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INTRODUCTION

BOYS & GIRLS CLUB WORKERS ASSOCIATION DIRECT REIMBURSEMENT DENTAL and VISION PLAN

This booklet is a description of the Boys & Girls Club Workers Association Direct Reimbursement Dental and Vision Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to reimburse Covered Persons for their out of pocket expense associated with certain Dental and Vision care or supplies.

For Boys & Girls Clubs participating in the Plan (Participating Club), coverage is available for all enrolled Eligible Employees and Dependents when they satisfy the Waiting Period and the eligibility requirements of the Plan.

The Boys & Girls Club Workers Association fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, exclusions, limitations, definitions, eligibility and the like.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were paid for, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished. If the Plan is terminated, the rights of Covered Persons are limited to covered expenses incurred before termination.

The Plan allows you to receive Dental and Vision services from **any** provider you chose. In some locations it may be possible for you to get **dental services at 20 – 30% lower cost** if you use a dentist who participates in the national Dental Provider Network called **DENTEMAX**. In addition to cost savings, an additional advantage to using DENTEMAX dental providers is that, if you choose the Plan can pay benefits directly to the network provider of service. When a DENTEMAX provider is not used, Plan participants must first pay the provider and then submit a claim for reimbursement. Plan benefits are the same whether, or not a participating Provider is used.

Important contact information: For Customer Service including questions on this Plan's benefits, claim status and eligibility for coverage call CTI Administrators toll free: (800) 245-8813 or visit our website at www.BGCWA.com. Use the quick link to the DENTEMAX web site to see if there is a DENTEMAX provider in your area.

SCHEDULE OF BENEFITS

Benefits Effective January 1, 2010

Deductible

There is no Deductible to be satisfied before this Plan begins to pay benefits.

Calendar Year Benefit Maximum on All Dental and Vision Expenses

Maximum Benefits incurred in a Calendar Year for any combination of covered Dental and Vision Services allowed by the Plan are:

- \$1,250 per Covered Person
- \$2,500 per Family (limited to \$1,250 per Covered Person)

Note: Maximum Benefits payable during the Calendar Year are determined by Incurred date (date that services are provided), not by date when payments are made to providers.

Dental Benefits

Covered services will be paid at the coinsurance percentages and subject to the benefit limitations and maximums shown in the Schedule of Benefits below:

Service	Coinsurance	Limitations
Exams, Cleanings, Bitewing X-Rays	100%	Limited to twice in a 12 month period
Sealants	100%	Covered for persons age 18 and under
Full Mouth X-Rays	100%	Limited to once every three years
Fluoride Treatment	100%	<ul style="list-style-type: none"> • Covered for persons age 18 and under • Limited to twice in a 12 month period
Diagnostic Procedures	70%	
Basic Dental Procedures	70%	
Major Dental Procedures	70%	
Orthodontia	70%	<ul style="list-style-type: none"> • Maximum amount payable on a course of orthodontia per Calendar Year is \$500. • Expenses will be reimbursed over the course of the time that the appliances are installed and remain in place. • No more than 25% of the total cost of the course of treatment will be allowed for the initial placement of the appliance. The remaining cost will be considered as "incurred" on a monthly basis and reimbursement will be pro-rated over the minimum expected course of orthodontic maintenance.

Vision Benefits

Vision care services are covered and will be paid at the coinsurance percentages and subject to the benefit limitations and maximums shown in the Schedule of Benefits below:

Service	Coinsurance	Limitations
Vision Exams	70%	
Eye Glasses - Lenses and Frames	70%	<ul style="list-style-type: none">• Maximum amount payable for eye glasses per Calendar Year is \$350.• Lenses must be prescription lenses.• Lenses and frames must be dispensed by a certified optician, optometrist or ophthalmologist.
Contact Lenses	70%	Contact lenses must be prescription lenses.

Discounts on Dental Services

You and your family members may save money on Dental services by using the DENTEMAX Dental Provider Network. This network of providers is available to use on a voluntary basis. For more information on how to select a Dental provider see the section of this booklet entitled "How the Direct Reimbursement Dental and Vision Plan Works".

ELIGIBILITY

Eligible Employee	You are eligible to enroll for this Plan if you are regularly scheduled to work at least 30 hours per week on a consistent basis for a participating Boys & Girls Club and you have satisfied the Waiting Period described below. Part-time employees who work less than 30 hours per week and temporary or seasonal employees are not eligible to enroll for this Plan. If your hours are reduced to less than 30 hours per week your Club may elect to continue your coverage under this Plan for up to one month if the reduction in hours is due to approved leave of absence or lay-off, or, for up to 12 months if due to Disability caused by sickness or injury, coverage may be continued.
Receiving Credit Toward Eligibility for Part-Time Hours	If you have been working at a participating Boys & Girls Club on a part-time basis (less than 30 hours per week), those part-time hours may be applied towards meeting the Waiting Period selected by your Club. At least 240 part time hours during the last six months will satisfy the 30 day or the 90 day Waiting Period.
Eligible Retiree	You are eligible to enroll for Retiree coverage under this Plan if you are under age 65 and, at the time of retirement, you were enrolled in the Boys & Girls Club Workers Association Dental and Vision Plan and had been in the Plan for at least five (5) years, and you were a 30-hour or more per week employee in the Boys & Girls Club movement for at least fifteen (15) years. Participating Clubs must agree to offer this Plan to all eligible Retirees and to pay the required premium on your behalf; they may require you to reimburse them for any or the entire premium.
Eligible Limited Hours Employee	If you are retained by a Chartered Club or the National Organization of the Boys & Girls Club of America (BGCA) to work on a "Limited-Hours" basis you may be eligible to continue your coverage under this Plan if the following conditions are satisfied: <ul style="list-style-type: none">• You are age 55 or over at the time you give up your regular employee position as a Boys & Girls Club professional; and• You will be scheduled to work a minimum of 780 hours (but not greater than 1,560 hours) in the upcoming 12-month period and will work no less than 30-hours in any consecutive two-month period; and• You have been actively employed within the B&GCA movement on a regular employee basis (not Limited-Hours or seasonal) for 15-years or more; and• At the time you become a Limited-Hours employee, you are still actively employed as a regular employee within the movement. This means that you cannot have retired or terminated your employment within the movement prior to becoming a Limited-Hours employee; and• While employed as a Limited-Hours employee you will not be collecting or eligible to collect any retirement benefits from a Chartered Club or the National Organization of the B&GCA; and• The Chartered Club or National Organization that employs you as a Limited Hours employee must have its other Eligible Employees covered by this Plan as well and must satisfy the Participation Requirements of this Plan; and• The Chartered Club or National Organization that employs you, as a Limited-Hours employee must, upon request, be able to furnish to the Claim Administrator documentation that the above requirements are being met. If adequate documentation cannot be provided to support continued eligibility, this coverage will be terminated retroactive to the latest day that eligibility as a Limited-Hours employee can be documented.

**Eligible
Dependent**

A Dependent is eligible to enroll for this Plan if he/she is related to the employee as one of the following:

- A covered employee's or a covered retiree's Spouse.
- A covered employee's unmarried Child(ren) from birth until the 19th birthday.
- A covered employee's Dependent Child(ren) over age 18 until the 26th birthday.
- A covered employee's Handicapped Dependent Child(ren)* over age 18.
- A covered employee's Child(ren) who is given the right to enroll in this Plan through a Qualified Medical Child Support Order (QMCSO) and who satisfies all other eligibility standards of this Plan. Employees may obtain a copy of QMCSO procedures from the Claim Administrator at no cost.
- A covered dependent college student will continue to be covered for one year if they take a medically necessary leave of absence (proof of medical necessity will be required).

At any time, the Plan may require proof that a spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

*The Plan reserves the right to have such Dependent examined by a physician of the Claim Administrator's choice, at the Plan's expense, to confirm the existence of incapacity for the purpose of extending coverage to a Handicapped Dependent Child. Coverage for a Handicapped Dependent Child will automatically cease on the earliest of the following:

- The date the Dependent's incapacity no longer exists; or
- The date the Dependent fails to submit to any required medical examination described above.

Note: If both husband and wife are employees of a Participating Club and have coverage through this Plan, their Children will be covered as Dependents of the husband or wife, but not of both. An employee can be covered as the Spouse of another employee, or as an employee, but cannot be covered as both Spouse and employee.

**Waiting
Period for
New
Employees**

Participating Clubs must select a Waiting Period that will apply to all new employees of that Club unless the employee was previously covered by the Dental Plan of another Club immediately before becoming an employee of this one. The Waiting Period will be either 30-days or 90-days of continuous employment. During the Waiting Period you must meet the definition of an Eligible Employee shown above and be Actively at Work and receiving your regular wage or salary from the Club.

**Waiting
Period for
Employees
Transferring
From a Club**

If you have transferred to a Participating Club that has this Plan and you were covered by the Dental Plan of the Club you transferred from, and there was no gap between your employments with the two Clubs then, with your new Club's approval the Waiting Period is waived.

ENROLLMENT REQUIREMENTS

Enrollment Process

An employee must enroll for employee and Dependent coverage by submitting a completed enrollment application to the Claim Administrator. Coverage in this Plan is not automatic. An enrollment application must be completed and signed by the employee and received by the Claim Administrator in order for coverage to become effective. Coverage will not be made effective retroactively. For an employee who already has Dependent coverage and is adding a newborn Child, the newborn Child may be covered from birth provided that the employee submits a completed enrollment application for said child within 60-days of the birth.

Timely Enrollment

Enrollment for coverage will be considered “timely” if the completed enrollment application is received by the Claim Administrator no later than:

- In the event of a newly Eligible Employee, 30-days after the first of the month following completion of the Waiting Period.
- In the event of an employee whose hours have been increased to 30-hours or more per week, 30 days after the date your hours increased.
- In the event of a newly Eligible Spouse, 30-days after the date he or she became an Eligible Spouse.
- In the event of a newly Eligible Dependent Child, 60-days after the date he or she became an Eligible Dependent Child.

Special Enrollment

If as a newly Eligible Person you decline coverage under this Plan, you may be able to enroll under the Special Enrollment provision. The enrollment of an Eligible Employee, Eligible Spouse, and Eligible Dependents will qualify for Special Enrollment if it occurs within 30-days of one of the following events and the event meets the criteria of a Special Enrollment event:

- The loss of coverage through another group insurance Plan (such loss of coverage cannot be caused by a failure to pay premiums or loss due to cause, such as the submission of a fraudulent claim.),
- Marriage,
- Child over the age of 19 and under the age of 24 who becomes a Full Time Student after a gap in eligibility,
- Birth, adoption, or placement for adoption of a Child.

In order to qualify as a Special Enrollment event that allows an Eligible Employee, Eligible Spouse and some or all Eligible Dependents to enroll the following criteria must be met:

- The employee or Dependent had health insurance coverage through another Plan at the time he or she became Eligible for coverage under this Plan, and
- The employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment, and
- The coverage lost was under COBRA and the COBRA coverage exhausted, or
- The coverage was lost as a result of loss of eligibility, death, termination of employment, reduction in hours worked, or employer contributions towards the coverage were terminated.
- In the case of a person becoming a Dependent of the employee through marriage, birth, adoption or placement for adoption; the Eligible Employee, Eligible Spouse and the newly acquired Eligible Dependent(s) may enroll even if they did not have coverage through another Plan. However, any other previously eligible Dependent Children for whom coverage had been declined, but who were now enrolling for coverage would be considered as Late Enrollments.
- In the case of a Dependent child over the age of 19 who ceased to be eligible for coverage because he or she was not enrolled as a Full Time Student at an

institution of higher learning or a Vocational Technical School, such Dependent may enroll under this provision even if they have not been insured through another Plan or COBRA. To qualify such Dependent must be under the age of 24 and a Full Time Student carrying sufficient credits to qualify as Full-Time in accordance with the requirements of the school college.

**Late
Enrollment**

An enrollment is considered a Late Enrollment if it is not a Timely Enrollment or, in the case of a Special Enrollment, if the enrollment application is not completed and submitted within 30-days of the Special Enrollment event.

EFFECTIVE DATE OF COVERAGE

Effective Date of Coverage For Timely Enrollment

For new employees enrolling on a timely basis the Effective Date for Employee and/or Dependent coverage is the first day of the month following the date that the employee satisfies the Waiting Period specified by the Club. Coverage will be effective on that date providing you are Actively at Work on that date. If you are not Actively at Work on the Effective Date, the Effective Date will be the first day you are Actively at Work. An Actively at Work requirement also exists for your Dependents, see the definition of "Actively at Work" for how this applies to a spouse and/ or child.

For employees enrolling for Dependent Coverage after the Effective Date of the employee, and who enroll on a timely basis, the Effective Date will be the first day of the month following the date they become Eligible Dependents. Exceptions are made for the birth of a newborn Child or the adoption, or placement for adoption, of a child; the Child is covered from birth or date of placement/adoption, provided the employee has enrolled the Child within 60-days of the date of birth or placement/adoption.

Effective Date of Coverage For Retired Employees and Limited Hours

The Effective Date of Retiree Coverage and of Limited Hours Employee coverage is the first day that the Participating Club considers the Employee as retired or working on a Limited Hours Employment basis for the purposes of all Employee benefits. Retired and Limited Hours Employees must continue their coverage under this Plan without a gap in coverage.

Employees Effective Date of Coverage For Special Enrollment

For persons enrolling during the 30-day Special Enrollment Period, the Effective Date will be as follows:

- In the case of enrollment as a result of lost prior coverage, the first day of the month following the date the prior coverage was lost;
- In the case of marriage, on the first day of the month beginning after the marriage;
- In the case of a Dependent Child's birth, as of the date of birth;
- In the course of a Dependent Child's adoption or placement for adoption, the first of the month following the date of the adoption or placement for adoption.
- In the case of a Dependent Child over age 19 but under age 24 who is enrolling as a Full Time Student after a gap in eligibility, the first day of the month in which the Child will resume classes on a full time basis.

Effective Date of Coverage For Late Enrollment

In the case of a Late Enrollment the Effective Date of coverage will be the next following January 1st.

TERMINATION OF COVERAGE

When Employee Coverage Terminates	<p>Employee coverage will terminate and benefits under this Plan will end on the earliest of these dates:</p> <ul style="list-style-type: none">• The date the Plan is terminated.• The last day of the calendar month in which the covered employee ceases to be in one of the eligible classes. This includes death or termination of Active Employment of the covered employee.• The end of the period for which the required premium contribution has been paid. <p>After coverage terminates an employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available see the next section entitled "CONTINUATION OF COVERAGE/COBRA".</p>
Rehired Employee	<p>A terminated employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, unless that employee has continued coverage with no lapse under COBRA coverage.</p>
Effect of Military Leave on Coverage Status	<p>Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no Pre-Existing Conditions exclusions applied in the Plan upon return from service. These rights apply only to employees and their Dependents covered under the Plan before leaving for military service.</p> <p>Plan exclusions and Waiting Periods may be imposed for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.</p>
When Dependent Coverage Terminates	<p>A Dependent's coverage will terminate on the earliest of these dates:</p> <ul style="list-style-type: none">•The date the Plan or Dependent coverage under the Plan is terminated.•The date that the employee's coverage under the Plan terminates for any reason including death.•The date a covered Dependent loses coverage due to loss of Eligible Dependent status.•The end of the period for which the required premium contribution has been paid. <p>After coverage terminates the Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available see the next section entitled "Continuation of Coverage/COBRA".</p>

CONTINUATION OF COVERAGE (COBRA)

COBRA Introduction	<p>“COBRA”, which stands for the Consolidated Omnibus Budget Reconciliation Act of 1985, is a Federal law that requires that as a Boys & Girls Club employee who participates in this Plan, you and your family members may be eligible to continue this Plan’s coverage even after your Boys & Girls Club employment has terminated, or after your Dependent ceases to meet the definition of an eligible Dependent. If you elect to continue your coverage under this law, you will need to pay the premium cost associated with your coverage on a monthly basis and within 30 days of the first day of each month.</p> <p>The occurrence of an event that makes you or a Dependent ineligible for coverage under this Plan is called the “qualifying event”. Examples of a qualifying event include: your employment with the Club ceases, your hours are reduced below 30-hours a week, a divorce, a child turns age 19, a child graduates.</p> <p>Your coverage continuation option is triggered when the Claim Administrator receives notice of a qualifying event, either from you, or the Participating Club. If the qualifying event results in the termination of a Dependent, <u>you</u> are responsible for making sure that the Claim Administrator is notified within 60-days of the date the qualifying event occurred. Once the Claim Administrator is notified, a letter advising you of your rights under COBRA will be mailed to your home at the last address that you provided. You should protect your COBRA rights by keeping the Claim Administrator aware of your current address.</p>
Coverage Continuation for Surviving Dependents	<p>A Dependent’s coverage does not necessarily end upon a Covered Employee’s death. The Dependent may remain on the Plan through the Participating Club where the deceased employee worked. Payment of the monthly premium is the Participating Club’s responsibility; although, the Club may ask the surviving insured Dependent(s) to pay a portion of, or all, the premium.</p> <p>Coverage for a surviving Dependent will terminate if she/he obtains other group dental and vision coverage or Medicare coverage.</p> <p>Surviving Dependent Children will be subject to existing age limits of the Plan, and will be offered COBRA continuation when their eligibility for coverage under the Plan ends due to exceeding age limitations.</p>
Benefits Affected by COBRA	<p>Any COBRA continuance option must include the offering of dental and vision benefits for which the person was covered just prior to the COBRA qualifying event. A Child born to or placed for adoption with the covered employee during the period of COBRA coverage must also be offered the dental and vision benefits.</p> <p>If the “qualified beneficiary” (a person eligible for COBRA continuance) was covered by these benefits prior to termination, he/she may, but is not required to, continue them under COBRA. At the time of COBRA enrollment, the qualified beneficiary will indicate which benefits, if any, he/she wishes to continue.</p>
Maximum Benefit Periods	<p>Continuation will be available for a qualified beneficiary up to a maximum time period shown below. Combined qualifying events will not continue a beneficiary’s coverage for more than 36-months beyond the date of the original qualifying event.</p> <ul style="list-style-type: none"> • Up to 18-months for an employee and his covered Dependent(s) when coverage terminates due to reduction of hours worked, or termination of employment for reasons other than gross misconduct. If the qualifying event was a termination or a reduction of hours and any qualified beneficiary is deemed to have been disabled (under Title II or XVI of the Social Security Act) before the end of the first 60-days of continuation coverage, all qualified

beneficiaries may be eligible to extend their COBRA coverage to 29-months from the date of the termination or reduction of hours. To receive this additional coverage, the Claim Administrator must be notified of the disability determination from the Social Security Administration before the expiration of the 18-month COBRA period and within 60-days of the determination. The Claim Administrator must also be notified within 30 days if that qualified beneficiary is deemed no longer disabled. If deemed no longer disabled, all qualified beneficiaries would no longer be eligible for the additional 11 months of coverage. From the 19th month to the 29th month, up to 150% of the applicable group health premium for this extension of coverage may be charged if the disabled qualified beneficiary is part of the extension.

- Up to 36-months for:
 - A covered Child who ceases to be an eligible Dependent;
 - a covered Dependent of a deceased employee;
 - a former covered Spouse whose coverage ceases due to divorce or legal separation; or
 - a covered Dependent when the employee's coverage ceases due to entitlement for Medicare.
- Continued coverage may cease before the end of the maximum period on the earliest of:
 - The date the Employer ceases to provide a group health and dental Plan to any employee; or
 - the date the qualified beneficiary first becomes, after the date of election, (1) covered under any other group health and dental Plan (as an employee or otherwise), or (2) entitled to benefits under Medicare (except as stated in item 1 above). However, a qualified beneficiary who becomes covered under a group health and dental Plan which has a Pre-Existing conditions limit must be allowed to continue COBRA coverage for the length of a Pre-Existing condition or to the COBRA maximum time period, if less. COBRA coverage may be terminated if the qualified beneficiary becomes covered under a group health Plan with a Pre-Existing conditions limit, if the Pre-Existing conditions limit does not apply to (or is satisfied by) the qualified beneficiary by reason of the group health Plan portability, access and renew ability requirements of the Health Insurance Portability and Accountability Act, ERISA or the Public Health Services Act.
- The date the cost of continued coverage is not paid by the due date.

Notice Requirements

When coverage terminates due to an employee's death, termination or eligibility for Medicare, the employer has 30-days in which to notify the Claim Administrator of the qualifying event. When coverage terminates due to divorce, legal separation or change of Dependent status, the qualified beneficiary has 60-days from the qualifying event or from the date coverage terminates in which to notify the Claim Administrator that the qualifying event has occurred.

Complete instructions on how to elect continuation will be provided by the Claim Administrator within 14-days of receiving notice of the qualifying event. Covered Persons then have 60-days in which to elect continuation. The 60-day period is measured from the later of the date coverage terminates or the date notice of the right to continue is sent. If continuation is not elected in that 60-day period, then the right to elect continuation ceases.

In order to protect your (and your family's) rights, you should keep the Claim Administrator informed of any address changes for you and your family. Keep a copy of any notices sent to the Claim Administrator for your records.

HOW THE DIRECT REIMBURSEMENT DENTAL and VISION PLAN WORKS

Use Any Covered Provider

This Plan allows you to use any covered provider you choose and still receive benefits for covered expenses.
 Covered providers for Dental Services are licensed dentist, oral surgeon, or orthodontist operating within the scope of his or her licensure and training.
 Covered providers for Vision Services are an optometrist (O.D) or ophthalmologist (M.D.), operating within his or her licensure and training.

DENTEMAX Dental Provider Network

You and your family members can save money on dental services by using the DENTEMAX Dental Provider Network. This network of dental providers is available to use on a voluntary basis.

Your Dental and Vision ID Card is the Key...

On your ID Card you will see the DENTEMAX logo. This logo tells every participating DENTEMAX dental provider that the BGCWA Dental and Vision Plan participates in the DENTEMAX Network and that you and your family members are eligible for discounts on dental services.

This Plan allows you to use any covered provider you choose and still receive benefits for covered expenses. However, if you use a participating provider of the DENTEMAX Network, you will receive discounted fees for service.

Additionally, you may assign benefits to your provider if they participate in the DENTEMAX Network. By assigning benefits to a participating provider in the DENTEMAX Network, you will not have to pay at the time of service; the provider may submit the claim directly to CTI Administrators for payment.
 (DENTEMAX providers may not be available in all locations.)

Finding a DENTEMAX Provider

The next time you or a family member needs to see a dental provider, check to see if there is a DENTEMAX provider nearby. You can do this by going to the B&GCWA website at www.BGCWA.com and clicking on the Quick Link to DENTEMAX. Follow the website instructions to locate providers near you, or call CTI Administrators at 800-245-8813 and the claims staff will be glad to assist you.

Note: Use of a DENTEMAX provider is not a guarantee of benefits under the B&GCWA Dental and Vision Plan. Refer to this document for a description of services covered under the B&GCWA Dental and Vision Plan.

When a DENTEMAX Network Provider is Used

This Plan allows you to use any covered provider you choose and still receive benefits for covered expenses. However, if you use a participating provider of the DENTEMAX Network, you will receive a discount in fees for service. Additionally, you may assign benefits to a provider if they participate in the DENTEMAX Network. By assigning benefits to a participating provider in the DENTEMAX Network, you will not have to pay at the time of service; the provider may submit the claim directly to the Claim Administrator, CTI Administrators, for payment.
 (DENTEMAX Providers may not be available in all locations.)

<p>When a DENTEMAX Network Provider is <u>Not Used</u></p>	<p>If you use a non-network provider, you must pay for the services yourself and then submit a claim for reimbursement. When you file your claim you will have to provide evidence of your payment (for more information see the section entitled "Claim Filing and Appeal Procedures").</p> <p>Claim Payments <u>cannot</u> be assigned and paid directly to a provider if they do <u>not</u> participate in the DENTEMAX Provider Network.</p>
<p>Covered Vision Expenses</p>	<p>It is a requirement of this Plan that the Employee pays for vision services first, then is reimbursed according to the schedule of benefits. Under no circumstances will vision benefits be paid directly to the provider of service. Once you have received services or made a purchase, you must pay for them. When you file your claim you will have to provide evidence of your payment (for more information see the section entitled "Claim Filing and Appeal Procedures").</p>
<p>Other Coverage</p>	<p>This Plan has been designed to reimburse you and your Dependent's, (if you have Dependent coverage) dental and vision expenses. It is intended that you be reimbursed only for your actual out-of-pocket-expenses. The amount of Benefits payable under this Plan will be offset by any payment made by any other insurance Plan a family member has; this includes a spouse's insurance Plan under which you, or your children, are covered as Dependents. If you, or your Dependents, have coverage for dental or vision expenses through any other Plan you will need to follow these steps to obtain reimbursement from this Plan:</p>
<p>When a DENTEMAX Network Provider is used</p>	<p>By assigning benefits to a participating provider in the DENTEMAX Network, you will not have to pay at the time of service.</p> <ul style="list-style-type: none"> • First, have your dental provider submit charges to any other dental Plans that cover you or any of your covered Dependents. • Obtain documentation of payment (or denial) from any other insurance Plan under which your dental expenses are covered. • Have your dental provider submit your claim and other insurance documentation of payment (or denial) to CTI Administrators for claims processing.
<p>When a DENTEMAX Network Provider is <u>not used</u></p>	<p>When a DENTEMAX Provider is <u>not</u> used or when requesting vision care reimbursements:</p> <ul style="list-style-type: none"> • First submit charges to other dental or vision Plans that cover you or any of your covered Dependents. • Obtain documentation of payment (or denial) from any other insurance Plan under which your dental or vision expenses are covered. • Pay the provider of service the amount you owe after the other Plan paid its share and obtain a receipt for the portion you paid, submit that receipt with your claim for reimbursement to this Plan.
	<p>This Plan will reimburse you according to the percentages shown in the Schedule of Benefits for any amounts not paid by the other Plans and which you have paid the provider of service. Reimbursement is based upon the actual out-of-pocket amount paid by you after all other sources of coverage have been used. The Plan will always pay the percentage shown in the Schedule of Benefits, not to exceed the Maximum Benefit Allowance.</p>

Following is an example of how benefits are calculated when an expense is covered by another Plan in addition to this Plan:

Example of Claim Reimbursement When There is Other Coverage

Total Covered Expense	\$140.00
Less amount paid by Other Insurance	<u>-60.00</u>
Amount remaining to be paid by Employee	\$ 80.00
BGCWA Plan Reimbursement @ 70% coinsurance	\$ 56.00

EXCLUSIONS

Charges for the following services are not covered under this Plan:

Take-Home or Over-the-Counter Purchases	Take-home items or items purchased over-the-counter such as toothpaste, tooth brushes, mouth rinse, bleach and/ or whitening kits and supplies, contact lens solution, eye glass cases.
Orthodontia Once the Calendar Year Maximum Benefit Has Been Met	Charges for orthodontia services once the maximum benefit of \$500 has been paid for a person in one Calendar Year
Vision Surgery	Vision Surgical procedures of any type
Non-prescription Lenses	Non-prescription lenses including sun-glass clips
Warranties	Warranties or service Plans to protect or replace or compensate you for lost or broken items
Eye Glasses Once the Calendar Year Maximum Benefit Has Been Met	Charges for eye glasses (lenses and frames) once the maximum benefit of \$350 has been paid for a person in one Calendar Year

CLAIM FILING AND APPEAL PROCEDURES

Claim Submission:

How to File a Claim

When a DENTEMAX Network Provider is Used:

This plan allows you to use any covered provider you choose and still receive benefits for covered expenses. However, if you use a participating provider of the **DENTEMAX Network**, you will receive a discount in fees for service. Additionally, you may assign benefits to a provider if they participate in the **DENTEMAX Network**. By assigning benefits to a participating provider in the **DENTEMAX Network**, you will not have to pay at the time of service. Ask your DENTEMAX provider to submit the claim directly to CTI Administrators for payment. Claim Payments cannot be made directly to a provider if they do not participate in the **DENTEMAX Provider Network**

When a DENTEMAX Network Provider is Not Used:

If you use a non-network provider or for vision services and supplies, you must pay for the services yourself and then submit a claim for reimbursement. Follow these steps:

1. Fill out a BGCWA Dental and Vision Expense Reimbursement Claim Form. A sample of this form is at the end of this booklet, you can photocopy it, or you can download a claim form from the BGCWA website: www.BGCWA.com, click on "On-Line Forms".
2. Attach an itemized bill and the PAID receipt documenting the date and type of service performed and the date you made full or partial payment for that service. Reimbursement is based upon the amount actually paid. If you have only paid part of the bill to your provider, you will only be reimbursed for the portion of the bill that you have actually paid.
3. If other insurance paid a portion of the bill, documentation of the amount paid by the other insurance must be attached.
4. Submit the completed claim form and attachment(s) to the Claim Administrator for processing using the following address:

CTI Administrators, Inc.
100 Court Ave. Suite 306
Des Moines, IA 50309-2200

Timely Claims Filing Requirement

Claims should be filed with the Claim Administrator within 90 days of the date the service was incurred. Claims filed later than 12 months after the date the service was incurred will not be covered by the Plan. This 12 month filing requirement will not apply when the person is legally determined to have been incapable of submitting the claim.

Incomplete Claim Submission

If the information provided with the claim is complete and sufficient to allow the Claim Administrator to determine benefits, an explanation of benefit determination will be mailed to you within 30 days of the date the claim is received.

If the Claim Administrator determines that more information is required, or, for reasons beyond the control of the Plan, a determination could not be made within the 30 day time limit stated above, a written notice will be sent to you within 30 days of the date the claim is received. You will have 45 days to provide the additional information necessary to complete the claim. Once the claim is complete, benefits will be determined within 15 days. All reimbursements for covered expenses will be made to the Covered Employee.

**Written
Notice of
Partial or
Full Claim
Denial**

If a claim is wholly or partially denied, the Claim Administrator will furnish the Covered Person with a written notice of this denial. This written notice will be provided within 30 days after receipt of an initial claim. The written notice will contain the following information:

- The specific reason or reasons for the denial; and
- specific reference to those Plan provisions on which the denial is based; and
- a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
- appropriate information as to the steps to be taken if a Covered Person wishes to submit the claim for review.

Appeal Procedure:

**Claim Appeal
Procedure**

In cases where the determination of benefits made by the Claims Administrator results in a full or partial denial of benefits, you, or someone you name to act for you (your authorized representative) may appeal the denial. Additionally, you, or someone you name to act for you (your authorized representative) can appeal the benefits determined on any claim if you do not feel they were calculated correctly. Your appeal can include additional information from you or your medical care-giver about the denied expense. Appeals must be in writing and mailed to:

Attn: Vice President of Claims
CTI Administrators, Inc.
100 Court Avenue, Suite 306
Des Moines, IA 50309-2295

Your appeal of denied benefits, or your request for a review of the benefit determination must be directed in writing to the above address within 180 days after the date you received the determination of benefits. The Vice President of CTI Administrators, the Claim Administrator, will make a review of the denial or of the payment calculation.

If the Vice President's review of the benefit determination results in the continued denial of a portion or all of the benefits, an independent review by a named fiduciary of this Plan will be performed. This person will not be the same person who made the initial benefit denial, nor will he/ she be the subordinate of that person or of the Vice President of the Claims Administrator. The fiduciary reviewing your appeal will give no deference to the initial claim denial and will consider all the arguments and documents submitted by you. For claims involving medical judgment, the fiduciary will consult with an independent health care professional.

In instances when you are appealing the benefit determination and the service has already been performed, you will receive a written response to your appeal not later than 60 days from the date the Claims Administrator receives it. If you are appealing the benefit determination for a service that has not yet been performed, you will receive a written response to your appeal not later than 30 days from the date the Claims Administrator receives it. The written response that will be sent to you will cite the specific Plan provision(s) and internal rules, guidelines or protocols upon which the denial is based. If medical judgment was the underlying cause of the denial, the response will include an explanation of the scientific or clinical judgment used, or will include a statement that such an explanation will be provided free of charge if requested.

If the Vice President's review and the independent fiduciary of the Plan's review continues to deny the payment or coverage you may be able to request an external review of your claim by an independent third party, who will review the claim and issue a final decision.

For questions about your appeal rights, you can contact the Employee Benefits Security Administration at 1-866-444- EBSA(3272).

**Your Right to
File a
Lawsuit**

A Participant must exhaust the above claims appeal procedure before filing a suit for benefits. Please refer to the section entitled "Your Rights Under ERISA" for additional information.

DEFINITIONS

We, Our, or Us	The Boys & Girls Club Workers Association.
Actively at Work	Employee: Performing all of the duties that pertain to your work at your normal place of employment as required by your employer. Dependent: Performing the daily activities normally associated with a person of same age and gender.
Calendar Year	The period of twelve (12) consecutive months commencing at 12:01 a.m. on January 1 and ending at 12:00 midnight on December 31 of a given year. For Participants enrolling during a Calendar Year, the Calendar Year begins on the Effective Date of their enrollment and ends on December 31 of that same year.
Certificate of Creditable Coverage	A document from the employer or a previous medical insurance carrier, which states that an Employee or Dependents have had other insurance coverage.
Child or Children	Persons under the age of 19, primarily Dependent upon the covered employee for support and maintenance and living in the same household as the employee and may include the following: <ul style="list-style-type: none"> • Natural Children; • Adopted Children or Children placed with a covered employee in anticipation of adoption; • Step-Children; • Foster Children; • Children for whom the covered employee is the Legal Guardian; • Children required to be covered under the terms of a Qualified Medical Child Support Order. <p>The phrase “Children placed with a covered employee in anticipation of adoption” refers to a Child whom the employee intends to adopt, whether or not the adoption has become final, who has not attained the age of nineteen (19) as of the date of such placement for adoption. The term “placed” means the assumption and retention by such employee of a legal obligation for total, or partial support of the Child in anticipation of adoption of the Child. The Child must be available for adoption and the legal process must have commenced.</p> <p>The phrase “primarily Dependent upon” shall mean Dependent upon the covered employee for support and maintenance as defined by the Internal Revenue Code and the covered employee must declare the Child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.</p>
Claim Administrator	CTI Administrators, Inc. who has been contracted by the Plan Administrator to perform certain administrative duties of the Plan.
Coinsurance	The percentage of a Covered Expense that is paid by the Plan as specified in the Benefit Summary. The remainder is paid by the Participant.
Covered Person	An employee or a Dependent, for whom written application has been made and accepted by Us and the required monthly contribution paid by the Participating Club.

Dependent	Legally married Spouse of an employee and/or eligible natural or adopted unmarried (never married) Dependent Children. Please refer to the Eligibility Section of this booklet for a more detailed definition.
Effective Date	The day an individual becomes a Covered Person provided he or she is Actively at Work on that day.
Eligible Employee	<p>A person who:</p> <ul style="list-style-type: none"> • is an employee of a Participating Club, who is regularly scheduled to work at least 30 hours per week on a consistent basis, and • has satisfied the Waiting Period selected by the Participating Club. <p>Part-time employees who work less than 30 hours per week and temporary or seasonal employees are not eligible to enroll for this Plan.</p>
Eligible Person	An employee or Dependent of an employee of a Participating Club who has met the necessary requirements to participate in this Plan.
Full-Time Student	An unmarried Child, age 19 through 24, who is attending school at an institution of higher learning or a Vocational Technical School and carrying sufficient credits to qualify as Full-Time in accordance with the requirements of the school (this will be verified by the Claim Administrator through a letter that will be sent to the employee once every six months as a claim is incurred), and who depends upon the employee for support (per IRS guidelines) and is not employed for more than 30 hours per week (a full-time basis) when school is in session. Students graduating in May or June will no longer be covered as of the end of the month in which they graduate, but will be eligible for continued coverage through COBRA as long as the employee notifies the Claim Administrator within 60 days of the date the Student is no longer eligible.
Handicapped Dependent Child(ren)	<p>A Child over the age of 18 who is incapable of self-sustaining employment by reason of physical or mental handicap, primarily Dependent upon the covered employee for support and maintenance, unmarried and covered under the Plan when attaining the age of 19.</p> <p>The following standards and criteria are applied when making determinations regarding Handicapped Dependents: Physical or mental handicap means a 'severe disability' of a person which:</p> <ul style="list-style-type: none"> • is attributed to a physical or mental impairment or combination of physical and mental impairments; • is manifested before the person attains age 19; • is likely to continue indefinitely; and • results in incapability of performing self-sustaining employment. <p>'Severe Disability' means substantial functional limitations in three or more of the following areas of major life activities:</p> <ul style="list-style-type: none"> • self care; • receptive and expressive language; • learning; • mobility; • self direction; • capacity for independent living
Limited	An employee age 55 or over scheduled to work for a chartered Boys & Girls Club or

Hours Employee	the National Organization for a minimum of 780 hours (but not greater than 1,560 hours) in the upcoming 12-month period and no less than 30 hours in any consecutive two-month period who met all of the requirements for becoming a Limited Hours Employee and retaining his/ her medical insurance under this Plan.
Participating Club Plan	Chartered Boys & Girls Club that has agreed to participate in the Plan according to the participation requirements established by the Boys & Girls Club Workers Association. The Plan of Benefits as described in this booklet.
Plan Administrator	The Boys and Girls Club Workers Association.
Provider	The name given to any professional or institution that delivers medical treatment, services or supplies.
Retiree	You are eligible to enroll for Retiree coverage under this Plan if you are under age 65 and, at the time of retirement, you were enrolled in the Boys & Girls Club Workers Association Dental and Vision Plan and had been in the Plan for at least five (5) years, and you were a 30-hour or more per week employee in the Boys & Girls Club movement for at least fifteen (15) years. Participating Clubs must agree to offer this Plan to all eligible Retirees and to pay the required premium on your behalf; they may require you to reimburse them for any or the entire premium.
Special Enrollment	An event that allows an eligible employee, spouse and some or all eligible Dependents to enroll for coverage if certain criteria are met.
Spouse	The definition of an eligible spouse for purposes of receiving coverage under this Plan is based on the Defense of Marriage Act (DOMA). DOMA was enacted in 1996 and provides that for purposes of any benefit under federal law, "marriage" is limited to the legal union between one man and one woman and the definition of a "spouse" is limited to a person of the opposite sex, a husband or wife.
Surgical Procedure	Cutting, suturing, treatment of burns, correction of fractures, reduction of dislocations, manipulation of joints under general anesthesia, electro cauterization, tapping (paracentesis), endoscopes, the injection of sclerosing solutions, obstetrical procedures, and elective sterilization.
Totally Disabled	A medically determinable physical or mental impairment that renders the Participant incapacitated as to be unable to engage in most of the normal activities of a person of like age and sex in good health.
Waiting Period	Period of time an Employee must wait after they are hired before they become eligible for benefits. This period is selected by the Club and must be applied consistently by the Club to all Employees.
Work Related Injury/Illness	Any Injury or Illness resulting from or complicated by the Covered Persons employment for gain or profit including self-employment, whether or not that person has Workers Compensation coverage.

YOUR RIGHTS UNDER ERISA

As a participant in Boys & Girls Club Workers Association Direct Reimbursement Dental and Vision Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

- Receive Information About Your Plan and Benefits
- Examine, without charge, at the Plan Administrator's office, during normal business hours, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator or the Claim Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. A Summary Annual Report is available on the web site at www.BGCWA.com or, if you do not have access to the internet, you can request a copy of the report by contacting CTI Administrators, 100 Court Avenue, Suite 306, Des Moines, IA 50309-2295, tel. (800) 245-8813.
- Continue Group Health Plan Coverage
- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the "Continuation of Benefits (COBRA)" section of this book and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health Plan, if you have creditable coverage from another Plan.
- You should be provided a Certificate of Creditable Coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months after your enrollment date in this Plan. Reference the "Limitation on Pre-Existing Conditions" section of this book for more information about this topic.
- Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit, or exercising your rights under ERISA.
- Enforce Your Rights. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Reference the "Claim Filing and Appeal Procedures" section of this book for more information.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and you exhaust all administrative remedies you then can file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against

for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- Assistance with Your Questions. If you have any questions about your Plan, you should contact the Claim Administrator, this company has been retained by the Plan Administrator to answer questions on its behalf. If the Claim Administrator does not answer your question satisfactorily, you can then call the Plan Administrator directly. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Claim Administrator or the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

NOTICE OF PRIVACY PRACTICES

When you apply to the Boys & Girls Workers Association Insurance Trust (B&GCWA Insurance Trust) for insurance services, you entrust us with personal health and financial information. This information is necessary because we rely on you as the best and most important source of information about you and other persons listed on your application. We may also collect personal information about you from other sources.

Information We Collect

As part of providing you with health insurance products, we may obtain public and nonpublic personal information including:

- Information from applications or other applications such as: name, address, telephone number, social security number, date of birth, gender, marital status, and Email address;
- Information about; transactions with us or our affiliates, such as type of product purchased, policy or account number, account balance, policy coverage, and payment and claims history;
- Information provided by employers, such as employee premium contribution amounts and employee or association eligibility;
- Information from other sources, such as motor vehicle reports, medical information, and information about your transactions with other insurance companies; and
- Information from consumer reporting agencies.

Information We Disclose

The B&GCWA Insurance Trust does not disclose nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law.

During the normal course of business, BGCWA Insurance Trust may share the personal information as described above with a company affiliated with BGCWA Insurance Trust. Also, BGCWA Insurance Trust may disclose information we collect, as described above, to persons or companies with which we have contracts to perform functions on our behalf. For example, we may share the information listed above with insurance carriers with which we jointly offer, endorse, or sponsor an insurance product. These include financial services providers such as: insurance companies, payment processing companies and non-financial services providers such as: mailing houses, data processing companies, and those that provide access to provider discounts for our insureds. These companies might assist us, for example, in fulfilling your service request, processing your transaction, or mailing account statements. All of these persons or companies, which act with us or on our behalf, are contractually obligated to keep the information that we provide to them confidential and to use the information only to provide the services we have asked them to perform for you and us.

Former Customers

If your customer relationship with BGCWA Insurance Trust is terminated, we will continue to treat and safeguard your information as described in this notice.

Security of Information

The B&GCWA Insurance Trust maintains policies that protect the security and confidentiality of customer information. This includes: limiting nonpublic personal information to employees who need the information in order to perform their duties, maintaining user passwords, and protecting information through security-enhancing software, such as virus and intrusion detection software.

Access To and Correction of Your Information

You have a right of access and correction with respect to information collected about you. You may obtain access to personal information about you that is contained in our files. You may also request correction, amendment, or deletion of any information in those files you believe to be inaccurate. The procedures for access and correction of your information will be provided to you upon your request.

This notice is being provided on behalf of BGCWA Insurance Trust and the companies with which we have contracts to perform functions on our behalf.

For a complete and current list of the companies with which we have contracts to perform functions on our behalf or for a copy of this policy is available by writing to:

BGCWA Insurance Trust
Attn: Privacy Officer
c/o CTI Administrators
100 Court Ave.
Suite 306
Des Moines, IA 50309-2295

GENERAL PLAN INFORMATION

Plan Name	Boys & Girls Club Workers Association Direct Reimbursement Dental and Vision Plan
Type of Administration	Administration is provided through a contracted third party Claim Administrator.
Sources of Contributions	Funding for the benefits is derived from the contributions made by the employer and covered employees. Benefits are paid directly from the Plan by the Claim Administrator.
Tax ID Number	13-6176007
Plan Effective Date	January 1, 1998
Plan Year Ends	July 31st
Employer Information	Participating Clubs of the Boys & Girls Club Workers Association c/o Boys and Girls Club Workers Association 1275 Peachtree Street NE Atlanta, GA 30309
Plan Administrator	Boys and Girls Club Workers Association c/o Board Secretary Boys & Girls Clubs of America National Headquarters 1275 Peachtree Street NE Atlanta, GA 30309 The Plan Administrator serves without compensation. All expenses for Plan administration, including compensation for hired services, will be paid by the Plan.
Named Fiduciary	Boys and Girls Club Workers Association c/o Board Secretary Boys & Girls Clubs of America National Headquarters 1275 Peachtree Street NE Atlanta, GA 30309
Agent for Service of Legal Process	Boys and Girls Club Workers Association c/o Board Chairperson Boys & Girls Clubs of America National Headquarters 1275 Peachtree Street NE Atlanta, GA 30309
Claim Administrator	CTI Administrators, Inc. 100 Court Avenue Suite 306 Des Moines, IA 50309-2295 (800) 245-8813 Website – www.BGCWA.com The Claim Administrator is not a fiduciary. A Claim Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's provisions as established by the Plan Administrator.

The Trust Agreement

This Plan is established under a Trust agreement, that agreement is made a part of the Plan. A copy of the appropriate agreement is available for examination by Employees and their Dependent(s) at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee or Dependent:

- A copy of the Trust Agreement;
- A complete list of employers and employee organizations sponsoring the Plan.

Clerical Error

Any clerical error by the Plan Administrator or its agent in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, the amount of overpayment may be deducted from future benefits payable.

Amending and Terminating the Plan

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any).