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Managed Long Term Disability

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

CERTIFICATE

UNICARE Life & Health Insurance Company certifies that it has issued Group Policy Number GLTD 145387 to the **BOYS & GIRLS CLUB WORKERS ASSOCIATION INSURANCE TRUST**, (herein called the “plan administrator”), insuring certain employees of the participating employers.

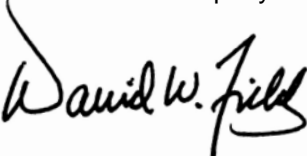
This booklet describes the benefits provided as of January 1, 2006, and contains all changes up to and including January 1, 2010. Certain terms of the Group Policy which affect your insurance are contained in the following pages.

The Group Policy was issued in the state of Alabama. Its laws and rules will govern in resolving any questions about the Group Policy.

While you remain insured, this booklet is your **Certificate of Insurance**. It replaces any prior booklet given to you for the types of insurance described here.

233 S. Wacker Dr., Suite 3900
Chicago, IL 60606-6309

UNICARE Life & Health
Insurance Company

A handwritten signature in black ink that reads "David W. Fild". The signature is written in a cursive, flowing style.

President and CEO

SCHEDULE OF BENEFITS

Your amounts of personal insurance are determined by this schedule.

Changes in amounts of personal insurance under this schedule are effective on the first day of a calendar month coinciding with or next following date they apply to you. However, changes due to your age or retirement will be the only changes to become effective while you are disabled. Here, the term "disabled" means that an injury or illness prevents you from doing substantially all of your usual duties for the plan sponsor.

PERSONAL LONG TERM DISABILITY INSURANCE

An amount equal to 66.67% of your monthly earnings not to exceed the maximum monthly benefit less other income benefits.

Maximum Monthly Benefit: \$15,000

Minimum Monthly Benefit: \$100

Benefit Waiting Period: 180 days

Maximum Benefit Period for Total Disability

Social Security Normal Retirement Age Duration (SSNRA)

Age at Disablement

Maximum Payment Duration

Less than age 60

To Social Security Normal Retirement Age (SSNRA)*

60	60 months or to SSNRA* whichever is greater
61	48 months or to SSNRA* whichever is greater
62	42 months or to SSNRA* whichever is greater
63	36 months or to SSNRA* whichever is greater
64	30 months or to SSNRA* whichever is greater
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Year of Birth***Social Security Normal Retirement Age**

Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 – 1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

BASIC TERMS

When used in this provision, these words and phrases have the meaning explained here and supersede any previously defined words and phrases listed elsewhere in this plan.

Active Employment

When used in this provision the term “Active Employment” means that you must be working:

1. for the plan sponsor on a permanent full-time basis and must be paid regular earnings;
2. at least 30 hours and either:
 - a. at the plan sponsor's usual place of business; or
 - b. at a location to which the plan sponsor's business requires you to travel.

Annual Salary

The term “Annual Salary” means your earnings in effect from the plan sponsor for the twelve month period immediately prior to the date total disability begins. It does not include bonuses, overtime pay, or extra compensation other than commissions. Commissions will be averaged over the 12 month period prior to the date total disability begins.

Basic Monthly Earnings or Predisability Income

The term “Basic Monthly Earnings” or “Predisability Income” means your monthly rate of earnings from the plan sponsor in effect immediately prior to the date total disability begins. It does not include bonuses, overtime pay, or extra compensation other than commissions. Commissions will be averaged over 12 month period prior to the date total disability begins.

Benefit Waiting Period

The term “Benefit Waiting Period” means a period of consecutive days of total disability for which no benefits will be paid by this coverage. The benefit waiting period is shown in the Schedule of Benefits of this plan and begins on the first day of your disability. It may happen that you will return to work during the benefit waiting period. If you do return to work for 14 or less days and can not continue to work, only those days during which you are not in active employment will be used to satisfy the benefit waiting period.

Disability Benefit

When the term “Disability Benefit” is used in this provision with the term retirement plan, “Disability Benefit” means money which:

1. is payable under a retirement plan due to disability as defined in that plan; and
2. does not reduce the amount of money which would have been paid as retirement benefits at the normal retirement age under the plan if the disability had not occurred. If the payment does cause such a reduction, it will be deemed a retirement benefit as defined in this provision.

Eligibility Waiting Period

The term “Eligibility Waiting Period” means the amount of time shown in the Plan Membership section for the continuous length of time you must serve in an eligible class to reach your eligibility date.

Eligible Survivor

When used in this provision, the term “Eligible Survivor” means your spouse, if living. Otherwise, this term means your children under age 25.

Evidence of Insurability

In this provision the term “Evidence of Insurability”, means a statement or proof of your medical history upon which eligibility for this coverage will be determined by the insurer.

Injury

The term “Injury” means bodily injury resulting directly from an accident and independent of all other causes. The injury must occur and disability must begin while you are insured under this provision. EXCEPTION: Any disability which begins more than 60 days after an injury will be considered an illness for the purpose of determining benefits under this provision.

Illness

The term “Illness” means a sickness or disease. It will include pregnancy unless excluded in the General Exclusion Section of this provision. The illness must begin while you are insured under this provision.

Gainful Occupation

The term “Gainful Occupation” means an occupation that is or can be expected to provide you with an income at least equal to 60% of your pre-disability income.

Usual Duties

The term “Usual Duties” means duties normally required for performance of your occupation which cannot be reasonably omitted or changed.

Doctor

The term “Doctor” means:

1. a person who is licensed to practice medicine and prescribe and administer drugs, or to perform surgery; and is performing tasks that are within the limits of the person’s medical license
2. a person with a doctoral degree in Psychology (Ph. D. or Psy. D.) whose primary practice is treating patients; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

For the purposes of Long Term Disability Benefits, Doctor will not include you, your spouse, children, parents or siblings for your claim.

Part–Time Basis

As used in this provision, the term “Part–Time Basis” means the ability to work and earn between 20% and 80% of your pre–disability income.

Last Monthly Benefit

The term “Last Monthly Benefit” means the net monthly benefit paid to you immediately prior to your death. It does not include any reduction for earnings.

Monthly Benefit

The term “Monthly Benefit” means the amount paid to the disabled plan member.

Other Income Benefits

As used in this provision, the term “Other Income Benefits” means those benefits shown here:

1. The amount for which you are eligible under:
 - a. Worker’s or Workmen’s Compensation Law;
 - b. occupational disease law; or
 - c. any other act or law of like intent.
2. The amount of any disability income benefits for which you are eligible under any compulsory benefit act or law.

3. The amount of disability income benefits for which you are eligible under:
 - a. any other group insurance plan of the plan sponsor;
 - b. any governmental retirement system as a result of your employment with the plan sponsor.
4. The amount of benefits you receive under the plan sponsor's retirement plan as follows:
 - a. any disability benefits; or
 - b. any retirement benefits.
5. The amount of disability or retirement benefits under the United States Social Security Act, the Canada Pension Plan, or the Quebec Pension Plan, or any similar plan or act, as follows:
 - a. disability or unreduced retirement benefits for which;
 - i. you are eligible; and
 - ii. your spouse, child or children are eligible because of your disability; or
 - iii. your spouse, child or children are eligible because of his or her eligibility for unreduced retirement benefits; or
 - b. reduced retirement benefits received by:
 - i. you; and
 - ii. your spouse, child or children because of your receipt of the reduced retirement benefits.
6. The amount of earnings you receive from partial disability employment.
7. The amount you receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act).
8. The amount you receive from a third party who was responsible for causing your disability, minus your attorney fees, by judgment, settlement or otherwise, not to exceed 50% of the net settlement.
9. The amount of benefits you receive from any unemployment compensation law.
10. The amount of benefits you receive under the mandatory portion of any "no fault" motor vehicle plan.
11. The amount of any salary continuation or accumulated sick leave.

These other income benefits, except retirement benefits, must be payable as a result of the same disability for which the insurer pays a benefit.

If the insurer determines that you may qualify for other income benefits listed above, the insurer will estimate the amount for which you may qualify. Then your monthly benefit will be reduced by the estimated amounts if such benefits:

1. have not been awarded; and
2. have not been denied; or
3. have been denied and the denial is being appealed.

Your monthly benefit will not be reduced by any estimated amounts if you:

1. apply for other income benefits, and appeal your denial of such benefits to all levels the employer believes are necessary; and
2. promise to pay the insurer any overpayment caused by an award by signing the insurer's payment option form.

If your monthly benefit has been reduced by an estimated amount, your weekly benefit will be adjusted when the insurer receives proof:

1. of the amount awarded; or
2. that benefits have been denied and the insurer determines that all necessary appeals have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment for any other income benefits, the insurer will deduct the lump sum from your monthly benefit by pro-rating the lump sum on a monthly basis over the time period for which the lump sum was given. If no time period is stated, the lump sum will be pro-rated on a monthly basis to the end of the maximum benefit period.

Recurrent Disability

As used in this provision, the term "Recurrent Disability" means a disability which is related or due to the same cause(s) as a prior disability for which a monthly benefit was payable.

Regular Care

The term "Regular Care" means:

1. you personally visit a doctor as frequently as is medically required, according to standard medical practice, to effectively manage and treat your disabling condition(s); and

2. you are receiving appropriate treatment and care of your disabling condition(s) which conforms with standard medical practice by a doctor whose specialty or experience is the most appropriate for your disabling condition(s) according to standard medical practice.

Vocational Rehabilitation

Vocational Rehabilitation is a process started as early as possible for a disabled employee. The process may include but is not limited to:

1. Assessing a disabled employee's potential for return to work with the previous employer or for placement with another employer;
2. Labor market surveys;
3. Development of alternative work plans;
4. Retraining; and
5. Assistance with job seeking skills.

Retirement Benefit

When the term "Retirement Benefit" is used with the term retirement plan in this provision, it means money which:

1. is payable under a retirement plan either in a lump sum or in the form of periodic payments; and
2. does not represent contributions made by you (payments which represent your contributions are deemed to be received over your expected remaining life regardless of when such payments are actually received); and
3. is payable upon;
 - a. early or normal retirement; or
 - b. disability if the payment does reduce the amount of money which would have been paid at the normal retirement age under the plan if the disability had not occurred.

Retirement Plan

As used in this provision the term "Retirement Plan" means a plan which would provide a retirement benefit to you. Such a plan is one that is not funded wholly by your contributions. The term "Retirement Plan" will not include: (a) a 401(K); or (b) a profit sharing plan; or (c) a thrift plan; or (d) an individual retirement account (IRA); or (e) a tax sheltered annuity (TSA); or (f) stock ownership plan; or (g) a non-qualified plan of deferred compensation. These terms are defined under the Internal Revenue Code.

Employer's Retirement Plan

The term "Employer's Retirement Plan" includes any retirement plan:

1. which is part of any federal, state, county, municipal or association retirement system; and
2. for which you are eligible as a result of employment with the plan sponsor.

Total Covered Payroll

The term "Total Covered Payroll" means the total amount of basic monthly earnings for which all plan members are insured under this provision or policy.

Total Disability

The term "Total Disability" means that during the benefit waiting period and the next 24 months of disability, you are:

1. unable to perform all of the usual duties of your occupation on a full-time basis because of a disability:
 - a. caused by injury or illness; and
 - b. that disability started while you were eligible for this coverage.
2. After 24 months of benefits have been paid, the term "Total Disability" means that you are unable to perform with reasonable continuity all of the usual duties of your own or any gainful occupation for which you are or become reasonably fitted by training, education, experience, age and physical and mental capacity.

The loss of a professional or occupational license or certification for any reason does not, in itself, constitute total disability.

PLAN MEMBERSHIP

ELIGIBILITY FOR INSURANCE

This section tells how you may become insured. The term “personal insurance” means your insurance under the plan with respect to yourself.

Personal Insurance

To obtain personal insurance, you need to be a qualified employee. You are a “qualified employee” only if you meet all of these requirements:

1. you are a full-time employee of the plan sponsor, working for pay on a scheduled normal work week of at least 30 hours, and
2. you perform that work at the plan sponsor’s usual place of business, except for duties of a kind that must be done elsewhere, and
3. you are in a covered employment class named in the group policy.

If you are a qualified employee on January 1, 2006, you are eligible for personal insurance on that date, provided you have completed the applicable waiting period for your class as defined in the group policy. Otherwise, you become eligible on the first day of the calendar month coinciding with or next following the date you become a qualified employee and complete the applicable waiting period for your class as defined in the group policy.

Specific information regarding the group policy and its terms may be obtained from the plan sponsor.

EFFECTIVE DATE OF INSURANCE

Once you have become eligible for insurance, this section tells when your insurance will begin.

Personal Insurance

Except as explained in this section, your personal insurance will begin on the date you become eligible for such insurance. Insurance will be effective at 12:01 a.m. on the day determined as follows, but only if your written application for insurance is: (a) made with the Insurer through your plan sponsor; and (b) on a form satisfactory to the Insurer.

Medical Underwriting

You must complete and send to the Insurer both parts of your application for Long-Term Disability Insurance. This form includes a request for medical data. Your insurance, if the Insurer approves your application, will start on the later of:

1. your eligibility date; or
2. the date the Insurer approves your application.

You will be insured for noncontributory insurance on your eligibility date.

You will be insured for contributory insurance on the latest of these dates:

1. your eligibility date, if you make written application for insurance on or before this date.
2. the date you make written application for insurance, if you do it on or before the 31st day after your eligibility date.
3. the date the Insurer gives it approval, if you:
 - a. make written application for insurance more than 31 days after your eligibility date; or
 - b. you terminate your insurance while continuing to be eligible.

DELAYED EFFECTIVE DATE FOR INSURANCE

The effective date of any initial, increased or additional insurance will be delayed for you if you are not in active employment because of a disability. The initial, increased or additional insurance will start on the date that you return to active employment.

If you enter another eligible class, you will not be eligible for any additional benefits until you have completed a 30–day waiting period, and have been actively at work one full day in the new class.

DISCONTINUANCE OF INSURANCE

Your personal insurance will cease on the first to occur of these dates:

1. the date the group policy is discontinued.
2. the date you are no longer eligible for that coverage. This may be due to a change in the group policy or because you transfer to an employment class that is not eligible.
3. the date ending the last period for which you made any required contribution toward the cost of that insurance.
4. the last day of the policy month in which you cease active work for the plan sponsor, except that if you are disabled or on a leave of absence or temporary layoff, your insurance may continue up to any time limit imposed by the group policy.

Specific information regarding the group policy and its terms may be obtained from the plan sponsor.

COVERAGE PROVISIONS

DESCRIPTION OF THE COVERAGES

The pages of this section specify when plan benefits will be paid. Any conditions governing whether, and how much benefit is paid for those events are also discussed in this section.

To receive plan benefits, you must be insured as described in the Plan Membership section of this summary. Then, your amounts of insurance are determined by the Schedule of Benefits.

Should you become entitled to benefits, the Claims and Plan Member Rights section of this summary tells how to present your claim.

PERSONAL LONG-TERM DISABILITY INSURANCE

TOTAL DISABILITY

When the insurer receives proof that you are totally disabled due to an illness or injury and require the regular attendance of a doctor, the insurer will pay a monthly benefit at the end of the benefit waiting period. The benefit will be paid for the period of total disability if you give to the insurer proof of continued:

1. total disability; and
2. regular attendance of a doctor.

The proof of continued disability must be given upon request by the insurer and at your expense. However, the insurer, at its expense, may also require that you be examined by its doctor at reasonable intervals. No benefits will be paid beyond any date that: (a) due proof that you remain totally disabled is not provided when requested by the insurer; or (b) you do not allow a doctor to examine you when required by the insurer.

The monthly benefit and the maximum benefit period are shown in the Schedule of Benefits of this plan. The monthly benefit will not:

1. exceed your amount of coverage; or
2. be paid for longer than the maximum benefit period.

TOTAL DISABILITY MONTHLY BENEFIT

To figure the amount of monthly benefit:

1. Multiply your basic monthly earnings by the benefit percentage shown in the Schedule of Benefits of this Plan.
2. Take the lesser of:
 - a. the amount determined in step (1) above; or
 - b. the maximum monthly benefit shown in the Schedule of Benefits of this plan and;
3. Deduct Other Income Benefits from this amount.

The total disability benefit payable will never be less than the minimum monthly benefit shown in the Schedule of Benefits of this plan.

TERMINATION OF TOTAL DISABILITY MONTHLY BENEFITS

The total disability monthly benefit will cease on the earliest of:

1. the date you cease to be totally disabled; or
2. the date you die; or
3. the end of the maximum benefit period.

PROGRESSIVE PARTIAL DISABILITY BENEFIT

The insurer will pay a progressive partial disability benefit for a disability which is caused by an injury or illness. You must meet the benefit waiting period shown in the Schedule of Benefits of this booklet and supply the insurer with proof that you are partially disabled and are under the regular care of a doctor. The benefit waiting period may be a combination of total disability and partial disability. It may also consist entirely of partial disability or total disability.

The following definitions apply only to the Progressive Partial Disability Benefit:

Annual Earnings/Salary

The term "Annual Salary" means your earnings in effect from the plan sponsor for the twelve month period immediately prior to the date total disability begins. It does not include bonuses, overtime pay, or extra compensation other than commissions. Commissions will be averaged over the 12 month period prior to the date the disability begins.

Benefit Waiting Period

As used in this provision, the term "Benefit Waiting Period" means a period of consecutive days of disability for which no benefit is payable. The benefit waiting period is shown in the Schedule of Benefits of this booklet and begins on the first day of the disability.

Basic Monthly Earnings or Pre-disability Income

The term "Basic Monthly Earnings" or "Pre-disability Income" means your monthly rate of earnings from the employer in effect immediately prior to the date the disability begins. It does not include bonuses, overtime pay, or extra compensation other than commissions. Commissions will be averaged over the 12 month period prior to the date the disability begins.

To qualify for progressive partial disability benefits you must be earning less than 80% of your pre-disability income or annual salary at the time partial disability employment begins; and

- be able to perform one or more, but not all of the material and substantial duties of your own or any other occupation on a full-time basis; or
- be able to perform all of the material and substantial duties of your own company or any other occupation on a part-time basis.

MONTHLY BENEFIT

To figure the amount of monthly benefit:

- A. Multiply your predisability income by the benefit percentage shown in the Schedule of Benefits.
- B. Take the lesser of:
 - the amount determined in step A. above; or
 - 100% of your predisability income less Other Income Benefits; or
 - the Maximum Monthly Benefit shown in the Schedule of Benefits.

TERMINATION OF THE PROGRESSIVE PARTIAL DISABILITY MONTHLY BENEFIT

The progressive partial disability monthly benefit will cease on the earliest of:

1. the date you cease to be partially disabled; or
2. the date the plan member dies; or
3. the end of the maximum benefit period; or
4. the date your earnings from any employment exceed 80% of your pre-disability income; or
5. the date you refuse to participate in or to continue to participate in an approved vocational rehabilitation program if offered.

Vocational Rehabilitation

If you are disabled and receiving a monthly benefit under the policy, you may be eligible for vocational rehabilitation services. These services may include vocational testing and training, job modifications, job placement, or other services determined to be reasonably needed to assist you in returning to active employment either full-time or part-time.

The insurer will determine the extent to which these services may be provided. The insurer will pay the service provider(s) for these services unless the insurer agrees to other arrangements.

The insurer's decision to offer these services will be based on:

1. your education, training and experience;
2. your transferable skills;
3. your physical and mental abilities;
4. your motivation to return to active employment;
5. the labor force demand for workers in the proposed occupation in your geographic area;
6. the expected liability for your long term disability claim.

To qualify for these services, you must:

1. have a disability which prevents you from performing some or all of the substantial duties of your regular occupation;
2. lack the skills, training, or experience you would need to perform another gainful occupation;
3. possess the physical and mental abilities you need to complete a rehabilitation program;
4. be reasonably expected to return to active employment with the assistance of these services.

A vocational rehabilitation program proposal may be made by either the insurer, your doctor or you. The insurer will prepare a written program with input from you, your doctor, your current employer and/or your prospective employer. Once the insurer approves a program, you will be provided services according to the written program.

The written program will describe:

1. the goals of the program;
2. the insurer's responsibilities;
3. your responsibilities;
4. the responsibilities of any third party(ies) associated with this program;
5. the expected dates of the services;
6. the expected costs of the services;
7. the expected duration of the program.

The insurer reserves the right to make the final decision concerning your eligibility to take part in this program, and the amount of services you will be provided.

If you agree to participate in the program and are unable to complete your responsibilities under the program without good cause, your monthly benefits may be reduced or discontinued.

The term “good cause” means documented physical or mental impairments, which leave you unable to take part in or complete the agreed upon program. It may also mean that you are involved in:

1. medical treatment which prevents or interferes with your taking part in or completing the program; or
2. some other vocational rehabilitation program which conflicts with your taking part in or completing the program developed by the insurer, and that program is reasonably expected to return you to active employment.

ALCOHOLISM AND SUBSTANCE ABUSE LIMITATION

There is a limit on the benefits to be paid due to alcoholism and substance abuse. Benefits to be paid for such a condition will not exceed 24 months of monthly benefit payments. However, if you meet one of the conditions specified below, this limitation will not apply.

1. If you are confined in the hospital as an inpatient at the end of the 24 month period, the monthly benefits will continue to be paid during the rest of that period of hospital confinement.

You may still be disabled when you are discharged from the hospital. In this case, the monthly benefit will be paid during a recovery period of up to 90 days. However, you may become confined in the hospital as an inpatient during that recovery period. Then, the monthly benefit will be paid during the confinement and for another recovery period of up to 90 days.

2. If you continue to be disabled and become confined:
 - a. after the 24 month period; and
 - b. for at least 14 consecutive days,

the monthly benefit will be payable during the confinement.

MENTAL ILLNESS LIMITATION

There is a limit on the benefits to be paid due to a mental or nervous disorder. Benefits to be paid for such a condition will not exceed 24 months of monthly benefit payments. However, if you meet one of the conditions specified below, this limitation will not apply.

1. If you are confined in the hospital as an inpatient at the end of the 24 month period, the monthly benefits will continue to be paid during the rest of that period of hospital confinement.

You may still be disabled when you are discharged from the hospital. In this case, the monthly benefit will be paid during a recovery period of up to 90 days. However, you may become confined in the hospital as an inpatient during that recovery period. Then, the monthly benefit will be paid during the confinement and for another recovery period of up to 90 days.

2. If you continue to be disabled and become confined:
 - a. after the 24 month period; and
 - b. for at least 14 consecutive days,
 - c. the monthly benefit will be payable during the confinement.

As used in this limitation, mental illness means a mental, nervous or emotional disease or disorder of any type.

RECURRENT DISABILITY

A recurrent disability will be treated as part of a prior disability if, after receiving disability benefits under this plan, you:

1. return to your regular occupation on a full-time basis for less than 6 months; and
2. during that time you perform all the usual duties of your occupation.

To qualify for a recurrent partial disability benefit, you must experience more than 20% loss of pre-disability earnings.

Benefit payments for a recurrent partial disability will be subject to the terms and provisions of this plan that applied to the prior disability.

COST OF LIVING FREEZE

After the first deduction for each of the other income benefits has been made to the monthly benefit, the monthly benefit will not be further reduced due to any cost of living increases payable under these other income benefits.

LUMP SUM PAYMENTS

Other income benefits which are paid in a lump sum will be prorated on a monthly basis over the time period for which the sum is given. If no time period is stated, the sum will be prorated on a monthly basis over your expected lifetime as determined by the insurer.

SIX MONTH SURVIVOR BENEFIT

The Insurer will pay a lump sum benefit to the eligible survivor when proof is received that you died:

1. after your disability had continued for 180 or more consecutive days; and
2. while you were receiving a monthly benefit.

This benefit will be an amount equal to six times your last monthly benefit.

If payment becomes due to your children, payment will be made to:

1. the children; or
2. a person named by the Insurer to receive payments on the children's behalf. This payment will be valid and effective against all claims by others representing or claiming to represent the children.

GENERAL EXCLUSIONS

This provision will not cover any total disability due to:

1. war, declared or undeclared or any act of war;
2. intentionally self-inflicted injuries;
3. active participation in a riot;
4. the insured individual's committing of, or the attempting to commit, a felony or any type of assault or battery.

A monthly benefit will not be paid for any period of disability during which you are incarcerated.

PRE-EXISTING CONDITION EXCLUSION

This provision will not cover any total disability:

1. which is caused or contributed to, by, or results from a pre-existing condition; and
2. which begins in the first 12 months after your effective date.

“Treatment” means consultation, care or services provided by a doctor including diagnostic measures and taking prescribed drugs and medicines.

“Pre-existing Condition” means an illness or injury for which you received treatment within 6 months prior to your effective date.

Pre-existing Condition Exception

The “Pre-existing Condition Exclusion” will not apply to you if you:

1. are in active employment on the effective date of this plan; and
2. were insured under the prior carriers policy on its termination date.

CLAIMS AND PLAN MEMBER RIGHTS

HOW TO CLAIM BENEFITS

Due written proof of claim is required in order to receive benefits under this group insurance plan.

Notice of Claim

Notice of a claim must be given within 20 days after a covered loss starts, or as soon as reasonably possible. Written notice can be given to the insurer at its home office or to the insurer's agent. Reference to a "loss" merely means that an event occurred or an expense was incurred for which this plan agrees to pay a benefit. The notice must identify you along with the group insurance policy number shown in the Certificate in the front of this summary.

Claim Forms

When the insurer receives the notice of claim, it will send the claimant forms for filing proof of loss. The needed forms may also be obtained from the plan sponsor. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving the insurer a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

Proof of Loss

Due written proof of loss must be given to the insurer within 90 days after such loss. Failure to furnish the proof within that time shall not invalidate or reduce the claim if the proof is given as soon as reasonably possible. But, unless delayed by the claimant's legal incapacity, the required proof must be furnished within 2 years of the specified time.

Filing Claim Forms

The proof of loss "claim forms" contain instructions as to how they should be completed and where they should be sent. Be sure to fully complete your portion of the forms. Unanswered questions may delay the processing of your claim.

Payment of Claims

Upon receiving the required due proof of loss, the insurer will pay any disability income benefits due at least as often as once a month; any balance remaining unpaid at the end of the period for which the insurer is liable will be paid at that time.

Physical Examinations

The insurer has the right to have a doctor it chooses examine the person whose injury or illness is the basis of a claim. This may be required at reasonable intervals until the claim is paid. If the person has died, the insurer may require an autopsy, unless it is prohibited by law. Such an exam or autopsy will be at the insurer's expense.

Legal Actions

There are time limits as to when legal action can be taken to obtain group insurance policy benefits. No legal action can be taken until 60 days after written proof of loss has been given as discussed above. No legal action can be taken more than 2 years after written proof of loss was required by the above terms. Legal action with respect to a claim that has been denied, in whole or in part, shall be contingent upon having obtained the insurer's reconsideration of that claim as explained next in this section.

Reconsideration Of A Denied Claim

If you are a plan member or a member's beneficiary, and your benefit claim is totally or partially denied, the insurer will give you a written notice. The notice will give the reasons for denial. If you do not agree with the reasons given, you may request reconsideration of your claim.

To do so, you should write to the insurer within the 60 days after you received the notice of denial. The insurer's name and address appear in Claim and Plan Member Rights section of this summary. They will also be on the notice of denial. You should say why you believe the claim was not properly denied. Include any data, questions or comments that you think are appropriate. Unless the insurer requests additional material in a timely fashion, you will be advised of their decision within 60 days after your letter is received.

SUMMARY PLAN DESCRIPTION

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not part of your Certificate. But, this document, together with the attached Certificate, issued by UNICARE Life & Health Insurance Company, constitutes the Summary Plan Description required by ERISA.

Plan Name. The designated name of the Plan is:

Boys & Girls Club Workers Association Insurance Trust Personal Long Term Disability Plan

Plan Sponsor. The name and address of the entity which established and maintains the Plan is:

**Boys & Girls Club Workers Association Insurance Trust
1230 W. Peachtree Street, NW
Atlanta, GA 30309-3404**

Plan Numbers:

Employer Identification Number (EIN): **13-6176007**

Plan Number: **501**

Type of Plan. The Plan is an employee welfare benefit plan providing group disability benefits.

Source of Plan Contributions. The contributions necessary to finance the Plan are provided by the Plan Sponsor.

Plan Year. The Plan's records are maintained on a plan year basis beginning each year on August 1st and ending on the following July 31st.

Type of Administration/Funding. Benefits are furnished under a disability plan purchased by the Plan Sponsor and provided by UNICARE Life & Health Insurance Company (UNICARE) under which UNICARE is financially responsible for the payment of claims.

UNICARE's address is:

UNICARE Life & Health Insurance Company
233 S. Wacker Drive, Suite 3900
Chicago, IL 60606

Plan Administrator. The name, address and phone number of the Plan Administrator is:

**CTI Administrators, Inc.
100 Court Ave., Suite 306
Des Moines, IA 50309-2295
(800) 245-8813**

Agent for Services of Legal Process. The name and address of the designated agent for the service of legal process for the Plan is:

**Boys & Girls Club Workers Association Insurance Trust
1230 W. Peachtree Street, NW
Atlanta, GA 30309-3404**

Description of Benefits. The certificate pages set forth the benefits provided under the Disability Plan. A brief explanation of these benefits may be found in the section titled SCHEDULE OF BENEFITS. A more detailed description of the benefits appears in the sections titled PERSONAL LONG TERM DISABILITY INSURANCE.

Eligibility for Participation. The eligibility requirements for participation under the Disability Plan are set forth in the certificate booklet in the section titled PLAN MEMBERSHIP under the subsections ELIGIBILITY FOR INSURANCE and EFFECTIVE DATE OF INSURANCE.

Grounds for Ineligibility or Loss or Denial of Benefits. Details describing the circumstances which may result in: (a) disqualification from the Disability Plan; (b) ineligibility for benefits; or (c) denial, loss forfeiture or suspension of benefits under the Plan are set forth in the certificate booklet, as outlined below:

- Reasons for ineligibility or loss of benefits may be found in the section titled PLAN MEMBERSHIP under the subsection DISCONTINUANCE OF INSURANCE.
- Benefits may be denied or adjusted if statements a Plan participant has made in connection with obtaining coverage were false.
- Information concerning situations under which benefits may be reduced or denied may also be found in the sections titled SCHEDULE OF BENEFITS, PERSONAL LONG TERM DISABILITY INSURANCE, and BASIC TERMS.

Claims Procedures. The certificate contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or UNICARE. In addition to this information, if this Plan is subject to ERISA, ERISA applies some additional claim procedure rules. The additional rules are set forth below. To the extent that the ERISA claim procedure rules are more beneficial to you, they will apply in place of any similar claim procedure rules included in the certificate.

UNICARE must notify you, within 45 days after they receive your claim for benefits, that they have it and what they determine your benefits to be. If they need more than 45 days to determine your benefits, due to reasons beyond their control, they must notify you within that 45 day period that they need more time to determine your benefits. They may extend the time to determine what your benefits are twice. But, in any case, even with an extension, or extensions, they cannot take more than 105 days to determine your benefits. If you do not submit all the necessary information for your claim to UNICARE, they must notify you, within 45 days after they get it and tell you what information is missing. You have 45 days to provide them with the information they need to process your claim.

If your claim is denied in whole or in part, you will receive a notice of the denial within 45 days after UNICARE has all the information they need to process your claim, if the information is received in a timely manner. The 45 day period may be extended up to a total of 105 days if they need more time to process your claim for reasons beyond their control. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial was made. You have 180 days to appeal their adverse benefit determination. Your appeal must be in writing. Within 45 days after they receive your appeal, they must notify you of their decision about it. (The 45 day period may be extended up to a total of 90 days if they need more time to process your claim for reasons beyond their control.) Their notice to you of their decision will be in writing.

Note: You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for with UNICARE and request a review of the denial. In connection with such a request

- Documents pertinent to the administration of the Plan may be reviewed free of charge; and
- Issues outlining the basis of the appeal may be submitted.

You may have representation throughout the review procedure.

STATEMENT OF ERISA RIGHTS

As a participant in the 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 shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other locations, such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements, 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 Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report; the Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

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 your 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, your union, 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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if your 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 case, the court may require the Plan Administrator to provide the materials requested and to pay you up to \$110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or federal court, except that, any dispute concerning denial or partial denial of a claim must be resolved by binding arbitration as provided in the Plan booklet, unless otherwise prohibited under any applicable state or federal law. 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 federal court. The court will decide who should pay court costs and legal fees. If you are unsuccessful, 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 Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. 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 Employee Benefits Security Administration.

SUMMARY ANNUAL REPORT

Summary Annual Reports are available for the Boys & Girls Workers Association benefit programs. The reports provide financial information on the benefits the Association has reported to the Federal Government that is required annually. If you would like additional information about the Boys & Girls Club Workers Association benefit programs, please access the web site, www.BGCWA.com or contact CTI Administrators, 100 Court Ave., Suite 306, Des Moines, IA 50309-2295; (800) 245-8813 if you do not have access to the internet.

In accordance with state insurance law, this booklet is composed of the following forms on file with the State Insurance Department.

CERTIFICATE: GCR 100

SCHEDULE OF BENEFITS: GCR 132, GCR 132

BASIC TERMS: GCR 2243, GCR 2244, GCR 2245, GCR 2246-1, GCR 2247, GCR 11174, GCR 11175, GCR 11177, GCR 11176

ELIGIBILITY: GCR 120, GCR 12210

EFFECTIVE DATE: GCR 12605, GCR 12606

DISCONTINUANCE OF INSURANCE: GCR 124

COVERAGE PROVISIONS: GCR 140, GCR 2249, GCR 2251, GCR 2252, GCR 2263, GCR 22133, GCR 22134, GCR 22135

EXCLUSIONS: GCR 2261-2, GCR 2264, GCR 22138

CLAIMS: GCR 170, GCR 1721