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INTRODUCTION

BOYS & GIRLS CLUB WORKERS ASSOCIATION
CLUB CHOICE MEDICAL PLAN

This booklet is a description of the Boys & Girls Club Workers Association Club Choice Medical Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against the cost of certain Medically Necessary and some specific preventive health care expenses.

For Boys & Girls Clubs participating in this Plan, (Participating Club) coverage is available for all eligible and enrolled 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, deductibles, maximums, 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 incurred as a result of an Accident, Injury or Illness that occurred, 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 Participants are limited to covered expenses incurred before termination.

The Plan features a Preferred Provider Network to control cost and assure quality care. The Boys & Girls Club Workers Association encourages you and your family to use Network Providers whenever medical services are needed. Plan benefits are greater when a Network Provider is used. This is because the Plan receives significant discounts when Network Providers are used.

The Plan also features a Prescription Drug Card, a Maintenance Drug Mail Order Program and a SpecialtyRX program for injectable drugs and their supplies; all of these prescription drug programs are administered by CVS/Caremark. CVS/Caremark has determined that this Prescription Drug coverage is creditable coverage in accordance with guidance from the Centers for Medicare and Medicaid Services.

The Plan requires pre-certification for all Hospital Confinements, Organ Transplants, treatment of autism spectrum disorders, certain types of outpatient surgery and certain “Specialty” medications.

Important contact information: For Customer Service including questions on this plan’s benefits, Network Providers, claim status and eligibility for coverage, call CTI Administrators, Toll free at (800) 245-8813, or visit our website at **www.BGCWA.com**.

- For Pre-certification call Hines & Associates Toll free: (800) 944-9401.
- For information about the Caremark SpecialtyRX Program call Caremark SpecialtyRX Customer Service at (866) 295-2779.
- For a list of CVS/Caremark Preferred Brand Name Drugs use the quick link to CVS/Caremark’s web site, or call the CVS/Caremark customer service department at (800) 966-5772.

SCHEDULE OF BENEFITS – CLUB CHOICE PLAN

Benefits Effective January 1, 2010

The following Schedule of Benefits will apply to all medically necessary treatment of an illness or injury, or testing used to diagnose an illness or injury:

Calendar Year Deductible

The Calendar Year Deductible applies to all covered services except

- Certain Preventive Care services (See the Preventive Care section of this Schedule of Benefits for a description of those services)
- Certain Office Services by a Network Provider (See the Co-payment section of this Schedule of Benefits for Co-payments applied to Office Services by a Network Provider).

For all other covered services the Deductible amount depends on whether a Network provider is used and is as follows:

Calendar Year Deductible - Services by a Network Provider*	**Calendar Year Deductible - Services by a non-Network Provider***
Single $750 Family $1,500	An additional Deductible of $150 per Individual Not to Exceed $300 per Family

*An additional Calendar Year Deductible of $150 per Person, not to exceed an additional $300 for a Family will apply if services are performed by a non-Network Provider and the treatment was not within 48 hours of the onset of an Emergency.

Coinsurance is the share of covered expense paid by the Plan and will depend on the type of service and whether a Network provider or a non-Network provider is used.

- **Coinsurance is 80% in the following situations**
  - Service is performed by a Network Provider,
  - Service is performed by a non-Network Provider for Emergency Care rendered within 48 hours of the onset of an Emergency,

- **Coinsurance is 65%** if Service is performed by a non-Network Provider. (does not apply to Emergency care within 48 hours of the onset of an Emergency)

- **Coinsurance for Services rendered in the Office of a Network Provider other than Physical Therapy, Occupational Therapy and Speech Therapy:**
  - **The first $500 in Covered Services**
    - **Coinsurance is 100% of the first $500** in charges for Services rendered in the office of a Network Provider after the Co-payment of $50 (See the section on Co-payment for more information on how this applies).
    - **Coinsurance is 80% after the first $500** in charges for Services rendered in the office of a Network Provider

- **Coinsurance for Routine Physicals**
  - **The first $500 in Covered Services**
    - **Coinsurance is 100% of the first $500** in charges for a Routine Physical Examination performed by a Network Provider with the deductible being waived
    - **Coinsurance is 100% of the first $500** in charges for a Routine Physical Examination performed by a non-Network Provider after the Co-payment of $50 with the deductible being waived
  - **After the first $500 in Covered Services**
    - **Coinsurance is 80% after the first $500** in charges for a Routine Physical Examination performed by a Network Provider with the deductible being waived
    - **Coinsurance is 65% after the first $500** in charges for a Routine Physical Examination performed by a non-Network Provider with the deductible being waived

- **Coinsurance on Prescription Drugs** Prescription Drug coverage for this Plan is administered by Caremark. There are three Prescription Drug programs. When you purchase a prescription through these programs you will pay a percent of the cost based upon the type of prescription and the program you are buying it through. The percent that you pay for each program, by drug category follows:

DRUG CATEGORY	RETAIL DRUG CARD PROGRAM	MAIL ORDER DRUG PROGRAM	SPECIALTY RX PROGRAM
Generic Drugs	20% with a minimum of $10.00 and a maximum of $20.00 for a 30 Day Supply	20% with a maximum of $30.00 for a 90 Day Supply	
Preferred Brand Name Drugs*	30% with a minimum of $30.00 and a maximum of $60 for a 30 Day Supply	20% with a maximum of $60.00 for a 90 Day Supply	
Other Brand Name Drugs*	40% with a minimum of $40.00 and a maximum of $80 for a 30 Day Supply	30% with a maximum of $120.00 for a 90 Day Supply	
Injectable and Oral Specialty Drugs			20% with a maximum of $350 for a 30 Day Supply

*The Plan will require the employee to pay the difference in cost between the brand name drug and the generic equivalent of that drug, even if a physician signs an order to dispense the brand name drug.

Important Notice for All Medicare Beneficiaries: The coverage provided through this Plan has been determined by Caremark to be creditable in accordance with guidance from the Centers for Medicare and Medicaid Services.

Co-payment

The Co-Payment is the amount that you must pay for certain services received in the office of a Network Provider. Co-Payment paid by you does not apply to the Deductible or the Calendar Year Out-of-Pocket Maximum. Unless otherwise indicated the deductible still will apply after the co-payment.

- **Co-Payment on Certain Office Services by a Network Provider**

  Covered services provided in the office of a Network Provider will require a $50 Co-payment for the first $500 of charges provided in the office on that day.

  Physical therapy performed by a licensed physical therapist or a physical therapy assistant, occupational therapy performed by a licensed occupational therapist, and speech therapy performed by a licensed speech therapist will not be subject to Co-Payment, but will be paid after the deductible is met and at the appropriate coinsurance level.

- **Co-payment on Magnetic Resonance Imaging (MRI), Computerized Tomography Scan (CT Scan) & Positron Emission Tomography (PET Scan)**

  Covered MRI, CT scans, and PET Scans will require an additional 5% Co-payment up to a maximum of $150 per occurrence before the Plan pays the covered expense at the appropriate deductible and coinsurance. The 5% Co-payment will not apply toward your calendar year deductible or out-of-pocket maximum accumulations.

- **Co-payment on Hospital In-patient Days**

  Covered services billed by a Hospital or other facility where you are admitted will require a $500 Co-payment per day (more than 23 hours) up to a maximum of $1,500 per confinement period. A confinement period is a consecutive number of days in the hospital without a discharge of 72 hours or more.

- **Co-payment on Emergency Room Facility**

Covered services billed by a Hospital or other facility for use of the Emergency Room will require a $100 Co-payment per emergency room visit. This co-payment will be waived if admitted to the hospital.

Calendar Year Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the maximum amount of Deductible and Coinsurance you must pay for Covered Expenses in a Calendar Year.

Services By a Network Provider or for Emergency Care within 48 hours of onset	Services By a Non-Network Provider
Single $5,000 Out-of-Pocket Maximum Family $7,500 Out-of-Pocket Maximum	An additional $2,000 per Individual will be charged to the Out-of-Pocket Maximum

The Calendar Year Out-of-Pocket Maximum does not include any of the following expenses:

- Co-Payments you pay
- Coinsurance you pay for Prescription Drugs;
- Your share of payments for any Behavioral Health Care treatment;
- Penalties for not pre-certifying an inpatient hospital confinement, organ and/or tissue transplant, surgery, or specialty drugs; and
- Charges for expenses that the Plan does not cover.

Lifetime Benefit Maximums on All Medical and Prescription Drug Expenses

- $2,000,000/person with a $1,000 Annual Restoration Amount
- $3,000 in charges for treatment of any Temporomandibular Disorder
- $1,000 Lifetime Maximum Benefit for Psychological Testing
- Lifetime maximum number of Applied Behavioral Analysis (ABA) visits with a certified provider or a program manager per dependent: 60
- Lifetime maximum number of treatment Applied Behavioral Analysis (ABA) with a therapy assistant per dependent: 450

Preventive Care

Certain services intended to prevent illness or provide confirmation of continued good health are covered by this plan and strongly encouraged as a way to promote a healthier lifestyle for all plan participants. Staying healthy is the most cost effective health care we have access to! The "Preventive Care" covered by this plan includes services performed on a routine basis and not because of, or resulting in any diagnosis of an illness or injury. If an illness or injury is diagnosed as a result of one of these preventive care services, the charge for that service will not be paid under this "Preventive Benefits" schedule, but instead will be reimbursed according to the schedule of benefits for any other medically necessary treatment of an illness or injury.

For the Preventive Care services listed below the Calendar Year Deductible is waived for services performed by both Network and non-Network Providers.

Covered Preventive Care Services with Deductible Waived	
Routine Physicals over age 2	All routine, incl. sports and school physicals
Immunizations for person over age 2	Limited to prevailing medical standards
Well Baby Care under age 2	Limited to prevailing medical standards
Mammograms – women age 35 or older or w/history of breast cancer in immediate family	Limited to One per Calendar Year
Prostate Specific Antigen (PSA) Testing	Limited to one per Calendar Year
Bone Density Scan - for women over age 45	Baseline, then every 5 years
Covered Preventive Care Services with Deductible and Coinsurance Applied	
Colon Examination – persons age 50 or older	Proctosigmoidoscopy, Sigmoidoscopy, or Colonoscopy once every 10 years.

Behavioral Health Benefits
This plan provides benefits for services necessary to treat Behavioral Health conditions such as mental and nervous disorders, drug addiction and substance abuse.

For the Behavioral Health services listed below the Calendar Year Deductible and Coinsurance described in this Schedule of Benefits will apply. However, any Coinsurance amount paid by you will not accumulate to your Calendar Year Out of Pocket Maximum. The schedule of benefits for Behavioral Health Care is as follows:

Covered Behavioral Health Care Services	
Inpatient Care and Partial Hospitalization – Mental/ Nervous Condition	Pre-certification required.
Inpatient Care – Drug/ Alcohol Addiction	Pre-certification required. Limited to one confinement of not more than 30 days per lifetime
Outpatient Care	Paid subject to the co-payment, deductible and coinsurance provisions described above.
Psychological Testing	Limited to Lifetime Benefit Maximum of $1,000

Brain Development Disorder Treatment Benefits for Dependent Children

This Plan provides benefits for behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) and/or related structured behavioral programs, when administered and supervised by the Autism Center at the University of Washington Center on Human Development and Disability (CHDD), or providers who have met the certification criteria established by the Autism Center at the CHDD, or those working under the direct supervision of the certified provider. This benefit will be available to dependent children whose primary diagnosis is Autistic Disorder, International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code 299.0, Childhood Disintegrative Disorder (ICD-9-CM code 299.1), Asperger's Disorder (ICD-9-CM code 299.8), or Pervasive Developmental Disorder (ICD-9-CM code 299.8).

ABA services must be pre-authorized by Hines and Associates or no benefit will be payable. If pre-authorized, ABA services will be paid subject to the Calendar Year Deductible and Coinsurance described in this Schedule of Benefits. However, any Coinsurance amount paid by you will not accumulate to your Calendar Year Out of Pocket Maximum. Coverage of these services will be limited as follows:

- Lifetime maximum number of treatment visits with a certified provider or a program manager per dependent: 60
- Lifetime maximum number of treatment visits with a therapy assistant per dependent: 450

Organ and/or Tissue Transplant Benefits
Covered Organ and/or Tissue Transplants will be paid according to the following schedule of benefits:

Any organ or tissue transplant listed below will be covered subject to referral to and pre-authorization by the Utilization Review Coordinator, Hines and Associates. Failure to pre-authorize a transplant procedure with Hines and Associates will result in the application of a $5,000 Deductible to all Covered Expenses incurred as a result of the transplant. This Deductible is in addition to any other plan Deductible and will not be accumulated to the Participants Out of Pocket Maximum.

All reasonable and necessary lodging and meal expenses incurred during the Transplant Benefit Period will be covered up to a maximum of $10,000 per transplant period.

Expenses incurred during any transplant period for the recipient and for the donor will accumulate towards the recipient's benefit and will be included in the participants Lifetime Benefit Maximum. Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a Participant under this plan are limited to a maximum of $10,000 per Transplant Benefit Period when the transplant services are rendered by a non-Network Provider. This does not include the donor's transportation and lodging expenses.

For the Transplant Procedures listed below the Calendar Year Deductible will apply. Coinsurance for network and non-Network Providers will be 100%, however if a non-Network Provider is used the plan will apply an Overall Payment Maximum as shown below and any amount over the maximum will be paid by you and will not accumulate to your Calendar Year Out of Pocket Maximum**.**

Covered Transplant Procedures	Non-Network Provider Overall Payment Maximum
Heart	Limited to $110,000 including a Physician's maximum of $20,000.
Lung	Limited to $155,000 including a Physician's maximum of $20,000.
Bone Marrow	Limited to $130,000 including a Physician's maximum of $20,000.
Liver	Limited to $130,000 including a Physician's maximum of $20,000.
Heart/Lung	Limited to $150,000 including a Physician's maximum of $20,000.
Pancreas	Limited to $70,000 including a Physician's maximum of $20,000.
Kidney	Limited to $55,000 including a Physician's maximum of $20,000.

Diabetic Education

The Plan covers one diabetic educational session with a covered provider of service in a patient's lifetime subject to the co-payment, coinsurance and deductible provisions described above.

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 Medical 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 (B&GCA) to work on a “Limited-Hours” basis you may be eligible to continue your coverage under this Plan if the following conditions are satisfied:

- 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 as long as the dependent is not eligible for medical insurance through his/her own employer,
- 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 Medical 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 Medical 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 be actively employed and working at a Club to enroll for coverage for him/herself or a dependent. The employee must enroll for employee and Dependent coverage by submitting a completed enrollment application that is signed and dated while he/she is still working and meets the definition of coverage for this plan 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 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

For Timely Enrollment

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 case 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 or July 1st.

TERMINATION OF COVERAGE

When Employee Coverage Terminates

Employee coverage will terminate and benefits under this Plan will end on the earliest of these dates:

- 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 including death or termination of Active Employment of the covered employee;
- The end of the period for which the required premium contribution has been paid.

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".

Rehired Employee

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.

Effect of Military Leave

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

on Coverage Status

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.

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.

When Dependent Coverage Terminates

A Dependent's coverage will terminate on the earliest of these dates:

- The date the Plan or Dependent coverage under the Plan is terminated;
- The date that the employee's coverage under the Plan terminates;
- 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.

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".

CONTINUATION OF COVERAGE (COBRA)

"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.

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.

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, you 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.

Coverage Continuation for Surviving Dependent

A Dependent's coverage does not necessarily end upon a Participant'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.

Coverage for a surviving Dependent will terminate if she/he obtains other group medical coverage or Medicare coverage.

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.

Benefits Affected by COBRA

Any COBRA continuance option must include the offering of Plan 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 Plan benefits.

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.

Maximum Benefit Periods

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.

- 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 Plan to any employee; or
  - the date the qualified beneficiary first becomes, after the date of election, (1) covered under any other group health 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 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 Requirement

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. Participants 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.

LIMITATION ON PRE-EXISTING CONDITIONS

For an Eligible Employee or a Dependent enrolling as a Late Enrollee or Special Enrollee, benefits for pre-existing conditions are limited as described below. This limitation does not apply to newly hired employees or new Dependents that have enrolled as a Timely Enrollee.

Pre-existing Condition Defined

A Pre-existing Condition is any condition medically diagnosed, treated, advised upon or consulted on with a Physician in the six (6) months immediately prior to your Effective Date with this Plan.

For the purpose of determining if a condition is a Pre-existing Condition, “treated” means services and supplies received or purchased, physician’s visits, consultations, diagnostic tests or medicines prescribed.

Pre-existing Conditions Limitation

No benefits will be paid for any expenses incurred as a result of or related to any Pre-existing Condition except in the following situations:

- the condition is pregnancy;
- the condition is on a newborn Child who was enrolled under this Plan within 60 days of birth;
- the condition is on a Child who is adopted or placed for adoption and enrolled in the Plan before attaining age 19;
- This limitation will cease to apply 12 months after the Patient’s Effective Date.

Reducing or Eliminating the Pre-existing Condition Limitation Period

If you transferred from another Club where you and/or your Dependents were covered by a medical plan, and you satisfied the Pre-existing Condition Limitation of that plan, then this Plan will waive its Pre-existing Condition Limitation.

The 12 months during which this limitation will apply to any Pre-existing Condition may be reduced or eliminated if the Eligible Person had creditable coverage from a prior health plan. There can have been no more than a 63-day break between the coverage end date from that Plan to the first day of the Waiting Period of this Plan.

An Eligible Person must request a Certificate of Creditable Coverage from a prior employer or medical insurance carrier, and submit it as proof of Creditable Coverage. If, after Creditable Coverage has been taken into account, there is still a part of the 12-month Pre-Existing Condition Limitation period remaining, then that is the only period of time during which benefits will be denied.

HOW THE MEDICAL PLAN WORKS

Selecting Your Providers

This Plan features Provider "Networks" as a way of controlling rising health care costs. A Network is a group of health care Providers who have agreed to discount their charges. The network designated as your primary Network is the Network whose logo appears on the top corner of your identification card. If you have a dependent residing at a different address than you (e.g. a child in college, or a child residing with a natural parent but at a different address), you can choose a different primary Network from the networks offered by this Plan for your dependent.

If you receive services from a Provider who is no longer in the Network, you will not receive the Network Provider benefits. However, if you appeal the reduced benefits, and it can be verified that your Provider was in the Network at the time you last received care by him/her, a one time allowance, for an "Office Visit", will be granted.

To find a Network Provider, or to determine if your caregiver, or hospital is in Network you can do either of the following:

- Call CTI Administrators at (800) 245-8813, a claims examiner will assist you, or
- Access the information on the internet at www.BGCWA.com using the quick link for "Finding a Doctor or Hospital".

If you or your dependents do not use the Providers in your primary Network, the services received will be paid at non-Network benefit levels.

Using Non-Network Providers

This Plan allows you to use any covered Provider you choose and still receive benefits for covered expenses. The highest benefit levels are paid only when you use a Network Provider.

When a non-Network Provider is used, the Plan pays at a lower coinsurance level and applies an additional deductible per person with a maximum additional deductible per family per year. The higher coinsurance and deductible that you pay will be accumulated to a higher Out-of-Pocket maximum per person per calendar year.

The Plan will pay at the non-Network benefit levels described above whenever you do not receive care from a Network Provider. If you or a dependent needs to seek medical care from a Provider who is not a Network Provider, this Plan may attempt to attain a discount on your behalf. The discounted amount, if any, will be written off by the Provider and will not be billed back to you.

Emergency Services

For services rendered within 48 hours of an accident or of the onset of an emergency condition the Plan will pay for a non-Network Provider at the same coinsurance level and deductible as a Network Provider. Emergency treatment rendered in the office of a non-Network Provider will be subject to deductible and coinsurance. In the case of an accident, Emergency is defined as an accidental bodily injury. In the case of an illness, Emergency is defined as a condition that the absence of immediate medical treatment could place the health of the patient in serious jeopardy, or cause serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Usual, Reasonable and Customary Allowances Paid

When services are rendered by, or received from a non-Network Provider, the amount in excess of the Usual, Customary and Reasonable fee as determined by the Claims Administrator will be your responsibility to pay in addition to any deductible, or coinsurance that may be applicable to the covered expense portion of the charge. Any amount in excess of the Usual, Customary and Reasonable fee is considered a non-covered expense and is not accumulated to your annual Out-of-Pocket Maximum.

Pre-Certification Requirement

When your Physician recommends that you or your Dependent must be hospitalized, recommends a Surgical Procedure including an organ or limb transplant, diagnoses your dependent child with an autism spectrum disorder and refers the child for treatment, or prescribes a Specialty drug, you or your Physician must telephone the Utilization Review Coordinator, Hines and Associates at (800) 944-9401. You are responsible for obtaining approval for the recommended hospital stay or surgery from Hines and Associates prior to having the services performed, or, in the case of an emergency, by the first business day. Benefit payment will be reduced by $500 if a hospital confinement, surgical procedure, or Specialty drug as described above is not pre-certified. Failure to pre-certify a transplant procedure will result in the application of a $5,000 Deductible to all Covered Expenses incurred as a result of the transplant. Failure to pre-certify treatment of an autism spectrum disorder will result in the denial of benefits for that therapy. These penalties will not be applied toward your Deductible or Out-of-Pocket Maximum. For specific information about this requirement refer to the "Utilization Review/ Pre-Certification Requirements" section of this book.

Prescription Drugs

There are three prescription drug programs available through this Plan: 1) the Retail Drug Card Program, 2) the Mail Order Program, and 3) Specialty RX Program. These programs are managed by Caremark. The Copayment structure is designed to encourage the use of Generic alternatives and/or Select Brand Name Drugs, which are brand name drugs that Caremark has determined to meet high levels of quality with maximum cost effectiveness. Refer to the Schedule of Benefits for the applicable Copayment applied to the type of drug you are purchasing. For specific information about this Plan's coverage for prescription drugs, refer to the "Prescription Drug Benefits" section of this book.

Due to many brand name prescriptions being released in generic equivalent form over the next several years, the Plan will require the employee to pay the difference in cost between the brand name and generic equivalent, even if a physicians signs an order to dispense the brand name drug.

Covered Expenses

The next section of this booklet is the "Covered Expenses" section. Each type of medical expense covered by this Plan and any limitations that applies to coverage of that expense is detailed in this section. The services are listed alphabetically by their common name. With the exception of Preventive Care, all services must be medically necessary to treat or diagnose an illness or an injury. There are separate sections detailing the coverage provided for "Preventive Care" and "Behavioral Health Care". If a service is not listed in one of these sections, it is not covered by this plan. If you cannot find a particular service listed, or if you have questions about the coverage specified, call the Claim Administrator, CTI Administrators Inc. at (800) 245-8813.

Plan Exclusions

Certain services are not covered by this Plan. The details regarding these excluded services are listed in alphabetical order in the "Medical Exclusions" section of this booklet. If you incur an expense for one of these services, it will be your responsibility to pay it and that expense will not accumulate to the Out-of-Pocket maximum specified in the schedule of benefits. To appeal a denied expense, follow the procedures shown in the "Claim Filing/ Appeal Procedures" section.

Plan Maximum and Annual Restoration of Benefits

While covered under this Plan the maximum lifetime benefit you and each of your covered Dependents can receive is $2,000,000 per person for medical and prescription drug expenses. For each year that you or your Dependent are covered by this plan, your benefit payments, up to the amount of $1,000 per calendar year will be restored.

COVERED EXPENSES

Covered Expenses under this Plan are limited to the following Medically Necessary services and supplies and Preventive Care unless otherwise noted in this document. Medical Necessity is determined by the Claim Administrator. All charges will be paid according to the Schedule of Benefits shown in the front of this booklet.

Allergy Antigen and Injections	If allergy antigen is prepared and billed for separately from the allergy injection, it will be considered as a "Medical Supply", and will be subject to the Calendar Year Deductible and Coinsurance. If you have purchased a supply of allergy antigen and are billed for your allergy injections with no separate charge for an office visit, the injection charge will be paid without Deductible or Coinsurance.
Ambulance	Ground or air transport ambulance service to the nearest Hospital or Skilled Nursing Facility where necessary emergency treatment can be provided.
Ambulatory/ Outpatient Surgical Facility	Outpatient surgery allows a Surgical Procedure to be performed without an overnight Hospital stay. Outpatient surgeries can be performed in the Outpatient department of a Hospital, a licensed Ambulatory Outpatient Surgical Facility or in a Physician's office. If an Outpatient surgery involves the use of anesthesia, an operating room, and a recovery room, it must be pre-certified. Refer to the Utilization Review/ Pre-Certification Requirements section of this booklet for instructions on how to pre-certify your surgery. Note: There is a $500 penalty for failure to pre-certify surgery.
Anesthesia	Anesthesia fees are covered when rendered in connection with a covered medical procedure (including covered oral surgery). Acupuncture when used as an anesthetic is covered. Services rendered by a Certified Registered Nurse Anesthetist (CRNA) are covered. If, both, an anesthesiologist and a CRNA bill for the same procedure, the allowance for both Providers combined will not exceed 100% of the allowable charge for that procedure.
Behavioral Health Care	Refer to the "Behavioral Health Benefits" section of this booklet.
Birth Control	All forms of prescribed birth control are covered under this plan. Refer to the "Prescription Drug Benefits" section of this booklet for further details.
Birthing Center	Care for pregnant women using the services of a nurse midwife in a licensed Birthing Center is covered.
Blood	Blood that has not been replaced is covered.
Cardiac Rehabilitation Therapy	Physician supervised cardiac rehabilitation is a covered expense.
Chemotherapy	Chemotherapy is covered. There is no coverage for high dose chemotherapy in connection with autologous bone marrow transplantation, stem cell rescue or other hematopoietic support procedures except in the case of acute leukemia in remission, resistant Hodgkin's lymphoma, Hodgkin's disease and neuroblastoma, and even then only if the patient qualifies as a good candidate according to generally accepted medical standards.
Chiropractic Care/ Spinal Manipulation	Chiropractic care/spinal manipulation services by a licensed MD, DO, or DC are covered. Under no circumstances will maintenance or palliative care be covered. For long term course of treatment a written approval should be requested from the Claim Administrator. Massage therapy rendered by, or in conjunction with a course of chiropractic care is not covered.
Dental Treatment	The following dental procedures are covered under the medical plan: • Care and treatment of sound natural teeth required as a result of, and rendered within 12 months of an accidental injury; • Dental surgery necessary to treat congenital defects of a Dependent Child; • Surgical removal of full bony impacted wisdom tooth, including medically necessary Inpatient confinement (Hospital Confinements must be pre-certified).

Diabetic Education One session of outpatient education for a person with the diagnosis of diabetes is covered in a covered person's lifetime.

Diagnostic Testing (X-rays and Labs) X-ray and laboratory services ordered by a Physician for the diagnosis and treatment of an Injury or Illness. Routine x-ray and laboratory services also are covered (refer to Preventive Care in the Schedule of Benefits section of this booklet for a description of routine services and how they are paid). Professional component charges from pathologists or laboratories associated with automated labs are not covered.

Dialysis Dialysis performed in a Hospital or Dialysis center is covered as well as dialysis equipment, supplies and self-management training.

Drug Addiction Treatment Refer to the Behavioral Health Care section of this booklet.

Durable Medical Equipment The rental or purchase of Medically Necessary Durable Medical Equipment such as oxygen equipment, hospital beds, wheel-chairs when prescribed by a Physician is covered. The Plan reserves the right to determine if the Durable Medical Equipment is to be rented or purchased, and at no time will the total amount of covered charges for rental exceed the purchase price. The reasonable cost of repair or replacement due to wear, breakage or change in the patient's physical condition will be covered if the item is medically necessary and the repair is necessary to restore or maintain the item's intended function. However, repair/replacement due to loss or negligence or replacement by a newer or more efficient model will not be covered. The Plan excludes equipment for control of air quality or temperature, and exercise equipment. For coverage description of other types of medically necessary supplies and of prosthetic devices see the section entitled "Medical Supplies

Emergency Room Services Medically Necessary Emergency room services are covered by this plan.

Extended Care Facility Refer to "Skilled Nursing Facility" in this section.

Home Health Care Charges for Home Health Care services and supplies are covered when the treatment is medically necessary and prescribed by a Physician. Home Health Care benefits include in-home Visits by a nurse (RN or LPN), home health aide, or licensed therapist. Services are limited to 100 Visits per Calendar Year. Each Home Health Care Visit is four hours or less.

Hospice Care Hospice Care is covered when the attending Physician has diagnosed the Participant's condition as terminal and determined that the person's life expectancy is less than six months. The Hospice Care Provider must be approved by Medicare or by the Joint Commission on the Accreditation of Hospitals, as a Hospice Care Agency. (Also see Nursing Home Care in this section)

Hospital Inpatient Hospital Inpatient benefits include the daily room and board and nursing service charges for each day of confinement up to the semi-private room rate of that Hospital and observation room services that will be over 23 hours. Charges for special care units, e.g., Intensive Care unit are covered providing that level of care is Medically Necessary and prescribed by a Physician. Medically Necessary miscellaneous service and supply charges incurred during a Hospital Inpatient period for which room and board benefits are covered, but do not include personal convenience items such as TV, telephone, admission kits, etc.

All Inpatient Hospital admissions and observation room services that will be over 23 hours must be pre-certified. Failure to obtain Pre-certification approval for confinement in the Hospital beyond the number of approved days results in a $500 benefit penalty. See the "Utilization Review/Pre-Certification Requirements" section of this booklet for further details

of how to obtain Pre-certification for an Inpatient stay.

Hospital Outpatient

Hospital Outpatient benefits include but are not limited to laboratory, X-ray, operating and recovery room charges, surgical supplies, radiation and chemotherapy, anesthesia, pre-admission testing and Emergency room care.

Certain Hospital Outpatient Surgical Procedures require Pre-certification approval. Failure to obtain Pre-certification approval results in a $500 benefit penalty. See the "Utilization Review/Pre-Certification Requirements" section for further details of how to obtain Pre-certification for an Outpatient Surgical Procedure.

Injectable and Oral Specialty Drugs

Medications taken by injection and the supplies that are necessary to administer them must be purchased from theCVS/Caremark SpecialtyRX pharmacy in order to be covered by this plan. **This does not include insulin for diabetes, or allergy antigen.** If you need to purchase an injectable form of a medication, you or your doctor need to contact CVS/Caremark SpecialtyRX pharmacy at (866) 295-2779 to determine if that medication is available. Medications available through SpecialtyRX will be covered only if they are purchased through SpecialtyRX; they will not be paid as a covered medical expense under any other benefit of this plan. For more information reference the "Prescription Drug Benefits" section of this booklet.

The purchase of injectable medications must be pre-certified. Failure to obtain Pre-certification will result in a $500 benefit penalty. See the "Utilization Review/Pre-Certification Requirements" section for further details of how to obtain Pre-certification.

Laboratory Tests

Reference "Diagnostic Testing (X-rays and Labs)" section of this book.

Maternity

Care and treatment of pregnancy and childbirth are covered the same as any other Illness. Ultrasound procedures are not covered unless Medically Necessary. Services must be provided by a licensed Physician (MD or DO) or a Certified Registered Nurse Midwife. As a service to expectant mothers the Plan offers Baby Advocacy/Birth Education program (BABE), which provides information on the importance of a healthy life-style during pregnancy, pregnancy monitoring, and toll-free telephone access to nurses with years of maternity nursing experience. To participate in BABE, upon confirmation of pregnancy call Hines & Associates at (800) 944-9401.

Group health plans may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a Provider obtain authorization from the Plan for prescribing a length of stay of 48 (or 96) hours or less. This Plan does require pre-certification of any maternity related confinement of longer than 48 (or 96) hours.

Medical Supplies

The purchase of a brace (except dental braces), splint, truss, cast, crutches or other appliances to aid in the function of an impaired body part are covered. The fitting and purchase of an initial prosthetic appliance that substitutes or supplements a missing part of the body is covered, subject to a maximum allowable charge for a single prosthetic device of $15,000. The reasonable cost to repair a covered Medical Supply due to wear, breakage or change in the patient's physical condition will be covered if the item is medically necessary and the repair is necessary to restore or maintain the item's intended function. However, repair/replacement due to loss or negligence or replacement by a newer or more efficient model will not be covered. Also included as a medical supply is allergy antigen that is prepared in advance for a Participant and billed separately from the injections of that antigen.

Mental/

Refer to the "Behavioral Health Care" section of this book.

Nervous Condition Treatment

Morbid Obesity Surgery

Prior approval is required before surgery to treat morbid obesity is performed; reference the "Utilization Review/ Pre-certification Requirements" section of this book. You must meet certain physical and mental status requirements to receive benefits. For an explanation of what these requirements are, you can call or write to the Claim Administrator.

Newborn Care

Coverage includes the following services in connection with a covered newborn Child:

- The necessary care and treatment of congenital defects and pre-maturity;
- Birth abnormalities;

Routine nursery care charges including room and board for a well newborn. (Reference 'Maternity' in this section for information regarding Federal Law governing the length of stay for a healthy newborn child.) This Plan does require pre-certification of any newborn confinement of longer than 48 hours (or 96 hours if delivered by c-section).

Nursing Home Care

Services rendered at a licensed Nursing Home are covered when the attending Physician has diagnosed the Participant's condition as terminal and determined that the person is not expected to live more than six months. (Also see Hospice Care in this section)

Occupational Therapy

Services of a licensed occupational therapist are covered. Therapy must be ordered by a Physician and be necessary to regain an ability lost due to an Injury or Illness. Covered charges do not include recreational programs, maintenance therapy, educational or job training of any kind. While these services may be performed in the office, they will always be subject to the appropriate deductible and coinsurance.

Pain Management

Treatment for chronic pain is covered for a maximum of twenty-four (24) outpatient Visits in a calendar year to a Licensed Pain Management Center.

Physical Therapy

Physical Therapy must be provided by a licensed physical therapist or licensed physical therapy assistant under the direct supervision of a licensed physical therapist, and prescribed by a Physician for treatment of an Illness or Injury. Massage therapy is not covered

Physician Visits

The covered services of a Physician include consultations, Inpatient Hospital Visits, office and clinic Visits, extended care facility Visits, and home Visits. Equipment or supplies purchased through your Physician, or at the time of a Visit will be paid under the benefit that applies to that type of expense. Telephone consultations and services rendered or purchased through the internet are not covered.

Podiatry

The services of a podiatrist for surgical treatment of the foot are covered. Physician prescribed orthotics (shoe inserts that are custom-built based upon a cast or impression of the patient's foot) are covered when used to treat abnormalities, disorders, or diseases of the feet. Such orthotics will be limited to one per affected foot and its replacement or repair due to deterioration. Orthopedic shoes are not covered. Certain other types of Foot Care are not covered; see "Foot Care" in the "Medical Exclusions" section of this book.

Prescription Drugs

Refer to the "Prescription Drug Benefit" section of this book.

Private Duty Nursing

Refer to the "Home Health Care" in this section.

Prosthetic Devices

Refer to "Medical Supplies" in this section of the book.

Radiation Therapy

Radiation Therapy is covered. There is no coverage for high dose Radiation Therapy in connection with autologous bone marrow transplantation, stem cell rescue or other

hematopoietic support procedures except in the case of acute leukemia in remission, resistant Hodgkin's lymphoma, Hodgkin's disease and neuroblastoma, and even then only if the patient qualifies as a good candidate according to generally accepted medical standards.

Skilled Nursing Facility

The room and board and nursing care furnished by a Skilled Nursing Facility will be covered if:

- The patient is confined as a bed patient in the facility; and
- The confinement starts immediately following a Hospital Confinement of 3 or more days; and
- The attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital Confinement; and
- The attending Physician completes a treatment Plan that includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

The maximum eligible daily charge is 50% of the Hospital's daily semi-private room rate. The maximum benefit is 100 days per Calendar Year.

Speech Therapy

Treatment by a licensed Speech Therapist to restore speech ability lost due to an Illness or Injury while a Participant under this plan. While these services may be performed in the office, they will always be subject to the appropriate deductible and coinsurance.

Sterilization

Sterilization procedures such as vasectomy and tubal ligation are covered. Reversal of sterilization is not covered.

Surgery

Covered services of a Physician include surgery. Certain types of surgery must be pre-certified. These include any surgery to be performed while you are an Inpatient at a Hospital, and surgery performed on an Outpatient basis if the surgery involves the use of anesthesia, an operating room or other similar surgical facility, and a recovery room. Failure to obtain approval for surgery results in a $500 penalty. See the "Utilization Review/Pre-Certification Requirements" section of this book for further details.

If the same surgeon performs multiple Surgical Procedures during the same operative session, benefits will be based on the Usual, Customary and Reasonable allowance for the primary procedure; and 50% of the Usual, Customary and Reasonable allowance for each additional procedure. Any procedure that would be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be allowed.

If an assistant surgeon is Medically Necessary, his/her covered expense will not exceed 20% of the Usual, Customary and Reasonable allowance for that surgical procedure.

Temporo-mandibular Joint Disorder (TMJ)

Care or treatment of TMJ to the extent the charges do not exceed $3,000 in an insured person's lifetime are covered. Charges will be limited to the Usual, Customary, and Reasonable allowance.

Vision Care

Charges for the initial eye exam and lens following cataract surgery are covered.

X-Rays

Refer to the "Diagnostic Testing (X-Rays and Labs)" in this section.

ORGAN AND/OR TISSUE TRANSPLANTS

Introduction

Transplant coverage is offered under this Plan through a preferred Provider Network of specialized professionals and facilities. Coverage is also provided for transplant services obtained outside of the preferred Network, at a reduced benefit level.

Pre-Certification

Expenses incurred in connection with any organ or tissue transplant listed in this provision will be covered subject to referral to and pre-certification by the Utilization Review

Requirement for Organ/ Tissue Transplants

Coordinator, Hines and Associates. (Cornea transplants are not subject to the pre-certification provision, but will be considered on the same basis as any other medical expense under this Plan.)

As soon as reasonably possible, but in no event more than ten (10) days after a Participant's attending Physician has indicated that the Participant is a potential candidate for a transplant, the Participant or his Physician should contact the Utilization Review Coordinator for referral to the Network's medical review specialist, for evaluation and pre-certification. A comprehensive treatment Plan must be developed for this plan's medical review, and must include such information as diagnosis, the nature of the transplant, the setting of the procedure, (i.e. name and address of the Hospital), any secondary medical complications, a five (5) year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment. (One or both confirming opinions may be waived by the plan's medical review specialist). Additional attending Physician's statements may also be required. The Participant may provide a comprehensive treatment Plan independent of the preferred Provider Network, but this will be subject to medical appropriateness review and may result in non-Network benefit coverage.

Failure to pre-certify a transplant procedure with Hines and Associates will result in the application of a $5,000 Deductible to all Covered Expenses incurred as a result of the transplant. This Deductible is in addition to any other Plan Deductible and will not be accumulated to the plan’s Out-of-Pocket Maximum.

Organ Transplant Network

As a result of the pre-certification review the Participant will be asked to consider obtaining transplant services from a participating Center of Excellence facility arranged by the Claim Administrator. The purpose of designating Centers of Excellence Networks is to perform necessary transplants in the most appropriate setting for the procedure, to improve the quality and probability of a successful outcome, and reduce the average cost of the procedures.

There is no obligation for the patient to use a participating transplant Network facility. However, benefits for the transplant and its related expenses may vary depending on whether services are provided in or out of the transplant Network. If a transplant is performed out of Network, but the Participant has received approval from the plan's medical review specialist for out of Network services, then Network benefits will apply to the transplant and its related expenses. If services are provided out of Network without approval from the medical review specialist, then out of Network benefits will apply.

Transplant Benefit Period

Covered transplant expenses will accumulate during a Transplant Benefit Period, and will be charged toward the Transplant Benefit Period maximums shown in the Schedule of Benefits.

Covered Transplant Expenses

The term "Covered Expenses" with respect to transplants includes the reasonable and customary expenses for services and supplies which are covered under this Plan (or which are specifically identified as covered only under this provision) and which are Medically Necessary and appropriate to the transplant, including:

- charges incurred for evaluation, screening, and candidacy determination process; and
- charges incurred for organ transplantation; and
- charges for organ Procurement, including donor expenses not covered under the donor's Plan of benefits; and
- coverage for organ Procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ; and
- coverage for organ Procurement from a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care; and if the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone

marrow (autologous) or the donor's marrow (allogenic); and

- coverage will be provided for search charges to identify an unrelated match, and treatment and storage cost of the marrow, up to the time of reinfusion. The harvesting of the marrow need not be performed within the Transplant Benefit Period; and
- charges incurred for follow-up care, including immuno-suppressant therapy; and
- charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two (2) other individuals; and
- all reasonable and necessary lodging and meal expenses incurred during the Transplant Benefit Period will be covered up to a maximum of $10,000 per transplant period.

Re-transplantation

Re-transplantation will be covered for up to two re-transplants, for a total of three transplants per person, per lifetime. Each transplant will be subject to the Pre-certification requirement for Organ Transplant. Each transplant and re-transplant will have a new benefit period and a new maximum benefit, subject to the plan's overall per-person maximum lifetime benefit.

Accumulation of Expenses

Expenses incurred during any transplant period for the recipient and for the donor will accumulate towards the recipient's benefit and will be included in the plan's overall per-person maximum lifetime benefit.

Donor Expenses

Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Plan or any other benefit Plan covering the donor. In addition, medical expense benefits for a donor who is not a participant under this Plan are limited to a maximum of $10,000 per Transplant Benefit Period when the transplant services are provided out of Network. This does not include the donor's transportation and lodging expenses.

Pre-Existing Conditions Limitation

Transplant charges will be subject to this plan's pre-existing conditions limitation.

PREVENTIVE CARE

Your Plan has benefits available for certain services intended to prevent illness, or provide early detection of illness. This "Preventive Care" includes exams, certain tests, and immunizations performed on a routine basis and not because of, or resulting in any diagnosis of an Illness or injury. These services will be paid as previously described in the Schedule of Benefits. A description of covered preventive care services follows.

Routine Physical

The Plan will cover Participants, age two and older for the following services:

- routine physical; or
- sports physical; or
- or school physical.

This benefit includes coverage for the office Visit and routine laboratory and x-rays services. If your Physician uses an outside laboratory to process the results of tests taken in the office, the charge from the outside laboratory will be paid as part of the services performed in the office.

Immunization

This Plan covers all immunizations in keeping with the prevailing medical standards for routine health care.

Well Baby Care

This Plan covers Well Baby Care for Children up to the age of two includes office examinations, immunizations, and routine tests in keeping with prevailing medical standards for routine Child care.

Mammogram

The Plan will cover one routine mammogram every Calendar Year for individuals age 35 and over in addition to the Routine Physical benefit described above. Mammograms can be covered for persons under age 35 if there are history of breast cancer in the immediate family.

Bone Density Scans

The Plan will cover one baseline bone density scan for women age 45 or older and one scan every five years thereafter.

Colon Exam

This Plan will pay a Preventive Care Benefit for a proctosigmoidoscopy, or a sigmoidoscopy. For persons age 50 or over, the Plan also covers a colonoscopy every 10 years. The charges for these services would be covered in addition to the Routine Physical benefit described above.

Prostate/ Testicular Exam

This Plan will pay for one Prostate/Testicular Exam (the procedure is called a prostate specific antigen or PSA test) in addition to the Routine Physical benefit described above.

Exclusions

Other than the services listed above, all preventive care is excluded from coverage including, but not limited to:

- routine eye examinations (except the first examination after cataract surgery)
- routine hearing examinations

PRESCRIPTION DRUG BENEFITS

Most Medically Necessary drugs or medicines that are prescribed by a Physician are covered under:

- the CVS/Caremark Mail Order Program; or
- the CVS/Caremark Retail Drug Card Program; or
- the CVS/Caremark SpecialtyRX Program.

The Plan requires the employee to pay the difference in cost between the brand name and generic equivalent, even if a physicians signs an order to dispense the brand name drug.

Important Notice for All Medicare Beneficiaries: CVS**/**Caremark has certified coverage provided through this Plan to be creditable in accordance with guidance from the Centers for Medicare and Medicaid Services.

Mail Order Drug Program

This program should be used to obtain long-term maintenance prescription medications. You can obtain up to a 90-day supply of your prescription and the prescription will be conveniently mailed to your home.
(Note: In order for birth control pills to be covered by the Plan they must be purchased through this program.)

Retail Drug Program

This program covers prescription medications purchased at any participating CVS/Caremark pharmacy. These participating pharmacies have agreed to discount the cost of the drugs you purchase through them if your insurance Plan uses CVS/Caremark's programs. Simply present your CVS/Caremark Medical identification card to the pharmacist and pay your Coinsurance to purchase up to a 30-day supply of any covered prescription.

Generic Drugs: Now, more than ever it is important that you ask your Physician about using lower- cost alternatives to brand name drugs. Generic equivalents are the least costly of all prescription medications and can save this Plan as much as 50% of the cost of the brand name medication. Due to many brand name drugs being released in generic equivalent form over the next several years, the Plan will require the employee to pay the difference in cost between the brand name and generic equivalent, even if a physicians signs an order to dispense the brand name drug.

Preferred Brand Name Drugs: If you need to purchase a brand name drug, CVS/Caremark has developed a Performance Drug List of brand name drugs that are more cost effective. The Performance Drug List is available and can be found on the CVS/Caremark web site, access **www.BGCWA.com** and use the CVS/Caremark quick link, or you can call the CVS/Caremark customer service department at (800) 966-5772. To encourage you to purchase from the Performance Drug List, your Coinsurance is reduced by one-third from what it will be if you buy a brand name drug that is not on the Performance Drug List.

Specialty RX Program

SpecialtyRX is a full-service specialty pharmacy offering delivery of injectable and select oral specialty medication and supplies to the location of your choice. Services include delivery notification and refill reminder calls to help you stay on your treatment plan. You'll also receive expert care services including counseling, follow up care calls, informative disease-related materials, and access to health experts 24 hours a day, seven days a week. **Note: In order for injectable drugs and their supplies to be covered by this Plan they must be purchased through the SpecialtyRX program.**

Specialty, or biotech, drugs refer to medications made from living sources (e.g. micro-organisms, blood cells, proteins), as opposed to traditional drug therapies, which are synthetic. Specialty drugs are often administered by injection by either the patient or the physician. Because biotech drugs are similar to substances found in the human body, they are more effective in fighting hard-to-treat conditions, such as multiple sclerosis, rheumatoid arthritis and growth hormone deficiency.

SpecialtyRX provides medications for many chronic conditions such as Multiple Sclerosis, Hepatitis C, Rheumatoid Arthritis, Respiratory Syncytial Virus Prevention, Hemophilia, Growth Hormone Deficiency, Gaucher Disease, Neutropenia, Cystic Fibrosis, Primary Pulmonary Hypertension, Crohn's Disease and many other chronic conditions.

To be referred to SpecialtyRX, the patient or prescribing physician will need to complete a patient referral form and fax it to CVS/Caremark SpecialtyRX.
If you have questions or need more information, please call the CVS/Caremark SpecialtyRX Customer Service line at (866) 295-2779. For your convenience, SpecialtyRX is available Monday through Friday, 8 a.m.- 6 p.m. EST. Complete orders received by 3 p.m. EST will be processed for next business day shipping.

Limitations on Covered Drugs

The following prescriptions are covered:

- Non-injectable Legend Drugs (drugs that federal or state law prohibits dispensing without a prescription)
- Compound prescriptions containing at least one Legend Drug
- Insulin and disposable Insulin syringes/needles
- Disposable blood/urine glucose /acetone testing agents (e.g. Chemstrips, Clinitest tablets, Diastix Strips and Tes-Tape)
- Non-emergency oral contraceptives, but only if purchased through the Mail Order Program
- All other forms of prescribed non-emergency birth control
- Tretinoin topical, (e.g. Retin-A) for individuals through age 25
- Epipens – up to two epipens per year
- Injectable drugs must be purchased through the SpecialtyRX program
- Growth hormones, but only if purchased through the SpecialtyRX program

The following items are not covered:

- Anorectics (drugs for the purpose of weight loss)
- Anti-wrinkle Agents (e.g. Renova)
- Cosmetic hair removal products (e.g. Vaniqa)
- Hair growth stimulants
- Immunization agents, blood or blood plasma
- Infertility medications
- Smoking deterrent medications (e.g. Nicorette, Nicoderm)
- Non-Legend Drugs
- Nystatin oral power
- Tretinoin topical (e.g. Retin-A) for individuals 26 of age or older.
- Therapeutic supplies or appliances, including syringes, support garments and other non-medicinal substances unless purchased through the SpecialtyRX program
- Drugs labeled "Caution-limited by federal law to investigational use," or Medication taken by, or administered to, an individual, in whole or in part, while a patient in a licensed hospital, extended care facility, or similar institution or experimental drugs
- Viagra, Levitra, or Cialis

BEHAVIORAL HEALTH CARE

Your Plan has specific limitations on benefits available for services provided for the treatment of Behavioral Health conditions such as mental and nervous disorders, drug addiction and substance abuse. These services will be paid as previously described in the Schedule of Benefits. A description of the covered expenses under this Plan for Behavioral Health Care follows:

Inpatient Care

Inpatient hospitalization for the treatment of Behavioral Health conditions is covered and, like any other Inpatient Hospital Confinement, requires Pre-certification. Please see the "Utilization Review/Pre-Certification Requirements" section of this booklet for instructions on how to pre-certify an Inpatient stay.

Inpatient hospitalization for the treatment of Drug Addiction or Substance Abuse will be limited to one confinement of not more than 30 days in the lifetime of an insured person.

Outpatient Care

Treatment rendered by a covered Provider on an Outpatient basis will be covered and paid according to the Schedule of Benefits.

Partial Hospitalization Program

This Plan will cover Partial Hospitalization Programs. Partial Hospitalization is a program that provides less than 24 hour Hospital care for patients that no longer require Inpatient care, but need more extensive treatment than Outpatient Visits. Covered Expenses include routine services, supplies, observation, group/family psychotherapy and other treatment by a Physician or nurse normally provided during an Inpatient hospitalization. This does not include room and board charges or take-home medication(s). Partial Hospitalization Program days are considered like Inpatient care days, and will be subject to the same Pre-Certification requirements and benefit limitations.

Psychological Testing

Testing necessary to determine the nature and extent of the Behavioral Health condition is covered by this plan. The test must be administered by a licensed psychiatrist or psychologist.

Not Covered

Certain types of counseling may be provided by a covered Provider, but are not covered under this benefit provision, or by this plan, these include:

- Marriage counseling
- Family child counseling
- Career counseling
- Social adjustment counseling
- Pastoral counseling
- Financial counseling
- Counseling performed over the phone or via the internet

Brain Dysfunction or Brain Development Disorder Treatment Benefits for Dependent Children

This Plan provides benefits for behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) and/or related structured behavioral programs, when administered and supervised by the Autism Center at the University of Washington Center on Human Development and Disability (CHDD), or providers who have met the certification criteria established by the Autism Center at the CHDD, or those working under the direct supervision of the certified provider. This benefit will be available to dependent children whose primary diagnosis is Autistic Disorder, International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code 299.0, Childhood Disintegrative Disorder (ICD-9-CM code 299.1), Asperger's Disorder (ICD-9-CM code 299.8), or Pervasive Developmental Disorder (ICD-9-CM code 299.8).

Covered Providers

Providers of this benefit must meet the certification criteria established by the Autism Center at the University of Washington's CHDD to provide Applied Behavioral Analysis (ABA) interventions for the above referenced diagnoses. Services of individuals who are under the direct supervision of a certified provider who follows the supervision guidelines outlined in the certification criteria (per CHDD) will also be covered. For the purpose of this benefit ONLY, services of a certified provider will be covered even if the provider does not meet the plan's requirements for an eligible provider under the Rehabilitative Care or Mental Health Care, Substance Abuse and Alcoholism Treatment benefit.

Lifetime Maximum on Number of Treatment Visits

Benefits not Subject to the Annual Out of Pocket Maximum

Benefits will be provided at Usual, Customary and Reasonable (UCR) charges up to the annual and lifetime maximum numbers of treatment visits per dependent as specified below. These benefits will be subject to the deductible and coinsurance. Even after an out-of-pocket maximum is reached by you, your family or dependent child with respect to other benefits in this plan, the plan will only pay at the applicable coinsurance for that provider for the covered autism therapy services (up to the lifetime visit limits described below).

- Lifetime maximum number of treatment visits with a certified provider or a program manager per dependent: 60
- Lifetime maximum number of treatment visits with a therapy assistant per dependent: 450

Note that the lifetime visit limits for certified providers and program managers are the total combined limits for services provided by both types of providers; separate limits do not apply for certified providers and program managers.

For purposes of this benefit, a "visit" is any continuous period of service provided to the dependent up to a three-hour continuous period. For example, if a certified provider visited the dependent between 9:00 a.m. and 10:00 a.m. and again between 2:00 p.m. and 5:00 p.m. on the same day, the certified provider would have had two visits with the child that day. If a therapy assistant provided services to a dependent between 12:00 p.m. and 5:00 p.m., the therapy assistant's five-hour session with the child would have constituted two visits because the length of time of continuous service exceeded three hours.

Pre-Certification and Continuing Certification Required for This Benefit

In order to be covered, services must be ordered by the physician who is treating the child and has diagnosed him/ her with autism, and must be pre-authorized by Hines and Associates (800) 944-9401. Authorization will be on a case-by-case basis, will be based on the plan's written criteria, and will apply to treatment plans of up to six months in duration. The dependent's parents (or other guardian), physician, or certified provider will have to obtain a pre-authorization for each new treatment period of up to six months. The plan reserves the right to have appropriate medical professionals review the treatment at any time to determine if it meets the eligibility criteria for coverage under the plan.

The following is the process for pre-authorization and continuing authorization of Autism benefit services under this plan:

1. The dependent's physician who is treating the dependent diagnoses the child with an Autism Spectrum Disorder (Autistic Disorder, Pervasive Developmental Disorder, Asperger's Disorder) and refers the patient to a certified provider.
2. An evaluation is performed by the certified provider to determine if the child is a candidate for an ABA and/or related structured behavioral program. If the child is determined to be a candidate by the evaluating certified provider, the certified provider would recommend a treatment plan including type and frequency of services. The certified provider must send the treatment plan to Hines and Associates. The evaluating provider or family of the autistic child must call Hines and Associates and request pre-authorization for treatment. If authorization is extended, it will be extended in six-month intervals.
3. Every six months, the certified provider who is overseeing the treatment must submit a progress report to Hines and Associates. The certified provider must follow supervisory guidelines outlined in the certification criteria for providers to determine that the services being provided by those under his or her supervision are in accordance with the treatment plan. If any substantial change in the frequency or type of program is necessary, pre-authorization must be requested from Hines to revise the treatment plan.

It is important that these pre-authorization and continuing authorization steps are followed to ensure coverage. Failure to meet these requirements will result in non-payment of benefit.

Autism Therapy Exclusions and Limitations

- This benefit is not provided for rehabilitative or mental health services.
- Benefits for services provided by volunteers, child care providers, family members and benefits paid for by state, local and Federal agencies will not be covered. Volunteer services or services provided by a family member of the child receiving the services by or through a school, books and other training aids will also not be covered.
- Other unspecified developmental disorders or delays, or any other delay or disorder in a child's motor, speech, cognitive, or social development are not covered under this benefit.
- This benefit only covers the fees for services performed by the certified provider and those providing interventions based on principles of ABA and/or related structured behavioral programs under the supervision of the certified provider.

Other expenses associated with providing the treatment, such as the travel, meals and lodging of the certified provider, those working under the certified provider's supervision, the dependent, and his or her family members will not be covered.

WOMEN'S HEALTH AND CANCER RIGHTS ACT of 1998 (WHCRA)

WHCRA provides important protections for individuals who elect breast reconstruction following a mastectomy.

Benefits Compliant With WHCRA

In compliance with WHCRA, this Plan includes coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the

mastectomy, including lymphedemas.

This coverage will be provided in a manner determined in consultation with the attending Physician and the patient. The coverage is subject to the same Deductible, co-insurance and limitations as any other benefits under this plan.

MEDICAL EXCLUSIONS

Charges for the following are not covered under this plan:

Abortion	Elective abortions. Medically Necessary abortions will be covered.
Acupuncture	Services related to acupuncture unless used as an anesthetic during surgery.
Complications of Non-covered Treatment	Care, services or treatment required as a result of complications from a treatment not covered under the plan.
Cosmetic Surgery	Services to change body size, appearance, texture, or proportion and which are not Medically Necessary or for the purpose of improving the psychological, mental or emotional well-being of the patient. This does not apply to: • Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or • Reconstructive surgery to correct a congenital deformity or anomaly of a Dependent Child.
Custodial Care	Services or supplies provided mainly as a rest cure or maintenance or intended to help a person in activities of daily living. This does not include care in a licensed nursing home for someone who has been diagnosed by his/her attending Physician as terminal and whose life-expectancy is no more than six months.
DNA Testing	DNA Testing will not be a covered expense.
Educational Services or Vocational Testing	Services primarily to educate one's self including diabetic education other than one outpatient training session in a person's lifetime, vocational testing or training including biofeedback, job training or recreational programs. This does not include testing to diagnose a Behavioral Health Condition, refer to the Psychological Testing benefit in the "Behavioral Health Care" section of this booklet.
Excess Charges Over UCR	The part of an expense for care and treatment of an Injury or Illness that is in excess of the Usual, Customary, and Reasonable allowance.
Exercise Programs	Exercise programs, except for Physician supervised cardiac rehabilitation, occupational or physical therapy.
Experimental Treatment	Care and treatment that is considered to be either Experimental or Investigational, as determined by the Claim Administrator.
Eye Care/Surgery	Radial keratotomy or other eye surgery to correct near-sightedness. Routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to the first exam and eyeglass lenses or contact lenses for aphakia patients, or soft lenses (sclera shells) intended for use as corneal bandages.
Family Planning	Services rendered as part of or in conjunction with family planning including, but not limited to genetic testing.
Foot Care	Non-surgical treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or

bunions, and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease or if the nail root must be removed). Orthopedic shoes and the purchase of more than one custom built orthotic per affected foot other than to replace an existing one due to normal deterioration.

Hair Loss Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, or for any condition.

Hearing Aids and Exams Charges for services or supplies in connection with hearing aids or exams for their fitting.

High Dose Chemotherapy There is no coverage for this treatment in connection with autologous bone marrow transplantation, stem cell rescue or other hematopoietic support procedures. For the diagnoses of acute leukemia in remission, resistant Hodgkin's lymphoma, Hodgkin's disease and neuroblastoma, coverage may be available if the patient qualifies as a good candidate according to generally accepted medical standards.

High Dose Radiation There is no coverage for this treatment in connection with autologous bone marrow transplantation, stem cell rescue or other hematopoietic support procedures. For the diagnoses of acute leukemia in remission, resistant Hodgkin's lymphoma, Hodgkin's disease and neuroblastoma, coverage may be available if the patient qualifies as a good candidate according to generally accepted medical standards.

Illegal Acts Charges for services received as a result of Injury or Illness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance
.

Illegal Use of Alcohol, Drugs, or Medications Services, supplies, care or treatment to a Participant for Injury or Illness resulting from voluntary taking of or being under the influence of alcohol or any controlled substance, drug, hallucinogen, narcotic not administered on the advice of a Physician.

Incidental Procedures Any secondary surgical procedure that is an integral part of the primary surgical procedure, that is unrelated to the diagnosis and would not have been performed without the primary surgical procedure.

Infertility Care and treatment for infertility, artificial insemination or in vitro fertilization, including reversal of sterilization procedures and surrogate mother embryo implantation. The Plan will pay for the initial consultation and laboratory work-up only for the purpose of diagnosing infertility.

Massage Therapy There is no coverage for massage therapy even if provided or recommended by a Physician or any other Provider who might be covered by this Plan for certain other services.

No Charge or No Obligation to Pay Expenses for which there would not have been a charge if no insurance coverage had been in force or for which you have no legal obligation to pay.

Not Recommended by Physician Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment that is appropriate care for the Injury or Illness.

Not Medically Necessary Treatment, care or services that are not consistent with the diagnosis, do not comply with acceptable medical standards for the most appropriate level of service which can be safely provided and that are primarily for the participants convenience.

Not Specified as Covered Services, treatments and supplies that are not specified as covered under this plan.

Nutritional Counseling	Charges for any type of Nutritional counseling.
Relative Performing Services	Professional service performed by a person who ordinarily resides in the Participant's home or is related to the Participant as a spouse, parent, child, brother or sister, whether the relationship is by blood or marriage.
Routine Care	Charges for routine or periodic examinations, screenings, or any services not directly related to the diagnosis or treatment of a specific Injury or Illness which is known or reasonably suspected except those benefits listed in the "Preventive Care" section of this booklet.
Self-Inflicted Injury or Illness	Any charges caused by suicide (attempted or otherwise), or an intentionally self-inflicted Injury or Illness, unless the person had previously been diagnosed by a psychiatrist or a psychologist as having a mental disorder.
Services Before or After Coverage	Care, treatment or supplies incurred before a person was covered or after coverage ceased under this plan. A charge is considered incurred on the date the service is rendered or purchase is made.
Services Not Rendered to a Specific Patient	Professional fees for services that are not actually rendered or required to be performed for a specific patient. An example would be charges from a pathology department for an automated lab that does not require a pathologist's interpretation.
Sex Changes	Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
Sleep Disorders	Care and treatment for sleep disorders unless deemed Medically Necessary.
Smoking Cessation Aids or Treatment	Programs, aids and treatment for the purpose of smoking cessation unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.
Sterilization Reversal	Care and treatment for reversal of surgical sterilization.
Telephone Consultations	Charges for consultation or advice from a covered Physician when rendered over the phone or by other electronic means.
Travel	Charges for travel or accommodations whether or not recommended by a Physician, except as described in the Organ and/or Tissue Transplants section of this booklet, or for Medically Necessary ground or air ambulance.
Ultrasound	Ultrasound procedures for maternity are not covered unless Medical Necessity has been demonstrated.
War	Any loss that is due to a declared or undeclared act of war.
Weight Control	Services provided for the purpose of weight control such as: surgery, services, supplies or medication to control food intake, HCG/ vitamin injections, biofeedback, hospital confinement for weight reduction, exercise programs, behavior modification therapy, group therapy, nutritional counseling, wiring of teeth, dietary food items.
Work Related	Care and treatment resulting from an Injury or Illness that is occupational -- that is, arises

from work for wage or profit including self-employment, is not covered. Any injury occurring while participating in, or attending any Boys & Girls Club event, activity or function regardless of where the Injury is sustained will be considered work related. You cannot choose between coverage under this Plan or coverage by a Worker's Compensation plan. Even if there is no Worker's Compensation coverage, this Plan will not cover expenses for any work related Illness or Injury.

UTILIZATION REVIEW / PRE-CERTIFICATION REQUIREMENTS

The Utilization Review Program will benefit you and your family by making sure appropriate medical care is rendered in the event of hospitalization or surgery. When your Physician recommends that you or your Dependent must be hospitalized, recommends a Surgical Procedure, or recommends treatment of a chronic condition with injectable medication, you or your Physician must telephone the Utilization Review Coordinator. The Utilization Review Coordinator is Hines and Associates and they can be reached at the following telephone number: **Hines and Associates – (800) 944-9401**

You are responsible for obtaining Utilization Review. You may ask your Physician or Hospital staff to obtain certification for you. However, it is your responsibility to make certain it is obtained.

Pre-Certification Required for Hospital Admission	All Hospital Admissions, with the exception of maternity admissions of less than 48 hours for a vaginal delivery or 96 hours if a cesarean section, must be pre-certified. If there is an Emergency admission to the Hospital, the patient, a family member, the Hospital, or a Physician must call on the first business day after the admission. The Utilization Review Coordinator will approve the number of days of Inpatient confinement being recommended by your Physician. If your Physician feels that it is Medically Necessary for you to stay in the Hospital for a greater length of time than has been approved, the Physician must call the Utilization Review Coordinator and have the additional days approved. You, your Physician, and the Hospital will receive written notification of the number of days that have been approved. It is always you and your Physician's decision to stay in or leave the Hospital; the approval is an approval for the purpose of insurance coverage only. Should you stay beyond the number of approved days, you will not be guaranteed the benefits of this Plan for any additional days spent in the Hospital and may incur a penalty.
Pre-Certification Required For Surgery	All surgeries involving anesthesia, the use of an operating room or surgical facility, and a recovery room must be pre-certified with the exception of a surgery that is due to an Emergency. It is always you and your Physician's decision to have a Surgical Procedure; Pre-certification provides approval for the purpose of insurance coverage only. Should you have surgery without first receiving Pre-certification, you will not be guaranteed the benefits of this Plan and may incur a penalty.
Pre-Certification Required For Specialty Drugs	Injectable or oral Specialty Drugs used to treat many chronic conditions can be purchased through this Plan's SpecialtyRX Program only and they must be pre-certified. Pre-certification guarantees that your care Provider understands and follows the terms of this policy to ensure that you receive the maximum benefits the Plan offers. If you fail to obtain Pre-certification you may incur a penalty.
Pre-Certification Required For Organ/ Tissue Transplant	Refer to "Organ And/Or Tissue Transplant" section of this book for specific instructions on this requirement.
Pre-Certification Required For Treatment of Autism Spectrum Disorder	In order to be covered, services must be ordered by the physician who is treating the child and has diagnosed him/ her with autism, and must be pre-authorized by Hines and Associates. Authorization will be on a case-by-case basis, will be based on the plan's written criteria, and will apply to treatment plans of up to six months in duration. The dependent's parents (or other guardian), physician, or certified provider will have to obtain a pre-authorization for each new treatment period of up to six months. The plan reserves the right to have appropriate medical professionals review the treatment at any time to determine if it meets the eligibility criteria for coverage under the plan.

The following is the process for pre-authorization and continuing authorization of Autism benefit services under this plan:

1. The dependent's physician who is treating the dependent diagnoses the child with an Autism Spectrum Disorder (Autistic Disorder, Pervasive Developmental Disorder, Asperger's Disorder) and refers the patient to a certified provider.
2. An evaluation is performed by the certified provider to determine if the child is a candidate for an ABA and/or related structured behavioral program. If the child is determined to be a candidate by the evaluating certified provider, the certified provider would recommend a treatment plan including type and frequency of services. The certified provider must send the treatment plan to Hines and Associates. The evaluating provider or family of the autistic child must call Hines and Associates and request pre-authorization for treatment. If authorization is extended, it will be extended in six-month intervals.
3. Every six months, the certified provider who is overseeing the treatment must submit a progress report to Hines and Associates. The certified provider must follow supervisory guidelines outlined in the certification criteria for providers to determine that the services being provided by those under his or her supervision are in accordance with the treatment plan. If any substantial change in the frequency or type of program is necessary, pre-authorization must be requested from Hines to revise the treatment plan.

It is important that these pre-authorization and continuing authorization steps are followed to ensure coverage. **Failure to meet these requirements will result in non-payment of benefit**.

Penalty for Non-Compliance

Benefit payment will be reduced by $500 if a hospital confinement (other than for the delivery of a newborn), or a surgical procedure, or the purchase of Specialty Drugs as described above is not pre-certified. This penalty applies regardless if the service is retroactively found to be Medically Necessary. The $500 penalty will also apply if the Hospital Confinement days exceed the number of days pre-certified. If a non-approved service is found to be not Medically Necessary, no benefits are payable. This $500 penalty will not be applied toward your Deductible or Out-of-Pocket Maximum.

Case Management

When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps life-long care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting--even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses, and recommends coordinated and/or alternative types of care. The case manager obtains agreement between the patient, the attending Physician and the Claims Administrator on a plan of care that will be covered by this plan. This plan of care may include some or all of the following:

- Personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options;
- assisting in obtaining any necessary equipment and services.

Once an agreement has been reached, the Claims Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the plan.

Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment Plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Not only large, long-term, catastrophic cases can benefit from professional assistance of case managers. The case managers may be able to assist a patient in obtaining a discount on the price of durable medical equipment, or arrange a home health RN visits for a few days after surgery. You are invited to call CTI Administrators to request assistance in these matters.

Pregnancy Assistance Program

This is a voluntary program in which the expectant mother may request assistance from the Utilization Review Coordinator during the first trimester of pregnancy. Upon confirmation of pregnancy, call Hines and Associates at (800) 944-9401. The Utilization Review Coordinator will discuss with the expectant mother her medical history and lifestyle factors. The Utilization Review Coordinators for this program are nurses who will provide information on how to recognize potential problems while stressing the importance of maintaining a healthy life-style. If a high-risk pregnancy is identified, the Utilization Review Coordinator will follow the course of the pregnancy and work with the Attending Physician to determine a treatment plan. This program is not meant to replace the medical care of a Physician but to give added support, services, and information.

CLAIM FILING AND APPEAL PROCEDURES

Pre-Service Benefit Determination

In advance of receiving a medical service or purchasing a medical supply or prescription drug, you can inquire about what this Plan will pay. This booklet is intended to provide you with detailed information about what is covered by this Plan, but if you have additional questions about this plan's benefits you should ask them before you receive services. You can call the Claims Administrator at (800) 245-8813 to discuss benefits, but information given over the phone will not bind benefit determination at the time an actual claim is filed.

In order for benefits to be determined before a service is rendered, the request should be submitted in writing and addressed as follows:

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

Such request must provide complete information from which to determine the benefits. If a request for benefits determination is complete, a written confirmation of the benefits the Plan will pay when the stated service is performed will be mailed to you within 15 days of the date it is received by the Claims Administrator.

If the Claims Administrator determines that more information is required, such information will be requested from you or the Provider of service in writing within 15 days of the date the request for pre-service benefit determination is received. You will have 45 days to provide the additional information necessary to complete the pre-service benefit determination. Once the requested information is received and the request is complete, a pre-service benefit determination will be mailed to you within 15 days.

How to File a Claim For a Completed Service or Purchased Supply

The instructions for how to file a claim can be found on the internet at www.BGCWA.com and are printed on the back of your medical identification card. Medical care Providers usually will require you to present them with your card at the time of medical service. You should make certain that the Provider correctly follows the procedures for submitting a claim for payment; if the procedures are not followed, there may be an unnecessary delay in the processing of the claim. Medical Providers normally will submit a claim on your behalf. However, if you need to submit a claim, simply follow the instructions you find on the above referenced website or on the back of your medical identification card. If, for some reason you do not have your card, call CTI Administrators at (800) 245-8813 and you will be instructed on how to submit your claim.

Timely Claims Filing Requirement

Claims should be filed with the Claims 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.

Notification of Benefit Determination on Initial Claims

For any medical service or supply that has been performed or purchased, if the information provided with the claim is complete and sufficient to allow the Claims Administrator to determine benefits, an explanation of benefit determination will be mailed to you and the Provider of medical care (if the benefits are assigned to him/ her) within 30 days of the date the claim is received.

If the Claims 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.

Written Notice of Partial or Full Claim Denial

If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant 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 Plan Participant wishes to submit the claim for review.

Claims Appeal Procedure

In cases where the determination of benefits made by the Claims Administrator results in a full or partial denial of benefits, you may appeal the denial. You can appeal the benefits determined on any claim if you do not feel they were calculated correctly. 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.

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.

COORDINATION OF BENEFITS

Coordination of Benefits defines the method and order of payment when a person is covered by this Plan and one or more other group insurance plan, including HMO plans or Medicare.

Method of Payment When there is Coverage by More than One plan

When a person is covered by this Plan and one or more other group plan, an HMO, or Medicare at the time of service, the plans will coordinate their benefit payments. The Plan that pays first is called the primary Plan and it will pay as if there was no other Plan involved. The Plan that pays next is the secondary plan; it and all other plans will pay the balance due up to 100% of the total Allowable Expenses.

Allowable Expense When This Plan is Secondary

The Allowable Expense for any service performed is the amount charged, if covered in part or in full by this plan, limited to the Usual, Customary and Reasonable (UCR) allowance for that service. To determine if the charge is over the UCR allowance, the highest UCR allowance of the plans will be used. If the primary Plan is an HMO (Health Maintenance Organization) plan, the Allowable Expense will be limited to the amount the HMO Provider has agreed to accept as payment in full. If the primary Plan uses a Network and the charge is from a Network Provider, the Allowable Expense will be the discounted amount agreed to by that Provider. If the Provider participates in this plan's Network, the Allowable Expense will be the lowest discounted amount agreed to by that Provider.

Payment Calculation When This Plan Is Secondary

When determining the benefit payable as the secondary plan, this Plan will calculate its normal claim payment (if there was no other insurance involved), including Deductible, Coinsurance and available payment. Any amount that would have accumulated to the Out-of-Pocket Maximum had this Plan been primary still will be accumulated to the Out-of-Pocket Maximum. The payment amount will be reduced so that the payments of all the insurance plans will not exceed the Allowable Expense. In no event will this Plan issue a payment for more than it would have paid if it had been the primary plan.

Plan Payment Order

When two or more plans are responsible for the same Allowable Expense, the determination of the order in which the involved plans will pay will follow these rules:

- Plans that do not have a Coordination of Benefits provision will pay first.
- The Plan that covers a person as an active Employee will pay before the plan, which covers the person as a Dependent.
- The Plan that covers a person as an active Employee or Dependent of an active Employee will pay before the Plan that covers that person as a laid-off or retired Employee or Dependent thereof.
- The Plan that covers a person as an active Employee or Dependent of an active Employee will pay before the Plan that covers the person as a COBRA beneficiary.
- In the event that a person is covered as an active employee on more than one plan, the Plan that was in effect first, will pay before the other plan.
- The Plan that covers a person on an Extension of Benefits provision for a disabling condition will pay before the Plan that covers that person as an active Employee or a Dependent thereof.
- When a Child is covered as a Dependent by the plans of both natural parents and the parents are not separated or divorced, the Plan of the parent whose birthday falls earlier in a year will pay before the Plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the Plan that has covered the Dependent for the longer amount of time will pay before the other parent's plan.

Plan Payment Order (Continued)

- When a Child is covered as a Dependent by the plans of both natural parents and the parents are divorced or legally separated, the Plan payment order will be determined as follows:
  - If a court decree exists and states which parent is financially responsible for paying or providing coverage for the Child's medical expenses, the Plan of that parent will pay first; the Plan of that person's Spouse (if there has been a remarriage) will pay next; the Plan of the parent not named in the divorce decree then will be considered; followed by the Plan of the Spouse of that parent (if there has been a remarriage); or
  - If no divorce decree stipulation exists, the Plan of the parent with custody will pay first; the Plan of the stepparent (if there has been a remarriage) with custody will pay next; and the Plan of the parent without custody will be considered third, followed by the Plan of the stepparent without custody (if there has been a remarriage); or
  - If the parents share joint custody and no divorce decree stipulation exists, the Plan payment order will be the same as for a Child whose parents are not separated or divorced (refer to 5. above);
  - If these rules cannot be made to apply, the plan, which has covered the Dependent for the longer time, will pay first.
- This Plan will be primary to Medicare for active Employees age 65 and older and their covered Dependents age 65 and older unless Medicare is selected as the primary plan, in which case this Plan will not pay as secondary to Medicare.
- Medicare will pay before this Plan for a Retired Employee and the Spouse of that Retired Employee if the Employee has elected the Retiree plan.

Right to Receive or Release Necessary Information

To make this provision work, this Plan may give or obtain needed information from another insurer, employer, or other person. This information may be given or obtained without the consent of or notice to any other person.

Requirement to Notify of Other Insurance Coverage

Any person covered by this Plan must notify the Claims Administrator about any other medical insurance coverage and/or payment of medical expenses by any insurance plan.

RIGHT TO THIRD PARTY RECOVERY

Plan's Right to Recover From or Subrogate Against Third Party Payer Proceeds

You or your Dependents may incur medical charges due to Illness or Injuries caused by the act or omission of a third party, or for which a third party may be responsible for payment. If you file a claim to this Plan for payment of those expenses, the Plan then has a property right in any settlement proceeds that you, your family member or a representative for you receives. If this Plan pays for expenses related to an Illness or Injury for which a third party is or may be determined to be liable, the Plan is extending benefits contingent upon and in reliance that you and your attorney agree that the Plan has an equitable lien on the proceeds of any settlement whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan agrees that it is repaid in full.

The Plan may make a claim directly against the third party or insurer. This is called subrogation.

If you accept benefits paid by this Plan for medical expenses and then receive proceeds from any other source, you and your attorney automatically agree to refund the Plan from those proceeds.

This right to third party recovery or subrogation applies if you recover money under an

uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, Worker's Compensation Plan or any other liability plan.

Amount Subject to Recovery or Subrogation

As the Participant, you agree to recognize the plan's Right To Third Party Recovery. These rights provide the Plan with a priority over any funds paid by a third party to you relative to the Injury or Illness, including a priority over any claim for non-medical charges, attorney fees, or other costs and expenses.

Notwithstanding its priority access to funds, the plan's subrogation and rights of recovery are limited to the extent to which the Plan has made, or will make, payments for medical charges, as well as any costs and fees associated with the enforcement of these rights.

When a right of recovery exists, you will need to execute and deliver all required instruments and papers, as well as doing whatever else is needed to secure the plan's right of subrogation, as a condition to having the Plan make payments. In addition, you will do nothing to prejudice the right of the Plan to subrogate.

Defined Terms

"Recovery" means monies paid to the Participant by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries or Illness whether or not said losses reflect medical charges covered by the plan.

"Subrogation" means the plan's right to pursue the Participant's claims for medical charges against the other party.

"Refund" means repayment to the Plan for medical benefits that it has paid for care and treatment of the Injury or Illness.

DEFINITIONS

We, Our, Us

The Boys & Girls Club Workers Association.

Accident

An unexpected and unintentional occurrence.

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.

Alcoholism

A chronic disease characterized by the use of alcohol to the extent that it interferes with the Participant's health, social, family or economic functioning.

Ambulatory Outpatient Surgical Facility

Any public or private establishment with an organized medical staff of Physicians with permanent facilities equipped and operated primarily for the purpose of performing Outpatient Surgical Procedures. The facility must have continuous Physician and registered professional nursing services available while a patient is in the facility and does not provide overnight accommodations.

Annual Restoration Amount

The amount by which the Lifetime Benefit Maximum will be restored unless the Plan paid less than that amount, in which case restoration will be the amount paid by the plan.

Birthing Center

A licensed freestanding facility that:

- is equipped and provides prenatal care, labor, delivery, and immediate postpartum care of a Child born at the facility;
- has a Physician or certified nurse midwife present at all births and during the immediate postpartum period;
- provides full-time nursing services directed by a Registered Nurse or certified nurse midwife;
- keeps medical records on each patient;
- is directed by at least one Physician who is a specialist in obstetrics and gynecology;

- extends staff privileges to Physicians who practice obstetrics and gynecology in an area Hospital;
- accepts only patients with low-risk pregnancies;
- has at least two (2) beds or two (2) birthing rooms for use by patients while in labor and during delivery; and
- has a written agreement with a Hospital in the area for Emergency transfers of a patient or Child.

The following are not considered a Birthing Center:

- a Physician's office;
- the patient's home;
- a private residence; or
- a facility, the primary purpose of which is to perform abortions.

Brand Name Drug Pharmaceutical products manufactured and sold under the name assigned by the developer/manufacturer.

Calendar Year The period of twelve (12) consecutive months commencing at 12:00 a.m. on January 1 and ending at 11:59 p.m. on December 31.

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 For children under the age of 19, a child must be primarily dependent upon the covered employee for support and maintenance and living in the same household as the employee and have one of the below listed relationships to the covered employee. For an adult dependent age 19 or over, the definition is a person who is not eligible for his/her own medical insurance through his/her own employer and who has one of the following relationships to the covered employee:

- 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;
- Grandchildren who live with the employee and are primarily dependent upon employee;
- Children required to be covered under the terms of a Qualified Medical Child
- Support Order.

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.

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.

Chronic Pain A pain which has a physical cause, is not subject to any underlying psychosis or severe neurosis, has been non-responsive to usual methods of pain management; and has caused a significant loss of ability to function independently.

Claims Administrator CTI Administrators, Inc. who has been contracted by the Plan Administrator to perform certain administrative duties of the plan.

Coinsurance The share of a Covered Expense that is paid by the Plan as specified in the Schedule of Benefits section of this booklet. The remainder is paid by the Participant.

Co-Payment That portion of a Covered Expense that is paid by the Participant as specified in the Schedule of Benefits.

Coordination of Benefits (COB) Following certain rules as explained in the section titled "Coordination of Benefits" in order to pay all available benefits when there is more than one health Plan or insurance carrier for an individual.

Cosmetic Surgery A Surgical Procedure performed to improve the texture or appearance of the skin or to improve or alter the relative size or position of any part of the body when that surgery is not Medically Necessary to correct or improve bodily functions.

Custodial Care Care designed to help a person in the activities of daily living, and may involve:

- Preparation of special diets;
- supervision over medication that can be self-administered; and
- assisting the person in getting in or out of bed; to walk; to bathe; to dress; to eat; and to use the toilet.

Continuous attention by trained medical or paramedical personnel is not necessary.

Deductible Expenses incurred for Covered Charges that a Participant must pay before receiving any benefits under this Plan (unless specifically designated otherwise).

Dependent Legally married Spouse of an employee and/or eligible natural or adopted Child.

Drug Addiction A condition caused by excessive or continued use of habit-forming drugs or substances. This does not include the use of tobacco or caffeine products.

Durable Medical Equipment Covered medical equipment designed for repeated use. It must be primarily and customarily used to serve a medical purpose, therefore, not being useful to a person in the absence of an Illness or Injury. This includes but is not limited to artificial limbs, eyes and other prosthetic devices, casts, splints, trusses, crutches, oxygen and rental of equipment for the administration of oxygen, wheelchairs and hospital beds.

Effective Date The day an individual becomes a Participant provided he or she is Actively at Work on that day.

Eligible Employee A person who:

- is an employee of a Participating Club, who is regularly scheduled to work and working at least 30 hours per week on a consistent basis, and
- has satisfied the Waiting Period selected by the Club.

Part-time employees who work less than 30 hours per week and temporary or seasonal employees are not eligible to enroll for this plan.

Eligible Expense Any Usual, Customary, and Reasonable Charge for any service or supply which is necessary for the medical care of the patient's Illness or Injury, which is ordered by a Physician, and which is commonly and customarily recognized as appropriate in the treatment of the patient's diagnosed Illness or Injury. The service or supply cannot be educational or Experimental in nature, or provided primarily for the purpose of medical or other research. In the case of a Hospital Confinement, the length of stay and Hospital services and supplies will be considered reasonably necessary only to the extent they are determined to be related to the treatment of the condition involved and not for scholastic education or vocational training of the patient. The service cannot be of a general nature

that is not rendered to a specific person covered under this plan.

Eligible Person

See the definition of "Eligible Employee" above. A Dependent of an employee is eligible if the employee is eligible through a Participating Club and the necessary requirements to participate in this plan as a Dependent have been met.

Emergency

In the case of an accident, care or transport received within 48 hours of an accidental injury; in the case of illness, a condition that could result in one of the following in the absence of immediate medical treatment:

- Placing the health of the patient in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

Experimental/ Investigational

A drug, device, appliance or medical treatment or procedure is Experimental or Investigational if:

- The drug or device cannot be lawfully marketed without approval of the US Food and Drug Administration and has not received full approval as proven effective treatment or reliable diagnostic tool at the time the drug or device is furnished; or
- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy as compared with the standard means of treatment or diagnosis.

Generic Drug

Pharmaceutical products manufactured and sold under their common chemical or official name. The generic equivalent of a Brand Name Drug must meet the same standards for safety, purity, strength and effectiveness as the Brand Name Drug. Both have the identical chemical composition and therapeutic effect.

Handicapped Dependent Child(ren)

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.

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:

- 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.

'Severe Disability' means substantial functional limitations in three or more of the following areas of major life activities:

- self care;
- receptive and expressive language;
- learning;
- mobility;
- self direction;
- capacity for independent living

Home Health Care

A Home Health Care agency is a public or private agency or organization, or a division thereof, primarily engaged in providing skilled nursing and other therapeutic services. In cases where State or local law provides for the licensing of agencies or organizations of this nature, the agency must be licensed or approved by State or local law as meeting the standards established for such licensing. A Home Health Care agency does not include an agency that is engaged primarily in the care and treatment of mental Illness.

Hospice Care Agency
An organization which meets all of the following criteria:

- Has twenty-four (24) hour Hospice Care available;
- is licensed and certified in accordance with the State in which the service is provided;
- provides skilled nursing services, medical social services, psychological and dietary counseling;
- provides Physician services, Physical Therapy, part-time Home Health aide services and Inpatient care;
- keeps medical records; and
- has a full-time administrator.

Hospital
An institution which:

- Is licensed and operated in accordance with the State in which the service is provided;
- provides diagnostic and therapeutic facilities for surgical and medical diagnosis;
- provides treatment and care of Injured and Ill persons by or under the supervision of a staff of Physicians who are duly licensed to practice medicine;
- continuously provides twenty-four (24) hour a day nursing service by registered graduate nurses;
- is not, other than incidentally, a sanitarium, nursing home, place for rest, place for the aged, or a facility primarily providing custodial educational or rehabilitative care;
- an institution which is an Ambulatory/Outpatient Surgical Facility, as defined in and licensed by the State in which the service is provided;
- a psychiatric Hospital which is an institution legally constituted and licensed as a psychiatric Hospital and properly accredited to provide psychiatric, diagnostic and therapeutic services for treatment of patients who have mental Illnesses; or facilities properly licensed for the care and treatment of Drug Addiction and Alcoholism.

Hospital Confinement
Being registered as a bed patient in a Hospital or a Skilled Nursing/Extended Care Facility upon the recommendation of a Physician.

Illness
A disease process or other health condition causing a Participant’s departure from good health. For the purpose of coverage under this plan, this includes pregnancy.

Incidental Procedure
A secondary surgical procedure that is an integral part of the primary surgical procedure, and is unrelated to the diagnosis, and would not have been performed in the absence of the primary surgical procedure.

Injury
Damage due to external trauma to some part of the Participant’s body.

Inpatient
A patient who has been admitted upon order of a Physician as a bed patient for treatment in a Hospital and incurs expense for room and board.

Intensive Care Unit
A section within a Hospital exclusively for critically ill patients. It must provide special supplies, equipment, and constant observation and care by Registered Nurses or other highly trained hospital personnel. It does not include any Hospital facility for the purpose of providing normal post-operative recovery treatment or service.

Legend Drug
A brand name or Generic Drug that cannot legally be obtained without a Physician’s written prescription.

Licensed Pain Management Center
A program or facility that has been accredited by the Commission of Accreditation for Rehabilitation Facilities to provide treatment for chronic pain.

Lifetime Benefit
The amount of Covered Expenses paid by this Plan for any Participant during his/her lifetime (including prescription drugs).

Maximum

Limited Hours Employee — An employee age 55 or over scheduled to work for a chartered Boys & Girls Club or 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.

Major Surgery — Any one surgical procedure that is not Incidental and for which the charge exceeds $1,000.

Medically Necessary — Treatment, care or services that are consistent with the diagnosis, comply with acceptable medical standards, are not primarily for the Participant's convenience and are the most appropriate level of service which can be safely provided. When applied to Hospital Inpatient care, it means that care cannot be safely provided on an Outpatient basis.

Medicare — The program of medical care benefits provided under the Title XVIII of the Social Security Act of 1965, as amended.

Mental or Nervous Condition — Any disorder classified in the Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV-R), or classified as Mental Disorders in the International Classification of Diseases.

Network/ Non-Network Providers — Network Providers are all Providers in your Primary Network which is designated by the logo on the top right hand corner of your Medical identification card. Any Provider not in your designated Primary Network is a Non-Network Provider.

Out-of-Pocket Maximum — The cost-sharing amounts for which the Participant is responsible annually, including Calendar Year Deductibles and percentage of Covered Expense not paid by the Plan (except for Behavioral Health Care). Co-Payments and Penalties for Prescription Drug do not accumulate to the Out-of-Pocket Maximum.

Outpatient — A Participant who receives treatment at a hospital, clinic, emergency treatment center, or ambulatory surgical center but who is not confined to continuous 24-hour hospitalized care.

Partial Hospitalization — A program that provides less than 24-hour care for Mental Health or Drug Addiction patients in transition from full-time Inpatient care to Outpatient care and a return to the community. Partial Hospitalization days are considered to be Inpatient days according to this plan.

Participant — The employee of a Participating Club and any of his/her Dependents covered under this plan. Participant also means and includes those former Employees and their Dependents who qualify for and have elected continuation of coverage under COBRA.

Participating Club — Chartered Boys & Girls Clubs that have agreed to participate in the Plan according to the participation requirements established by the Boys & Girls Club Workers Association.

Physician — A licensed practitioner of the healing arts when practicing within the scope and/or limitation of his/her license and while providing services covered under this plan, as follows:

- Doctor of Medicine (MD)
- Doctor of Dental Surgery (DDS)
- Doctor of Optometry (OD)
- Physician Assistant (PA)
- Psychologist
- Nurse Practitioner
- Doctor of Osteopathy (DO)
- Doctor of Chiropractic (DC)
- Licensed Clinical Social Worker
- Certified Nurse Midwife
- Mental Health Counselor

Plan — This Plan of Benefits.

Plan Administrator — The Boys and Girls Club Workers Association.

Preferred Provider Organization (Network) — A Network of health care professionals and facilities that have agreed to provide services to Participants at costs which are lower than those that would apply in the absence of such an arrangement. Providers may be added or deleted from the Network at any time.

Pre-certification — The process of obtaining approval for certain Hospital Confinements, certain surgeries including organ or tissue transplants, and injectable or oral Specialty Drugs. This approval is required in order to receive maximum benefits.

Pre-existing Condition — Any condition medically diagnosed, treated, advised upon or consulted on with a Physician in the six (6) months immediately prior to your effective date with this plan.

Prescription Drugs — Medicines prescribed by a Physician and dispensed by a licensed pharmacist necessary to treat an Injury or Illness. (Also see Specialty Drugs)

Procurement — Services associated with obtaining an organ from a donor, including, but not limited to, surgical removal of the organ from the donor, pathology and radiology services and services necessary to preserve the viability of the organ to be transplanted and transporting the organ from within the United States and Canada to the place where the transplant is to take place.

Provider — The name given to any professional or institution that delivers medical treatment, services or supplies.

Radiation Therapy — The use of ionizing radiation in the treatment of cancer. This may include:

- X-ray therapy; or
- Radium therapy; or
- Radioactive isotopes.

Skilled Nursing Facility — A facility which:

- Holds a license as a skilled nursing home (if required in the State);
- operates primarily for the skilled nursing care and rehabilitation of ill or injured persons as Inpatients;
- has a written agreement with a Hospital to accept patients who no longer require Hospital treatment but require continued skilled nursing care;
- gives around the clock nursing service under the direction of a full-time registered nurse;
- has a Physician on call at all times; and is not, other than incidentally, a place for alcoholics, drug addicts or the mentally ill.

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.

Specialty Drugs — Specialty, or biotech, drugs refer to medications made from living sources (e.g. micro-organisms, blood cells, proteins), as opposed to traditional drug therapies, which are synthetic. Specialty drugs are often administered by injection by either the patient or the physician. Because biotech drugs are similar to substances found in the human body, they are more effective in fighting hard-to-treat conditions, such as multiple sclerosis, rheumatoid arthritis and growth hormone deficiency.

Speech Therapy — The treatment of defects and disorder of the voice and of spoken communication.

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, electrocauterization, tapping (paracentesis), endoscopy, the injection of sclerosing solutions, obstetrical procedures, and elective sterilization

Temporomandibular Joint Disorder A disorder, which affects the joint between the temporal bone in the skull (temple area) and the mandible (lower jawbone).

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.

Transplant Benefit Period The period of time beginning on the date of the initial evaluation and ending on the date twelve (12) consecutive months following the date of the organ or tissue transplant. For bone marrow transplant, the date the marrow is re-infused is the date of the transplant.

Usual, Customary and Reasonable (UCR) Allowance The allowable fee for services charged by Physicians which are:

- Usual--The most consistent fee charged for a given service.
- Customary--A fee within range of usual charges for a given service by most Physicians in a specific locale, all of whom have similar training and experience.
- Reasonable--A fee which meets the Usual and Customary criteria or which merits special consideration by a medical review committee, based on the severity and complexity of treatment of a particular case.

Utilization Review The process of reviewing the appropriateness and the quality of care provided to patients before, during or after the services are rendered.

Visit Each attendance of a Physician or medical practitioner, including a Registered Nurse, to the Participant regardless of the type of professional services rendered during such attendance, whether it be termed a consultation, treatment, or given some other name. Such attendance must be on a person-to-person basis, not by telephone or any electronic medium (such as the internet).

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 Participants 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 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 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, B&GCWA Insurance Trust may share the personal information as described above with a company affiliated with B&GCWA Insurance Trust. Also, B&GCWA 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 B&GCWA 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 B&GCWA 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:

Privacy Officer
c/o CTI Administrators
100 Court Ave. STE 306
Des Moines, IA 50309-2295

GENERAL PLAN INFORMATION

Plan Name	Boys & Girls Club Workers Association Medical Plan
Type of Plan	The Plan is a group health 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 Claims Administrator.
Plan Number	Medical Plan 503
Tax ID Number	13-6176007
Plan Effective Date	January 1, 1998
Plan Year Ends	December 31st
Employer Information	Participating Clubs of the Boys & Girls Club Workers Association c/o Boys and Girls Club Workers Association 1275 West Peachtree Street Atlanta, GA 30309
Plan Administrator	Boys and Girls Club Workers Association c/o Board Secretary Boys & Girls Clubs of America National Headquarters 1275 West Peachtree Street 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 West Peachtree Street 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 West Peachtree Street Atlanta, GA 30309
Claim Administrator	CTI Administrators, Inc. 100 Court Avenue Suite 306 Des Moines, IA 50309-2295 (800) 245-8813 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.
If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination.

Amending and Terminating the Plan

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.

BY THIS AGREEMENT, The Boys & Girls Club Workers Association Medical Plan B is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for The Boys & Girls Club Workers Association on or as of the day and year first written below.

Boys & Girls Club Workers Association

By ____

Chairperson

Date __________________