculation of such sum. If no period of time is stated, the sum will be spread on a weekly basis over your life expectancy, using appropriate actuarial tables.

3. Table of Other Income Benefits

"**Other Income Benefits**" are those benefits listed below which apply to you, and to your spouse, child, or children, as indicated:

The Other Income Benefits are:

- a. The amount you receive under any salary continuance or sick pay plan of the Employer.
- b. The amount you receive or for which you are eligible under any Compulsory Benefit act or law.
- c. The amount of any disability income benefit for which you are eligible under: (a) any other group insurance plan of the Employer; (b) any governmental retirement system as a result of your job with the Employer; (c) any individual disability policies sponsored by the Employer.
- d. The amount of benefits you receive under the Employer's Retirement Plan as follows: (a) any disability benefit; (b) any retirement benefits.

The above amounts are benefits resulting from the same disability for which a Weekly Benefit is payable under This Plan.

D. Successive Periods of Disability

Successive periods of Full Disability and/or Partial Disability will be considered one continuous Period of Disability if:

1. the periods of Full Disability and/or Partial Disability are due to the same or related causes and are not separated by at least ten days of Active Work at your job; or
2. the periods of Full Disability and/or Partial Disability are due to different causes and are not separated by one day of Active Work at your job.

Our liability for the entire Period of Disability will be subject to the terms of This Plan in effect at the beginning of such continuous Period of Disability.

E. Exclusions

This Plan does not cover any Full Disability and/or Partial Disability which results from or is caused or contributed to by:

1. an Occupational Injury;
2. an Occupational Sickness;
3. the commission of a felony; or
4. a Pre-Existing Condition, unless the Full Disability begins after you have been covered under This Plan for 12 months in a row.

Note: We will give credit toward the satisfaction of the above Pre-Existing Condition period or portion thereof already served under a prior group short term disability policy or other disability benefit arrangement provided through your previous employer if:

- a. you were insured under the prior short term disability policy continuously to the date preceding your Effective Date; and
- b. you make a timely request for coverage under This Plan.

We will not give credit toward the satisfaction of the above Pre-Existing Condition period if you are requesting an increase in your benefits under This Plan.

F. Continuity of Coverage Upon Transfer of Insurance Carriers

In order to prevent loss of your Short Term Disability Benefits because of a transfer of insurance carriers, This Plan will provide coverage for you as follows:

1. Failure To Be Actively At Work Due To Injury Or Sickness

This Plan will cover you for Short Term Disability Benefits, if you:

- a.** were covered under the prior carrier's short term disability plan at the time of transfer; and
- b.** are not Actively at Work due to Injury or Sickness;

provided the required payment toward the cost of SHORT TERM DISABILITY BENEFITS is made to us for you.

The benefit payable will be that which would have been paid by the prior carrier had coverage remained in force, less any benefit for which the prior carrier is liable.

However, in no event will benefits be payable for any Period of Disability which began prior to the time of transfer.

2. Disability Due To A Pre-Existing Condition

If you were covered under the prior carrier's short term disability plan at the time of transfer and Actively at Work and covered under This Plan on its effective date, benefits may be payable for a Full Disability and/or Partial Disability due to a Pre-Existing Condition.

The benefit will be determined according to This Plan, if you:

- a.** satisfy the Pre-Existing Condition exclusion under This Plan; or

- b. would have satisfied the Pre-Existing Condition exclusion/limitation under the prior carrier's plan, giving consideration towards time covered under This Plan and the prior carrier's plan.

However, no benefit will be paid if you cannot satisfy the Pre-Existing Condition exclusion/limitation under **a.** or **b.** above.

Form G.23000-5B as amended by G.24365(02)

**CLAIM PROCEDURE FOR
SHORT TERM DISABILITY BENEFITS**

A. When Notice of Claim Must be Given

Written notice of a claim must be given to us for Short Term Disability Benefits within 10 days after the start of the Full Disability.

B. Claim Forms

When we receive written notice of a claim, we may furnish printed forms for filing proof of the claim. If we do not furnish printed forms within 10 days after you give us notice, you must furnish your own form of proof in writing.

Proof must describe the event, the nature and the extent of the cause for which a claim is made; it must be satisfactory to us.

C. When Proof of Claim Must Be Given

Written proof of a claim must be given to us not later than 90 days after the end of the period for which Weekly Benefits are payable for Short Term Disability Benefits.

D. Late Notice or Proof

If notice or proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the notice or proof is given as soon as possible.

E. Time Limits on Starting Lawsuits

No lawsuit may be started to obtain benefits until 60 days after proof is given.

No lawsuit may be started more than 3 years after the time proof must be given.

F. Medical Examinations

While a claim is pending, we, at our expense, have the right to have you examined by Doctors of our choice when and as often as we reasonably choose.

G. Time Limit for Payment of a Claim

1. As to a Claim For Short Term Disability Benefits

If the written proof of a claim:

- a.** has been made on time; and
- b.** is satisfactory to us;

we will pay the accrued benefits not later than the end of each period of 30 days for which the benefits are due.

If we fail to comply with the provisions of this Section **G** with respect to a claim, in whole or in part, we will pay interest to the claimant. The amount of interest will be equal to 18 percent per year on the amount of benefits for that part of the claim with respect to which we have not been in compliance with this Section **G**.

PROVISIONS APPLICABLE TO PREGNANCY

The Short Term Disability Benefits will be payable for a pregnancy (and the resulting childbirth) of an Employee. These benefits will be determined on the same basis as the benefits due to a sickness.

Form G.23000-M

WHEN BENEFITS END

- A.** All of your benefits will end on the last day of the calendar month in which your employment ends. Your employment ends when you cease Active Work as an Employee. However, for the purpose of benefits, the Employer may deem your employment to continue for certain absences. See **CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE**.
- B.** If This Plan ends in whole or in part, your benefits which are affected will end.
- C.** Your Short Term Disability Benefits will end as set forth in the **SHORT TERM DISABILITY BENEFITS** provisions.
- D.** If a Covered Person does not make a payment which is required by the Employer to the cost of any benefits, those benefits will end; they will end on the last day of the period for which a payment required by the Employer was made.

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred before those benefits ended.

Form G.23000-F

**CONDITIONS UNDER WHICH YOUR ACTIVE
WORK IS DEEMED TO CONTINUE**

If you are not Actively at Work as an Employee because of a situation set forth below, the Employer may deem you to be in Active Work as an Employee only for the purpose of continuing your employment and only for the periods specified below in order that certain of your benefits under This Plan may be continued.

All such benefits will be subject to prior cessation as set forth in WHEN BENEFITS END.

In any case, the benefits will end on:

1. the date the Employer notifies us that your benefits are not to be continued; or
2. the end of the last period for which the Employer has paid premiums to us for your benefits.

Your Sickness or Injury

The period determined in accordance with the Employer's general practice for an Employee in your job class.

Your Leave of Absence or Lay Off

The period determined in accordance with the Employer's general practice for an Employee in your job class.

However, in the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA), the period cannot be longer than 12 weeks in any 12 month period following the date the leave of absence begins.

Form G.23000-L

NOTICES

This certificate is of value to you. It should be kept in a safe place.

As soon as your benefits end, you should consult your Employer to find out what rights, if any, you may have to continue your protection.

Our Home Office is located at One Madison Avenue, New York, New York 10010.

Form G.23000-E

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CLAIMS INFORMATION

Procedures for Presenting Claims for Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions about the insurance benefits and to assist you or, if applicable, your beneficiary in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

The completed claim form should be returned to the Employer who will certify that you are insured under the Plan and will then forward the claim form to MetLife.

When the claim has been processed, you or, if applicable, your beneficiary will be notified of the benefits paid. If any benefits have been denied, you or, if applicable, your beneficiary will receive a written explanation.

Requesting a Review of Claims Denied In Whole or In Part

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by MetLife. This request for review should be sent to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit any data, questions or comments you or, if applicable, your beneficiary deems appropriate.

MetLife will re-evaluate all the information and you or, if applicable, your beneficiary will be informed of the decision in a timely manner.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Discretionary Authority of Plan Administrator And Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Contributions

You must make a contribution to the cost of the Short Term Disability Benefits.

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FUTURE OF THE PLAN

It is hoped that the Plan will be continued indefinitely, but Cobb County School District reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

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MetLife[®]

Metropolitan Life Insurance Company
One Madison Avenue, New York, NY 10010-3690

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