2016 benefits handbook
HYPERLINKS IN THIS DOCUMENT

There are two kinds of links in this online document:

- An external hyperlink will open a targeted page on the Internet. Each shows the target URL (example: www.myuhc.com).
- An internal link will take you to a referenced section or to a definition in the Glossary. Each of these will be a single word or a phrase that is underscored (examples: “see the Medical Expenses Covered section”; “beneficiary”).

In each case, use your back button to return to the page where you started.

If you are using a printed copy of this document, the underscored word or phrase may be an indication that the Glossary will provide more information.

This handbook is available online at http://bsabenefits.mercerhrs.com.
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Plans
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Our medical plans are self-funded and administered by UnitedHealthcare. A self-funded plan means just that: we fund the plan ourselves. The premiums you and your employer pay for those benefit plans are placed into a BSA account specifically for each plan. Claims and a small amount of administrative cost are then paid from that account.

Types of Plans

The BSA Medical Plan offers a choice between the Traditional PPO Plan and the High Deductible Health Plan with Health Savings Account. These plans use one of two networks, Choice Plus or Options PPO, which will be assigned to you based on your home zip code. The network name is shown in front of the medical plan name in the summaries below. If your home address changes, contact the BSA Benefits Center at 800-444-4416 to determine if your network will change.

- **The Choice Plus Traditional PPO Plan, page 45.** In addition to a deductible, this plan has copays and coinsurance. Benefits are provided for services from an in-network or out-of-network physician, specialist, or facility, except for preventive care services, which must be received in-network. Out-of-network benefits are subject to a percentage of eligible, reasonable, and customary charges.

- **The Choice Plus High Deductible Health Plan With Health Savings Account, page 45.** This plan has a higher deductible that must be met before the plan pays 100 percent of covered charges. Benefits are provided for services from an in-network or out-of-network physician, specialist, or facility, except for preventive care services, which must be received in-network. Out-of-network benefits are subject to coinsurance after the deductible is met and subject to a percentage of eligible, reasonable, and customary charges.

- **The Options PPO Traditional PPO Plan, page 69.** In addition to a deductible, this plan has copays and coinsurance. This plan covers individuals, including those living outside the United States, who have limited or no access to in-network physicians, specialists, or facilities. Benefits are provided when an in-network or out-of-network physician, specialist, or facility is used. Out-of-network benefits are subject to coinsurance after the deductible is met and subject to a percentage of eligible, reasonable, and customary charges.

- **The Options PPO High Deductible Health Plan With Health Savings Account, page 69.** This plan has a higher deductible that must be met before the plan pays 100 percent of covered charges. This plan covers individuals, including those living outside the United States, who have limited or no access to in-network physicians, specialists, or facilities. Benefits are provided when an in-network or out-of-network physician, specialist, or facility is used. Out-of-network benefits are subject to coinsurance after the deductible is met and subject to a percentage of eligible, reasonable, and customary charges.

- **The Medicare Supplement Plan, page 109.** This plan provides supplemental benefit for individuals who are under age 65, enrolled in Medicare Parts A and B and not in a Medicare prescription drug plan or other Medicare supplement plan.

Health Savings Account

An HSA is a tax-advantaged bank account that can be used to pay for qualified health expenses incurred by you or your eligible dependents. An HSA is available only to those participating in a medical plan that is qualified by the Internal Revenue Service (IRS) as a high-deductible plan and is not covered by another health plan or Medicare. Because the Traditional PPO plan is not qualified as a high-deductible medical plan, participants in this plan may not open or contribute to an HSA.

For detailed information, refer to the Health Savings Accounts section, page 91.

Choosing a Medical Plan

When choosing a plan, it may be helpful to use the plan comparison tool to estimate your family’s healthcare costs under each medical plan that is offered.

Go to [www.pcestimator.com](http://www.pcestimator.com) and use the login BoyScouts2015 and password “Benefits2015” to access the site. The tool already has information about the BSA medical plans, but it will need some information about you and your dependents.

Once you have entered the required information, you will see a comparison of the estimated out-of-pocket costs for the year under each plan. You can also use the Health Savings Account Calculator to determine how much you should contribute each month to an HSA and what your tax savings could be, based on your contribution amount.
Eligibility

FOR EMPLOYEES

If you were hired or rehired on or before May 31, 2004, and are in a regular position scheduled to work 21 hours or more per week year-round with the BSA or a local council, you and your eligible dependents are eligible to enroll.

If you were hired or rehired on or after June 1, 2004, and are in a regular position scheduled to work 30 hours or more per week year-round with the BSA or a local council, you and your eligible dependents are eligible to enroll.

If you were hired or rehired in any position scheduled to work less than 30 hours per week year-round, you are eligible to enroll under the following circumstances:

- You were hired or rehired on or before Nov. 1, 2014, and you actually worked 30 or more hours per week on average in the 12-month period from Nov. 1, 2014, through Oct. 31, 2015. In this event, you are eligible Jan. 1, 2016. Your eligibility continues for the next 12 calendar months and will end Dec. 31, 2016, unless you have continued to work an average of 30 or more hours per week.

- You were hired or rehired after Nov. 1, 2014, and you actually worked 30 or more hours per week on average in the 12 calendar months following the month you were hired. In this event, you are eligible the first day of the calendar month following 13 full months of employment. Your eligibility continues for the next 12 calendar months and will end unless you have continued to work an average of 30 or more hours per week.

Enrollment must be completed within 30 days from the date of your initial eligibility. Coverage will then be effective from the date of your initial eligibility. If you and/or your eligible dependents do not enroll within 30 days from the date of eligibility, your next enrollment opportunity will occur during the next annual enrollment period or if a special enrollment period applies. Refer to the Special Enrollment Periods and Annual Enrollment Period sections on pages 7 and 6, respectively.

FOR DEPENDENTS

Eligible dependents include:

- Your spouse. (If your spouse is a BSA or local council employee, he or she must be enrolled as an employee, not as a dependent.)
- For the purposes of the plan, “spouse” is the person to whom you are legally married and does not include a person who is a husband or a wife by reason of a common-law marriage.
- Your children (and stepchildren) from birth up to the last day of the month in which they turn age 26, including:
  - Your children related by blood or marriage
  - Children you have legally adopted (including a child for whom legal adoption proceedings have been started)
  - Children of whom you have legal custody
  - Children for whom you are required to provide coverage as part of a divorce decree, if otherwise eligible

Eligible dependents do not include: a BSA or local council employee or retiree, or a person receiving BSA Long-Term Disability benefits.

Beginning Jan. 1, 2009, you will need to provide Social Security numbers for all your dependents during enrollment if you wish to enroll them in your medical coverage. Under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), plan sponsors of group health plans are required to gather and maintain Social Security numbers for all covered members and provide them to Medicare. The BSA is covered under this requirement because it is a sponsor of a group health plan.

If you are required by a Qualified Medical Child Support Order (QMCSO), as defined in the Employee Retirement Income Security Act of 1974 (ERISA), as amended, to provide health benefits coverage for your children, you may enroll them. Proof of the support order may be requested at any time.

Note: A person cannot be covered as a dependent of more than one employee under this plan.

You are responsible for notifying the BSA Benefits Center within 30 days of the date a dependent is no longer eligible. You may reach the BSA Benefits
Effective Jan. 1, 2011, the BSA no longer offers medical plan coverage to retirees and dependents age 65 and over. If you are a retiree age 65 or over who would like assistance from UnitedHealthcare in securing replacement coverage, UnitedHealthcare representatives are immediately available to answer your medical plan questions at 800-440-2520 (TTY users, call 711), 8 a.m. to 8 p.m., local time, seven days a week.

FOR CHILDREN 26 AND OLDER
At the end of the month in which dependent children turn age 26, they are no longer eligible for benefits under this plan unless they are unmarried, unable to be self-supporting because of mental or physical handicap, and depend mainly on you for support. A request to continue coverage for such a dependent child must be submitted to UnitedHealthcare at least 30 days before the dependent’s coverage would otherwise end due to age.

UnitedHealthcare will review the medical evidence supporting such incapacity and dependency and determine whether the continuation is approved. If approved, UnitedHealthcare may need to review the medical evidence and dependency each year in order for coverage to continue. They may also require proof of continuing eligibility at any time.

FOR SURVIVORS OF EMPLOYEES/RETIREES
Survivors of BSA employees and retirees under age 65 are eligible for coverage under the BSA Medical Plan. Coverage under this plan will continue for those who meet the definition of survivor (in the Glossary) of an employee or retiree whose date of death was on or before Dec. 31, 2004.

Coverage under this plan will continue for those who meet the definition of survivor (in the Glossary) of an employee or retiree whose date of death was on or after Jan. 1, 2005, and who had at least 10 years of service (defined by the years of employment that were eligible for BSA benefits).

Survivors may continue only the coverage in effect at the time of the employee’s or retiree’s death, and medical coverage will end when the survivor reaches age 65. Survivors will not be responsible for the remainder of the month in which the employee or retiree passed away, plus one full month of premiums.

The annual enrollment period and special enrollment period do not apply to survivors.

FOR RETIREES
BSA retirees and dependents under age 65 are eligible for coverage under the BSA Medical Plan.

If your retirement date was on or before Dec. 1, 2004, and you meet the definition of retiree in the Glossary, medical coverage was continued upon your retirement from the BSA or a local council.

If your retirement date was on or after Jan. 1, 2005, you meet the definition of retiree in the Glossary, and you have at least 10 years of service (defined by the years of employment that were eligible for BSA benefits), you may continue your medical coverage upon your retirement from the BSA or a local council.

You may enroll yourself and/or any eligible dependents if you qualify for a special enrollment period and request enrollment accordingly.

The annual enrollment period does not apply to retirees.

FOR CHILDREN 26 AND OLDER
At the end of the month in which dependent children turn age 26, they are no longer eligible for benefits under this plan unless they are unmarried, unable to be self-supporting because of mental or physical handicap, and depend mainly on you for support. A request to continue coverage for such a dependent child must be submitted to UnitedHealthcare at least 30 days before the dependent’s coverage would otherwise end due to age.

UnitedHealthcare will review the medical evidence supporting such incapacity and dependency and determine whether the continuation is approved. If approved, UnitedHealthcare may need to review the medical evidence and dependency each year in order for coverage to continue. They may also require proof of continuing eligibility at any time.

FOR SURVIVORS OF EMPLOYEES/RETIREEES
Survivors of BSA employees and retirees under age 65 are eligible for coverage under the BSA Medical Plan. Coverage under this plan will continue for those who meet the definition of survivor (in the Glossary) of an employee or retiree whose date of death was on or before Dec. 31, 2004.

Coverage under this plan will continue for those who meet the definition of survivor (in the Glossary) of an employee or retiree whose date of death was on or after Jan. 1, 2005, and who had at least 10 years of service (defined by the years of employment that were eligible for BSA benefits).

Survivors may continue only the coverage in effect at the time of the employee’s or retiree’s death, and medical coverage will end when the survivor reaches age 65. Survivors will not be responsible for the remainder of the month in which the employee or retiree passed away, plus one full month of premiums.

The annual enrollment period and special enrollment period do not apply to survivors.

IF YOU BECOME DISABLED
Medicare coverage is available to disabled people who receive Social Security checks and meet the requirements of the Social Security disability program. To qualify, you must be entitled to Social Security benefits for at least 24 consecutive months. You will automatically be enrolled by Medicare after you have qualified for Social Security disability benefits for two years.

If you are enrolled in the BSA Medical Plan when you become eligible for Medicare Parts A and B and you
are under age 65, you must enroll in both Parts A and B to continue coverage under the BSA Medical Plan. At this time, your medical coverage will transition to the Medicare Supplement Plan and this Plan will pay benefits second to Medicare.

If you choose not to enroll in Medicare Parts A and B or you are age 65 or over, all coverage under the BSA Medical Plan will be canceled effective the date you first became eligible for Medicare.

Pursuant to the Omnibus Budget Reconciliation Act of 1993 (OBRA), Medicare eligibility is extended to people of any age who need maintenance dialysis or a kidney transplant because of end-stage kidney failure. Only the family member who has end-stage kidney failure is eligible for Medicare protection. For more information, you can request a free copy of the pamphlet “Medicare Coverage of Kidney Dialysis and Kidney Transplant Services” from the Social Security Administration, or the Consumer Information Center, Department 59, Pueblo, CO 81009.

If you (as an employee) or an eligible dependent are covered under the BSA Medical Plan and enrolled in Medicare, benefits under the BSA Medical Plan will be coordinated with Medicare benefits. The BSA Medical Plan will be primary except in these situations:

- When you or a covered dependent are enrolled in Medicare due to disability and you, the employee, are not actually working.
- After 30 months of Medicare entitlement when you or a covered dependent are enrolled in Medicare due to end-stage renal disease and remain covered under the BSA Medical Plan.

Effective Jan. 1, 2011, the BSA Medical Plan will no longer provide Medicare Supplement Plan benefits for Long-Term Disability Plan participants OR their dependents who are age 65 or over.

See the Medicare Supplement Plan chapter for more information.

REQUIRED CONTRIBUTIONS

Premiums for elected benefits must be paid by the employee and employer in self-funded plans. The employer may not make contributions on the employee's behalf. The employee may make their contributions toward premiums through payroll deduction.

Premiums will be considered past due if not paid by the last day of the month for which they are owed. Failure to make timely payment of premiums within 60 days or more will cause the employee's benefits to end, and they will be offered COBRA for the eligible benefit plans that were canceled due to non-payment of premium.

Enrollment

HOW TO ENROLL

To enroll, call the BSA Benefits Center at 800-444-4416 or log onto http://bsabenefits.mercerhrs.com within 30 days of the date you become eligible. Coverage will then be effective on your eligibility date. If you do not enroll within the first 30 days of your eligibility, your medical plan election will default to no coverage and your next enrollment opportunity will occur if a special enrollment period applies or during the next annual enrollment period. Refer to the “Special Enrollment Periods” and “Annual Enrollment Period” sections.

MEDICAL ID CARDS

Magnetic-swipe ID cards will be mailed to your home address after the enrollment information has been transmitted to UnitedHealthcare.

Additional or replacement cards may be requested by calling UnitedHealthcare Member Services or through www.myuhc.com.

ANNUAL ENROLLMENT PERIOD (FOR EMPLOYEES ONLY)

There will be an annual enrollment period each year. During this time, you may cancel coverage for yourself and for any eligible dependents for any reason. You may enroll yourself and/or any eligible dependents who did not qualify for a special enrollment period and who, as of Jan. 1 following the applicable annual enrollment period, will not have coverage elsewhere.

Any changes made during the annual enrollment period will be effective on Jan. 1 following the annual enrollment period.
MEDICAL ENROLLMENT PERIOD (FOR RETIREES AND SURVIVORS ONLY)

If you and/or a dependent are covered under the Choice Plus or Options PPO UnitedHealthcare networks, you may elect the Traditional PPO or High Deductible Health Plan With Health Savings Account during the medical enrollment period each year. If you are enrolled in Medicare or any other health plan, you cannot make contributions to an HSA. Your election will be effective on Jan. 1 following the medical enrollment period.

SPECIAL ENROLLMENT PERIODS (FOR EMPLOYEES AND RETIREES ONLY)

If you decline enrollment or cancel coverage for yourself or your dependents (including your spouse) because of other health-care coverage during initial eligibility or the annual enrollment period, in the future you may be able to re-enroll in the BSA Medical Plan, provided that you request enrollment within 30 days after your other coverage ends. The specific requirements for these special enrollment periods are described below.

You and/or your dependent do not need to elect COBRA continuation coverage to request special enrollment.

A special enrollment period is available for you and/or your dependents if the following conditions are all met:

- You and/or your dependents were covered under another group health plan or had health insurance coverage at the time coverage in the BSA Medical Plan was previously offered.
- That other group health plan coverage or health insurance coverage was the reason for declining enrollment.
- Your and/or your dependents' other coverage has been under a COBRA continuation provision and that other coverage has been exhausted, or you or your dependents' other coverage has not been under a COBRA continuation provision and either that other coverage has terminated as a result of loss of eligibility (including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment); or employer contributions toward that other coverage have terminated. This is true even if you and/or your dependent continue to receive coverage under the prior plan and pay the amounts previously paid by the employer. Loss of eligibility for an individual also includes loss of group HMO coverage because the individual no longer lives or works in the HMO service area and has no other benefit option available; and loss of coverage because the plan no longer offers benefits to a class of individuals that includes you and/or your dependents.
- You request enrollment no later than 30 days after the date of the exhaustion of coverage described above or the termination of coverage or employer contributions described above, whichever is applicable.

If all of these conditions are met, enrollment will be effective on the first day the other coverage ends.

If other coverage was terminated for cause, or because required contributions were not paid on a timely basis, then you are not eligible for a special enrollment period.

If you get married while you are enrolled in (or while you are eligible for) the BSA Medical Plan, you will have a special enrollment period during the 30 days following your marriage. During that 30-day enrollment period, you may enroll yourself if you were not enrolled, and provided that you enroll yourself or you were already enrolled, you may enroll your new spouse and stepchildren. Enrollment in these circumstances will be effective on the date of marriage.

If you acquire a new dependent by birth, legal adoption, or placement for adoption while you are enrolled in (or while you are eligible for) the BSA Medical Plan, you will have a special enrollment period during the 30 days following the birth, legal adoption, or placement for adoption. During that 30-day enrollment period, you may enroll yourself if you were not enrolled, and provided that you enroll yourself or you were already enrolled, you may enroll either or both of your new dependents and your spouse.

Enrollment in these circumstances will be effective on the date of birth, legal adoption, or placement for adoption. You must add your new dependent even if your coverage tier is employee, spouse, and two or more children. Coverage is not automatic for newborns.

The following events will also be considered a change in family status:

- Termination of your or your dependent’s Medicaid or Children’s Health Insurance Program (CHIP) coverage as a result of loss of eligibility. (You must contact the BSA Benefits Center within 60 days of termination.)
• You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP (You must contact the BSA Benefits Center within 60 days of determination of subsidy eligibility).

CHANGING COVERAGE (FOR EMPLOYEES ONLY)

You may cancel coverage for yourself or any covered dependents if you have a qualifying life event as described in the Premium Only Plan under Section 125 of the Internal Revenue Code (see the 125 Plan chapter). **These provisions will apply even if you are not enrolled in the Premium Only Plan.**

By enrolling in this plan, you acknowledge that the information that you have provided is accurate and complete to the best of your knowledge. This information may be investigated and verified, and is subject to the eligibility provisions of the plans. You further acknowledge that if any of this information is found to be false or misleading, you may be required to reimburse the plans for monies spent as a result of any false or misleading statements, and if coverage is through current employment, any false or misleading statements may subject you to discipline, up to and including termination of your employment.

If you are not allowed to add or cancel coverage as described in the “Special Enrollment Periods” or “Changing Coverage” sections, your next opportunity will be during the annual enrollment period.

CHANGING COVERAGE (FOR RETIREES AND SURVIVORS ONLY)

You may cancel coverage at any time by contacting the BSA Benefits Center at 800-444-4416. Coverage will be canceled effective the first of the next month, provided that your request is made on or before the fifth business day, unless you specifically request a later date (effective the first day of a month). A request made on or after the sixth business day will be effective the first of the month following the next month.

If coverage is canceled under the BSA Medical Plan, retirees or dependents may re-enroll only if they qualify for a special enrollment period as defined on page 7. Otherwise they may not enroll at a later date, regardless of the reason the BSA coverage was canceled.

Survivors are not eligible for the special enrollment period and will not be eligible to enroll at a later date, regardless of the reason the BSA coverage was canceled.

WHEN COVERAGE ENDS

Your coverage will terminate on the earliest date on which any of the following occurs:

• When your employment ends. If it is due to retirement from the BSA or a local council, see the applicable provision.
• When you retire from the BSA or a local council as defined in the Glossary but you are not eligible to continue benefits into retirement as defined under the “Eligibility” section.
• When the employee or dependent ceases to be eligible for benefits, as defined under the “Eligibility” section.
• When the retiree, surviving spouse, Long-Term Disability Plan participant, or dependent ceases to be eligible for benefits as defined under the “Eligibility” section.
• When your death occurs. Your dependents may continue benefits as survivors, as defined in the “Eligibility” section and/or as defined in the Glossary.
• When you do not make the required contribution for the plan benefits. Coverage will end on the date through which you made your last contribution.
• When the plan ends in whole or in part.

OTHER EVENTS ENDING YOUR COVERAGE

The BSA Medical Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

• You commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person’s eligibility or status as a dependent; or
• You commit an act of physical or verbal abuse that imposes a threat to the BSA Benefits Center’s staff, UnitedHealthcare’s staff, a provider or another covered person.
If the group contract between the BSA and UnitedHealthcare is canceled, UnitedHealthcare, as the claims administrator, may end the claims-processing activities.

Any claims you have submitted to UnitedHealthcare that:
- Have not been processed before the date of cancellation,
- Have not actually been paid before the date of cancellation, or
- Are incurred after the date of cancellation, will not be paid by UnitedHealthcare, even if the expenses that resulted in the claim were incurred before that date.

The BSA will provide information about where to file claims.

CONTINUATION OF COVERAGE (COBRA)

Boy Scouts of America is required to offer continuation of coverage in certain cases as a result of Public Law 99-272, Title X, Consolidated Omnibus Budget Reconciliation Act (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Refer to the Legal Notices chapter for more information.

Medical Plan Overview

This section applies to the Choice Plus and Options PPO networks.

You and your physician will decide which medical services and supplies are necessary for you, but the plan pays only for those covered expenses that UnitedHealthcare determines are covered health services. UnitedHealthcare must be notified in advance of all inpatient admissions and certain outpatient procedures. (See Personal Health Support on page 102). UnitedHealthcare, in its discretion, will calculate covered expenses following evaluations and validation of all physician, specialist, and facility billings as described under eligible expenses in the Glossary.

Expenses covered for out-of-network physicians, specialists, and facilities are the reasonable and customary charges for the services and supplies listed below. The service or supply must be given for the diagnosis or treatment of sickness or accidental injury. Please refer to each plan chapter for any exceptions.

MEDICAL EXPENSES COVERED

Allergy shots and testing.

Ambulance.
- Emergency ambulance transportation (ground and air) by a licensed ambulance service to the nearest hospital where emergency health services can be performed.
- Non-emergency transportation provided by professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is for any of these reasons:
  - From a non-network to a network hospital
  - To a hospital that provides a higher level of care that was not available at the original hospital
  - To a more cost-effective acute care facility
  - From an acute facility to a sub-acute setting
- Air ambulance transport only in the following circumstances: Patient requires transportation to a hospital or from one hospital to another because the first hospital does not have the required services and/or facilities to treat the patient; and ground ambulance transportation is not medically appropriate because of the distance involved, or because the patient has an unstable condition requiring medical supervision and rapid transport.

Ambulatory surgical center charges. A center’s services given within 72 hours before or after a surgical procedure. These services have to be given in connection with the procedure.

Anesthetics. Anesthetics and charges for administering them.

Assistant surgeon. See “Physician’s services.”

Audiologists. Charges by a licensed or certified audiologist for physician-prescribed hearing evaluations to determine the location of a disease within the auditory system or for validation or organicity tests to confirm an organic hearing problem.

Bereavement counseling. Covered for the immediate family, if the patient was receiving hospice care covered under the BSA Medical Plan.

Birthing center.

Breast reconstruction. See “Mastectomy.”
Breast reduction. Breast reduction surgery is a covered health service if all of the following are true:
- There is documentation of shoulder grooving or excoriation resulting from the brassiere shoulder straps, due to the weight of the breasts.
- There is documentation from medical records of medical services related to complaints of the shoulder or neck, or back pain attributable to macromastia.
- The proposed surgery is determined not to be cosmetic by Personal Health Support.

Cardiac rehabilitation services.
- Services must be performed by a licensed therapy provider under the direction of a physician.
- Benefits are available only for the rehabilitation services that are expected to result in significant physical improvement in the patient’s condition within two months of the start of treatment.
- The primary intent is to improve the functional capacity of the heart and to provide the necessary skills for self-monitoring of unsupervised exercise.
- Membership to health clubs or equipment to use at home is not covered.
- Initial treatment plan must be approved by UnitedHealthcare.

Additional visits in excess of 20 may be requested.

Chelation therapy. Only to treat heavy metal poisoning.

Chemotherapy.

Chiropractic care. Children under 12 are covered for manipulative therapy only for acute or repetitive musculoskeletal injuries excluding birth trauma and scoliosis. Coverage includes per visit one spinal manipulation, one extra spinal manipulation, and up to three modalities.

Cholesterol testing.

Clinical trials. The Affordable Care Act requires health plans to provide benefit coverage for certain routine patient care costs for qualified individuals who participate in a qualified clinical trial. The clinical trial must be in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. Coverage does not apply to investigational devices, drugs, or services. You must notify Personal Health Support before these services are provided.

Cochlear implant. Diagnosis of severe to profound bilateral sensorineural hearing loss and severely difficult discrimination or post-lingual sensorineural deafness in an adult.

Contact lenses. Covered only for keratoconus or if related to cataract extraction—crystalline.

Dental services—accident or injury.
- Treatment is necessary because of accidental damage or injury.
- Notification/pre-certification required.
- Dental services must be received from a doctor of dental surgery, “D.D.S.,” or doctor of medical dentistry, “D.M.D.”
- Damage is severe enough that the initial contact with the physician or dentist occurred within 72 hours of the accident.
- Benefits are available only for treatment of a sound, natural tooth. The physician or dentist must certify that the injured tooth was either:
  - A virgin or unrestored tooth
  - A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, and no root canal therapy; is not a dental implant; and functions normally in chewing and speech
- Dental services for final treatment to repair the damage must fulfill both of the following:
  - It started within three months of the accident.
  - It was completed within 12 months of the accident.
- Removal of any bony impacted tooth, requiring general anesthetic and performed by an oral surgeon that is not covered by dental insurance.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an “accident.”

Dialysis.

Durable medical equipment (DME) (Also see “Medical supplies.”)
- Rental up to the purchase price
- Coverage is provided for durable medical equipment that meets the minimum specifications for accommodating your needs and each of the following criteria:
— Ordered or provided by a physician for outpatient use
— Used for medical purposes
— Not consumable or disposable
— Not of use to a person in the absence of a disease or disability

If more than one piece of durable medical equipment can meet the patient’s functional needs, benefits are available only for the most cost-effective piece of equipment.

Examples of durable medical equipment include, but are not limited to:

- Equipment to assist mobility, such as wheelchairs and hospital-type beds.
- Oxygen concentrator units and the purchase or rental of equipment to administer oxygen (including tubing and connectors).
- Braces, including adjustments to shoes to accommodate braces that stabilize an injured body part.
- Braces that straighten or change the shape of the body part is an orthopedic device, and is not covered under the DME benefit. (Dental braces are also excluded from coverage.)
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure. (Air conditioners, humidifiers, dehumidifiers, air purifiers, and filters are excluded from coverage.)
- Devices that replace a limb or body part, including artificial limbs, artificial eyes, and breast prostheses (as required by the Women’s Health and Cancer Rights Act of 1998).
- Glucose monitoring device.
- External insulin pump and pump supplies (for type 1 diabetes).
- Duplicate prosthetics, appliance cost for replacement of stolen prosthetic devices, and prosthetics that are less than five years old are not covered.
- If more than one prosthetic device can meet the patient’s functional needs, benefits are available only for the most cost-effective prosthetic device.

UnitedHealthcare will decide if the equipment should be purchased or rented. To receive benefits, you must purchase or rent the durable medical equipment from the vendor identified by UnitedHealthcare. Any purchase or rental over $1,000 requires notification to UnitedHealthcare as outlined on page 103.

**Emergency health services.** Services for a serious medical condition or symptom resulting from injury, sickness, or mental illness which arises suddenly, and in the judgment of a reasonable person requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

- Member must call within 48 hours. Otherwise non-notification penalty would apply.
- If admitted directly through the ER to an inpatient stay, copay is waived. Notification/pre-certification required if results in an inpatient stay.

**Enhanced autism spectrum disorder.** Services are habilitative in nature and demonstrate a measurable and beneficial effect on health outcomes; including intensive behavioral therapies, such as Applied Behavioral Analysis (ABA).

**Enteral nutrition.** If sole source of nutrition or when a certain nutritional formula treats a specific inborn error of metabolism. Infant formula available over the counter is not covered.

**Excision of radicular or dentigerous cyst.**

**Family planning.** Includes Norplant, oral contraceptives, IUD, diaphragm, and Depo-Provera.

**Foot care.** Only for care and treatment as a result of severe systemic disease.

**Health-care professional services.** The services of a licensed or certified health-care professional acting within the scope of that license or certification. Expenses for covered services given by a health-care professional are payable on the same basis as expenses for covered services given by a physician.

**Health education programs.** Covered when:

- The services are billed by a hospital.
- Care is rendered by medical professionals.
- The program is an integral part of the covered treatment plan. This includes, but is not limited to:
  — Insulin training and diet management for diabetics
  — Diet management for cardiac patients
  — Ostomy care
  — Self-catheterization
Medical plans

There are a few exceptions when the extra cost for a private room can be covered:

— When the hospital is an all-private-room hospital
— When the hospital's semi-private rooms are filled and only a private room was available
— When a private room must be used to keep the patient isolated because of the diagnosis

These exceptions can only be identified on an appeal basis.

• Other services and supplies received during the inpatient stay. These benefits include, but are not limited to, the following:
  • Tetanus toxoid
  • Influenza vaccine
  • Hepatitis B vaccine
  • Tetanus immunizations following an injury
  • Anti-rabies treatment following an animal bite
  • Rh immune globulin
  • Gamma globulin administration
  • Allergy serum
  • Lyme disease medication
  • Meningitis vaccine

Covered health services do not include shots or immunizations related to travel.

Infertility treatment. Diagnosis and treatment in a physician’s office or facility of the underlying medical condition causing infertility. Charges for procedures that facilitate a pregnancy but do not treat the cause of infertility are not covered. Assisted reproductive technologies are excluded.

Inpatient rehabilitation facility. Room and board in a semi-private room and other services and supplies. These benefits are available only for the care and treatment of an injury or sickness that would have otherwise required an inpatient stay in a hospital. Custodial care is excluded. Payment for skilled-nursing facility charges will be limited to 365 days of confinement during any one person’s lifetime. Prior notification/pre-certification to Personal Health Support is required.

Jaw joint disorder (TMJ or temporomandibular joint). Surgery to the joint of the jaw.

Hearing aids. If hearing loss is due to an illness or injury, coverage includes prescription and fittings. Replacement hearing aids are not covered.

Hearing care. Hearing screenings as part of a routine preventive office visit.

Home health care. Notification/pre-certification required.

• The limit applies to all days or visits used or charges incurred.
• Services must be received from a home health agency, ordered by a physician, and provided by or supervised by a registered nurse in your home.
• Benefits are available only when the home health agency services are provided on a part-time, intermitted schedule and when skilled care is required.
• Skilled care is skilled nursing, skilled teaching, and skilled rehab. Services must be:
  — Provided by a licensed technical or professional health-care worker
  — Provided in order to obtain the specific medical outcome
  — Ordered by a physician
  — Not used for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from bed to chair
  — Required clinical training for the provider
  — Not used for custodial care

• Each visit, whether 15 minutes or up to 4 hours, by any member of the home health care team will count as one visit. The maximum number of visits per calendar year are 240.

Hospice care charges. Must be recommended by a physician. Services must be rendered by a licensed hospice agency. Notification to Personal Health Support prior to service is required (see page 102).

Hospital charges. Prior notification/pre-certification to Personal Health Support is required.

• Room and board
  — Charges made for a semi-private room, a ward, or an intensive care unit
  — Private room charges, up to the highest semi-private room rate for that facility

Immunizations/shots. These benefits include, but are not limited to, the following:

• Tetanus toxoid
• Influenza vaccine
• Hepatitis B vaccine
• Tetanus immunizations following an injury
• Anti-rabies treatment following an animal bite
• Rh immune globulin
• Gamma globulin administration
• Allergy serum
• Lyme disease medication
• Meningitis vaccine

Hearing care. Hearing screenings as part of a routine preventive office visit.

Home health care. Notification/pre-certification required.

• The limit applies to all days or visits used or charges incurred.
• Services must be received from a home health agency, ordered by a physician, and provided by or supervised by a registered nurse in your home.
• Benefits are available only when the home health agency services are provided on a part-time, intermitted schedule and when skilled care is required.
• Skilled care is skilled nursing, skilled teaching, and skilled rehab. Services must be:
  — Provided by a licensed technical or professional health-care worker
  — Provided in order to obtain the specific medical outcome
  — Ordered by a physician
  — Not used for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from bed to chair
  — Required clinical training for the provider
  — Not used for custodial care

• Each visit, whether 15 minutes or up to 4 hours, by any member of the home health care team will count as one visit. The maximum number of visits per calendar year are 240.

Hospice care charges. Must be recommended by a physician. Services must be rendered by a licensed hospice agency. Notification to Personal Health Support prior to service is required (see page 102).

Hospital charges. Prior notification/pre-certification to Personal Health Support is required.

• Room and board
  — Charges made for a semi-private room, a ward, or an intensive care unit
  — Private room charges, up to the highest semi-private room rate for that facility

There are a few exceptions when the extra cost for a private room can be covered:

— When the hospital is an all-private-room hospital
— When the hospital’s semi-private rooms are filled and only a private room was available
— When a private room must be used to keep the patient isolated because of the diagnosis

These exceptions can only be identified on an appeal basis.

• Other services and supplies received during the inpatient stay. These benefits include, but are not limited to, the following:
  • Tetanus toxoid
  • Influenza vaccine
  • Hepatitis B vaccine
  • Tetanus immunizations following an injury
  • Anti-rabies treatment following an animal bite
  • Rh immune globulin
  • Gamma globulin administration
  • Allergy serum
  • Lyme disease medication
  • Meningitis vaccine

Covered health services do not include shots or immunizations related to travel.

Infertility treatment. Diagnosis and treatment in a physician’s office or facility of the underlying medical condition causing infertility. Charges for procedures that facilitate a pregnancy but do not treat the cause of infertility are not covered. Assisted reproductive technologies are excluded.

Inpatient rehabilitation facility. Room and board in a semi-private room and other services and supplies. These benefits are available only for the care and treatment of an injury or sickness that would have otherwise required an inpatient stay in a hospital. Custodial care is excluded. Payment for skilled-nursing facility charges will be limited to 365 days of confinement during any one person’s lifetime. Prior notification/pre-certification to Personal Health Support is required.

Jaw joint disorder (TMJ or temporomandibular joint). Surgery to the joint of the jaw.
Laboratory tests and X-rays. X-rays or tests for diagnosis or treatment.

Licensed counselor services. The services of a licensed counselor for treatment of mental health or substance use disorder, and the services of psychiatric health-care professional types including social workers and licensed counselors. Must be approved through United Behavioral Health.

Mammograms.

Mastectomy. Breast reconstruction in connection with a mastectomy performed while covered under the BSA Medical Plan. Includes coverage for (in a manner determined in consultation with the attending physician and patient):
- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis and physical complication of mastectomy, including lymphedemas

Maternity benefits. Group health plans and health insurance issuers offering group insurance coverage generally 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 generally does not prohibit the mother’s or newborn’s attending health-care professional, after consulting with the mother, from discharging the mother or her newborn earlier or require 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a health-care professional obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of the above periods.

Maternity office visits.

Medical supplies. (Also see “Durable medical equipment.”)
- Appliance that replaces a lost body organ or body part or helps an impaired one to work. An example is an artificial limb or eye. Only the charge for the first appliance is covered.
- Blood or blood plasma (only if not donated or replaced).
- Oxygen and the charges for administering it. This includes rental of the required equipment.
- Rental of a wheelchair or hospital-style bed.
- Rental of a device to help breathing when the patient is paralyzed.
- Colostomy supplies.
- Glucose monitor if prescribed by a physician.
- Blood pressure machine if prescribed by a physician.

Mental health services. Mental health services include those received on an inpatient basis in a hospital or alternate facility, and those received on an outpatient basis in a provider’s office or at an alternate facility. Benefits include the following services provided on either an outpatient or inpatient basis:
- Diagnostic and evaluation assessment
- Treatment planning
- Referral services
- Medication management
- Individual, family, therapeutic group, and provider-based case management services
- Crisis intervention

Benefits include the following service provide on an inpatient basis:
- Partial hospitalization/day treatment
- Services at a residential treatment facility

Benefits include the following services provided on an outpatient basis:
- Intensive outpatient treatment

The mental health/substance use disorder administrator determines coverage for all levels of care. If an inpatient stay is required, it is covered on a semi-private room basis. Refer to your specific plan information for pre-notification requirements.

Contact the mental health/substance use disorder administrator for referrals to providers and coordination of care.

Nursing services.
- The services of a registered nurse (RN).
- The services of a licensed or certified nurse-midwife or nurse-practitioner in accordance with the requirements of the state on jurisdiction of practice, practicing within the scope of that license or certification and rendering a service covered under the plan. Covered expenses given by a licensed or certified nurse-midwife or nurse-practitioner are payable on the same basis as covered expenses given by a physician. The nurse-midwife must be affiliated with an Ob/Gyn.
**Nutrition counseling.** Must be by a registered dietician for chronic diseases in which a dietary adjustment has a therapeutic role. Limited to three individual sessions per lifetime for each condition. Examples include participants with diabetes mellitus, coronary artery disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria, and hyperlipidemia.

**Not covered for obesity/weight loss or conditions which have not been shown to be nutritionally related, including but not limited to chronic fatigue syndrome and hyperactivity.**

**Occupational therapy.**
- Services must be performed by a licensed therapy professional under the direction of a physician.
- Benefits are available only for the services that are expected to result in significant improvement in the patient's condition within two months of the start of treatment.
- Occupational therapy improves the patient's ability to perform tasks required for independent functioning when the function has been temporarily lost and can be restored, e.g., strokes, cerebrovascular accidents. Its focus is on coordination of finer, more delicate movements.
- Vocational rehabilitation training is not covered.

Additional visits in excess of 30 must be approved by UnitedHealthcare.

**Oral surgery.** Covered if part of the treatment of an underlying medical condition. (This does not include periodontal procedures or treatment for impacted wisdom teeth.)

**Orthognathic surgery.** As required for direct trauma of acute traumatic injury or cancer. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment for obstructive sleep apnea.

It is also covered in the following situations:
- A jaw deformity resulting from facial trauma or cancer OR
- A skeletal anomaly of either the maxilla or mandible, that demonstrates a functional medical impairment such as one of the following:
  - Inability to incise solid foods
  - Choking on incompletely masticated solid foods
  - Damage to soft tissue during mastication
  - Speech impediment determined to be due to the jaw deformity
  - Malnutrition and weight loss due to inadequate intake secondary to the jaw deformity

**Orthoptic therapy.** Training by an optometrist or an orthoptic technician. Limited to 30 visits for children and 20 visits for adults per lifetime.

**Ostomy supplies.** Includes pouches, face plates, and belts; irrigation sleeves, bags, and catheters; and skin barriers.

**Outpatient occupational therapy.**
- Services must be performed by a licensed therapy professional under the direction of a physician.
- Benefits are available only for services that are expected to result in significant improvement in the patient's condition within two months of the start of treatment.
- Occupational therapy improves the patient's ability to perform tasks required for independent functioning when the function has been temporarily lost and can be restored, e.g., strokes, cerebrovascular accidents. Its focus is on coordination of finer, more delicate movements.

Initial treatment plan must be approved by UnitedHealthcare.

Additional visits in excess of 20 must be approved by UnitedHealthcare.

**Outpatient physical therapy.**
- Services must be performed by a licensed therapy professional under the direction of a physician.
- Benefits are available only for services that are expected to result in significant improvement in the patient's condition within two months of the start of treatment.
- The cost of a non-licensed physical therapist is not covered.

Additional visits in excess of 30 must be approved by UnitedHealthcare.

**Outpatient surgery, diagnostic, and therapeutic services.** Services for outpatient covered health services received at a hospital or alternate facility, including:
- Outpatient surgery and related services
- Lab and radiology/X-ray
- Mammography testing
- Other diagnostic tests and therapeutic treatment (including cancer chemotherapy or intravenous infusion therapy)
Benefits include only the facility charge and the charge for required services, supplies, and equipment. Benefits for professional fees related to outpatient surgery, and diagnostic and therapeutic services are described under “Physician's office services.”

When these services are performed in a physician’s office, benefits are described under “Physician’s office services.”

**Pap smear.** Refer to specific plan for level of coverage.

**Physician's office services.** Benefits payable for covered health services received in a physician’s office include:
- Treatment of a sickness or injury
- Preventive health care
- Immunizations

**Physician's services.** Services for surgical procedures, including those listed below. (Covered expenses for services of an assistant surgeon are limited to one-fifth of the amount of covered expenses for the surgeon’s charge for the surgery. The assistant surgeon must be a physician, and surgery must warrant an assistant surgeon. This does not include coverage for a surgical assistant.)
- **Reconstructive surgery** to improve the function of a body part when the malfunction is the direct result of one of the following:
  - Birth defect
  - Sickness
  - Accidental injury
- Reconstructive breast surgery following a mastectomy.
- Reconstructive surgery to remove scar tissue on the neck, face, or head. Limited to scars caused from sickness or accidental injury.
- Services for other medical care and treatment, such as hospital, office, or home visits or emergency room treatment services.
- Multiple surgical procedures—more than one surgical procedure performed during the same operative session. Covered expenses are limited as follows:
  - Expenses for a secondary procedure are limited to 50 percent of the covered expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session
  - Expenses for any subsequent procedure are limited to 25 percent of the covered expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session

**Physiotherapy.** The services of a physical therapist if expected to result in significant, objective, and measurable physical improvement in the functional condition within two months of start of treatment.

**PKU testing.** Within the first two weeks of life.

**Preventive health care.** Refer to the specific plan for level of coverage.

**Private-duty nursing.** Must be given on an outpatient basis by a licensed nurse (RN, LPN, or LVN). Requires Personal Health Support approval.

**Prosthetic devices.** See “Durable medical equipment.”

**Psychologist's services.** Must be approved through United Behavioral Health.

**Pulmonary rehabilitation therapy.**
- Service must be performed by a licensed therapy professional under the direction of a physician.
- Benefits are available only for services that are expected to result in significant improvement in the patient's condition within two months of the start of treatment.

Additional visits in excess of 30 must be approved by UnitedHealthcare.

**Radiation therapy.**

**Reconstructive procedures.** Services when a physical impairment exists and the primary purpose is to improve or restore physiological function. Services include surgery and other procedures associated with an injury, sickness, or congenital anomaly. The fact that the physical appearance may change or improve as a result of the procedure(s) does not automatically qualify the surgery as cosmetic when a physical impairment exists and the surgery restores or improves function.

Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a covered person may suffer psychological consequences or socially
avoidant behavior as a result of an injury, sickness, or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. Prior notification/pre-certification to Personal Health Support is required.

**Rehabilitation therapy.**
- **Inpatient** payments are limited to a combined total of 120 days of confinement in a hospital and/or rehabilitation facility each calendar year.
- If expected to result in significant, objective, and measurable physical improvement in the functional condition within two months of start of treatment.
- **Outpatient charges** made by a hospital or rehabilitation facility. Initial treatment plan must be approved by UnitedHealthcare.

Additional visits in excess of 20 must be approved by UnitedHealthcare.

**Social worker services.** Services by a person who specializes in clinical social work and is licensed or certified as a social worker by the appropriate authority. Must be approved through United Behavioral Health.

**Speech therapy.** Covered only when the speech impediment or speech dysfunction results from injury, stroke, or congenital anomaly, or is required following the placement of a cochlear implant.
- Treatment for learning disabilities and developmental delays are excluded.
- Services must be performed by a licensed therapy professional under the direction of a physician.
- Benefits are available only for the services that are expected to result in significant improvement in the patient's condition within two months of the start of treatment.
- Coverage is reviewed when notification/pre-certification is received or with receipt of the first claim. Additional visits in excess of 30 must be approved by UnitedHealthcare.

**Sterilization.** Reversals are excluded.

**Substance Use Disorder Services.** Substance use disorder services include those received on an inpatient basis in a hospital or alternate facility, and those received on an outpatient basis in a provider's office or at an alternate facility. Benefits include the following services provided on either an outpatient or inpatient basis:
- Diagnostic and evaluation assessment
- Treatment planning
- Referral services
- Medication management
- Individual, family, therapeutic group, and provider-based case management services
- Crisis intervention
- Detoxification (sub-acute/nonmedical)

Benefits include the following service provided on an inpatient basis:
- Partial hospitalization/day treatment
- Services at a residential treatment facility

Benefits include the following services provided on an outpatient basis:
- Intensive outpatient treatment

The mental health/substance use disorder administrator determines coverage for all levels of care. If an inpatient stay is required, it is covered on a semi-private room basis. Refer to your specific plan information for pre-notification requirements.

Contact the mental health/substance use disorder administrator for referrals to providers and coordination of care.

**Transplant services.** Benefits are available to the donor and the recipient when the recipient is covered under this plan. The transplant must meet the definition of a covered health service and cannot be experimental, investigational, or unproven. Examples of transplants for which benefits are available include but are not limited to:
- Heart
- Heart/lung
- Lung
- Kidney
- Kidney/pancreas
- Liver
- Liver/kidney
- Liver/intestinal
- Pancreas
- Intestinal
- Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high-dose chemotherapy. Not all bone marrow transplants meet the definition of a covered health service.
Benefits are also available for cornea transplants that are provided by an in-network physician at an in-network hospital. The plan does not require that cornea transplants be performed at a designated United Resource Network facility in order to be a covered benefit.

Other transplant services must be received at a designated United Resource Network facility to be a covered benefit.

The plan has specific coverage policies and guidelines regarding transplant services. Contact Member Services at 800-632-3203 for information about these policies and guidelines. Transplant services must be coordinated with UnitedHealthcare as soon as the possibility of a transplant arises, and before the time an evaluation is performed at a transplant center.

**Treatment center services.** Room and board and other services and supplies.

**Tubal ligation.**

**Urgent care center.** Facilities with extended hours situated in convenient locations that provide quick and convenient walk-in medical care with no appointment necessary for minor injuries and illnesses.

**Vasectomy.**

**Virtual visits.** For covered health services that include diagnosis and treatment of low acuity medical conditions through the use of interactive technology. These services are only available through a Designated Virtual Network Provider. Not all medical conditions can be appropriately treated through a virtual visit. Virtual visits do not include visits by fax, standard telephone calls, or for visits that occur within medical facilities.

**Well-baby care.** Charges incurred during a newborn child's initial hospital stay, if the newborn child is an eligible, covered dependent under the BSA Medical Plan:

- Hospital charges for nursery care
- Hospital charges for other services and supplies
- A surgeon's charge for circumcision
- Charges for physicians' visits

**Well-woman exam.** Includes breast examination, mammogram, pelvic examination, and pap smear. One well-woman exam is covered per calendar year.

**Wigs and hairpieces.** Only when a permanent or temporary hair loss results from treatment of a malignancy, or when permanent hair loss results from an accidental injury.

**MEDICAL EXPENSES NOT COVERED**

These expenses are not covered under the BSA Medical Plan even if:

- The service, treatment, or supply is recommended or prescribed by a physician.
- The service, treatment, or supply is the only available treatment for your condition.

**Alternative treatments.**

- Acupressure and acupuncture
- Aromatherapy
- Holistic or homeopathic care and herbal medicine, including drugs and ecological or environmental medicine
- Hypnotism
- Massage therapy
- Naturalist
- Naturopathic medicine
- Rolfing
- Other forms or alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health
- **Breast reduction.** When performed to improve appearance or for the purpose of improving athletic performance. Breast reduction surgery is covered when a reconstruction has been performed on the other breast (as part of the federal mandate). See Medical Expenses Covered.

**Chelation therapy, except to treat heavy-metal poisoning.**

**Comfort or convenience items, including but not limited to:**

- Television
- Telephone
- Beauty/barber service
- Guest service
- Exercise equipment
- Devices and computers to assist in communication and speech
• Home remodeling to accommodate a health need. Examples include:
  — Ramps
  — Swimming pools
• Supplies, equipment, and similar incidental services and supplies for personal comfort. Examples include:
  — Air conditioners
  — Air purifiers and filters
  — Batteries and battery chargers
  — Dehumidifiers
  — Humidifiers, saunas, and hot tubs

Complications. Surgical or non-surgical treatment related to a non-covered health service. Examples include gastric bypass, obesity surgery, and physical appearance procedures.

Custodial care. This includes services and supplies that meet one of the following conditions:
• Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment
• Care that can safely and adequately be provided by people who do not have the technical skills of a covered health-care professional
• Care that meets one of the above conditions is custodial care regardless of the following:
  — Who recommends, provides, or directs the care
  — Where the care is provided
  — Whether or not the patient can be, or is being, trained to care for himself or herself

Dental (non-accident).
• Dental care except as described under Medical Expenses Covered
• Preventive care, diagnosis, and treatment of or related to teeth, jawbones, or gums, including extraction, restoration, replacement, medical, or surgical treatments of dental conditions and services to improve dental clinical outcomes
• Dental implants
• Dental braces
• Dental X-rays, supplies, and appliances and all associated expenses, including hospitalization and anesthesia. The only exceptions to this are for any of the following:
  — Transplant preparation
  — Initiation of immunosuppressives
  — The direct treatment of acute traumatic injury
  — Cancer
  — Cleft palate
• Treatment of congenitally missing, malpositioned, or supernumerary teeth, even part of congenital anomaly.

Domiciliary care.

Drugs. See Pharmacy Expenses Covered
• Shots to prevent disease, except as specifically described under this plan
• Non-injectable medications given in a physician's office, except as required in an emergency.

Drug treatment for baldness. Unless a permanent or temporary hair loss results from treatment of a malignancy or permanent hair loss as the result of an accidental injury.

Experimental, investigational, or unproven services. Drugs, treatments, services, devices, any related confinement, or supplies that are considered investigational because they do not meet generally accepted standards of medical practice in the United States regardless of whether it is the only available treatment for a particular condition.

Foot care.
• Routine foot care (including the cutting or removal of corns and calluses except when needed for severe systemic disease)
• Nail trimming, cutting, or debriding
• Treatment of flat feet
• Treatment of subluxation of the foot
• Hygienic and preventive maintenance foot care. Examples include:
  — Cleaning and soaking the feet
  — Applying skin creams to maintain skin tone
  — Other services that are performed when there is not a localized illness, injury, or symptom involving the foot
**Gastric bypass.** Gastric bypass or any treatment or surgical procedure to treat obesity, whether or not it is for medical reasons. Complications related to gastric bypass.

**Growth hormone therapy.**

**Gynecomastia (abnormal breast enlargement in males).** Treatment of a benign condition.

**Hair transplants.** Unless a permanent or temporary hair loss results from treatment of a malignancy or permanent hair loss as the result of an accidental injury.

**Hair weaving.** Unless a permanent or temporary hair loss results from treatment of a malignancy or permanent hair loss as the result of an accidental injury.

**Hyperhidrosis.** Medical and surgical treatment of excessive sweating.

**Medical supplies and appliances.**
- Devices used specifically as safety items or to affect performance in sports-related activities
- Prescribed and non-prescribed medical supplies and disposable supplies including:
  - Elastic stockings
  - Elastic bandages
  - Gauze
  - Dressings
- Orthotic appliances that straighten or re-shape a body part
- Tubings, nasal cannulas, connectors, and masks except when used with durable medical equipment
- Implanted insulin pumps
- External insulin pumps (for type 2 diabetes)
- External insulin pumps that deliver insulin in to the intraperitoneal cavity

**Mental health and substance use disorder.**
- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association
- Services or supplies for the diagnosis or treatment of mental illness, alcoholism, or substance use disorder, that in the reasonable judgment of the mental health and substance use administrator, are any of the following:
  - Not consistent with generally accepted standards of medical practice for the treatment of such conditions
  - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome and therefore considered experimental
  - Not consistent with the mental health and substance use disorder administrator’s guidelines or best practices as modified from time to time
  - Not clinically appropriate for the patient’s mental illness, substance use disorder, or condition based on generally accepted standards of medical practice and benchmarks
- Mental health services as treatments for V-code conditions as listed within the current edition of the American Psychiatric Association’s (APAs) Diagnostic and Statistical Manual of Mental Disorders
- Mental health services as treatment for a primary diagnosis of insomnia, other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders, and other disorders with a known physical basis
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, and paraphilias (sexual behavior that is considered deviant or abnormal)
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction, and learning
- Tuition for services that are school-based for children and adolescents under the Individuals with Disabilities Education Act
- Learning, motor skills, and primary communication disorders as defined in the current edition of the American Psychiatric Association’s (APAs) Diagnostic and Statistical Manual of Mental Disorders
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction

**Medical plans**
Naturopath providers.

Nutrition.
- Nutrition counseling services for obesity/weight loss or conditions which have not been shown to be nutritionally related, including but not limited to chronic fatigue syndrome and hyperactivity
- Weight reduction, special foods, food supplements, liquid diets, diet plans, or any related product
- Megavitamin and nutrition-based therapy
- Weight loss programs, health clubs, and spas
- Nutritional and electrolyte supplements including infant formula, donor breast milk, nutritional supplements, dietary supplements, oral vitamins, and oral minerals.

Obesity surgery.
- Complications related to obesity surgery even if there is a diagnosis of morbid obesity.

Physical appearance procedures.
- Abdominoplasty
- Complications related to physical appearance procedures.
- Cosmetic procedures including pharmacological regimens, nutritional procedures and treatments, scar or tattoo removal, revision procedures (such as salabrasion, chemosurgery, and other skin abrasion procedures), or skin abrasion procedures performed as a treatment for acne. This exclusion does not apply to reconstructive surgery specified as a covered expense in the plan.
- Liposuction
- Physical trainers or conditioning programs such as athletic training, body building, exercise fitness, flexibility, and diversion or general motivation
- Replacement of an existing breast implant if the earlier implant was performed as a cosmetic procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed a mastectomy.)
- Treatment for obesity, including surgery, whether or not it is for medical reasons
- Weight-loss programs whether or not they are under medical supervision. Weight-loss programs for medical reasons are also excluded.

Post-cochlear implant therapy.

Providers.
 Certain providers, as listed below.
- Expenses that are not payable by the insured or that are payable under workers' compensation, Medicaid, Medicare, or any other state or federal government program; under another group plan; as a result of a third-party action; or under any automobile or homeowner's insurance policy
- Private-duty nursing services that are not a covered health expense (In most cases, private-duty nursing while the patient is confined in a hospital is not a covered health expense.)
- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent, or child; includes services a provider may perform on himself/herself
- Services performed by a provider with the same legal residence
- Services given by volunteers or people who do not normally charge for their services
- Services given by a licensed pastoral counselor to a member of his or her congregation in the course of his or her normal duties as a pastor or minister
- Services provided at a free-standing or hospital-based diagnostic facility without an order written by a physician or other provider
- Services that are self-directed to a free-standing or hospital-based diagnostic facility
- Services ordered by a physician or other provider who is an employee or a representative of a free-standing or hospital-based diagnostic facility, when that physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received (This exclusion does not apply to mammography testing.)
- Services provided by a naturopath provider.

Psychosurgery.

Reproduction. Health services and associated expenses for infertility treatment:
- Embryo-transfer procedure
- Fertility testing
- Drug enhancement for fertility
• Artificial insemination
• In-vitro fertilization, GIFT, and ZIFT
• Charges for procedures that facilitate a pregnancy but do not treat the cause of infertility
• Reversal of sterilization
• Impregnation or fertilization charges for the surrogate donor
• Surrogate parenting
• Fees or direct payment to a donor for sperm or ovum donations
• Monthly fees for maintenance and/or storage of frozen embryos (sperm or eggs)
• Health services and associated expenses for elective abortion

Respite care/rest cures.

Routine preventive health services.
• Examinations for employment
• Non-school-related athletic examinations
• FAA physical examinations
• Examinations and immunizations related to travel
• Examinations required for weight-loss clinics
• Blood testing for marriage licenses
• Routine chest X-rays

Services provided under another plan, including but not limited to:
• Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes, but is not limited to coverage required under workers’ compensation, no-fault auto insurance, or similar legislation. If coverages under workers’ compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for injury, sickness, or mental illness that would have been covered under workers’ compensation or similar legislation had that coverage been elected
• Health services for the treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities that are reasonably available to you
• Health services while on active military duty

Sex change/transformation surgery.

Snoring. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea, and appliances for snoring.

Speech therapy, except as described in Medical Expenses Covered.

Sterilization reversals.

Telephone consultations.

Tobacco dependency.

Transplants.
• Health services for organ and tissue transplants, except those described under Medical Expenses Covered
• Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person (These donor costs may be payable for a transplant through the organ recipient’s benefits plan.)
• Health services for transplants involving mechanical or animal organs
• Transplant services not performed at a designated United Resource Network facility
• Any solid organ transplant that is performed as a treatment for cancer
• Any multiple organ transplants not listed as a covered health service under “Transplant services” under Medical Expenses Covered

Travel.
• Health services provided in a foreign country, unless required for emergency health services
• Travel or transportation expenses, even though prescribed by a physician

Vision and hearing.
• Charges for a surgical procedure to correct refraction errors of the eye (such as nearsightedness or farsightedness), including any confinement, treatment, services, or supplies given in connection with, or related to, the surgery
• Eyeglasses and examinations for prescriptions or fittings, unless following cataract surgery
• Hearing aids, prescriptions, and fittings, unless the hearing loss is due to an injury or illness
• Cochlear implants, unless those described under Medical Expenses Covered
Vocational **rehabilitation training.**

**Wigs or toupees.** Unless a permanent or temporary hair loss results from treatment of a malignancy or permanent hair loss is the result of an accidental **injury.**

**Other exclusions.**

- Sensitivity training, education training therapy, or treatment for an education requirement
- Education, training, and bed-and-board while confined in an institution that is mainly a school, or other institution for training, a place of rest, a place for the aged, or a **nursing home**
- Charges made by a hospital for room, board, or other fees during confinement in a hospital area used as a special care area, by whatever name called, including but not limited to the following (benefits for a covered facility that is part of a hospital, as defined, are payable at the coverage level given in the plan for that type of facility, not at the coverage level for a hospital):
  - Skilled-nursing facility
  - Hospice
  - Treatment center
  - Birth center
  - Ambulatory surgical center
  - Adult or child day-care center
  - Halfway house
  - Vocational rehabilitation center
  - Any other area of a hospital that renders services on an **inpatient** basis for other than acute care of sick or injured people
- Stand-by services required by a physician
- Services or supplies that are not a covered health expense, including any confinement, treatment, service, or supply given in connection with a service or supply that is not a covered health expense
- Expenses incurred before you or your **dependent** were covered
- Medical exams or tests not needed to treat sickness or accidental **injury**, except those listed under Medical Expenses Covered
- Health services and supplies that do not meet the definition of a **covered health service**
- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the plan when:
  - Required solely for purpose of career, education, sports or camp, travel, employment, insurance, marriage, or adoption
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country
- Health services received after the date your coverage under the plan ends, including health services for medical conditions arising before the date your coverage under the plan ends
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the plan
- Any charges for missed appointments, room or facility reservations, completion of claim forms, or record processing
- Any charges higher than the actual charge. The actual charge is defined as the **provider’s** lowest routine charge for the service, supply, or equipment.
- Any charge for services, supplies, or equipment advertised by the provider as free
- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse, or medical competency
- Any charges prohibited by federal anti-kickback or self-referral statutes
- Any additional charges submitted after payment has been made and your account balance is zero
- Any charges by a resident in a teaching hospital where a faculty **physician** did not supervise services
- **Outpatient rehabilitation** services, spinal treatment, or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring
- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies
PHARMACY PROGRAM

The plan’s pharmacy program is administered by OptumRx. This program makes it possible to purchase medically necessary prescriptions from a local pharmacy participating in OptumRx’s network or through the OptumRx mail-order program. To be covered, prescriptions must be filled through OptumRx’s pharmacy benefit program.

A local pharmacy should be used for short-term prescriptions. Mail-order should be used for ongoing, long-term (maintenance) prescriptions.

Eligibility for the Pharmacy Program

The UnitedHealthcare pharmacy program is available to anyone covered under the BSA Medical Plan.

Deductible

In the Traditional PPO Plan, there is a $50 deductible per person, per calendar year.

In the High Deductible Health Plan With Health Savings Account, the cost of prescriptions applies toward the medical plan deductible.

Copays (after the deductible is met)

In the Traditional PPO Plan, there are three copay types:

- Tier 1 (the lowest copay, $7)
- Tier 2 (the midrange copay, $30 to $60)
- Tier 3 (the highest copay, $50 to $100)

There are no copays in the High Deductible Health Plan With Health Savings Account.

Please refer to the chapter that outlines your medical plan type and level of coverage to learn more about your plan.

Refer to “Pharmacy Expenses Covered” and “Pharmacy Expenses Not Covered” on page 25 and page 26. If the drug is on the OptumRx Prescription Drug List (PDL), and the BSA Medical Plan does not cover the prescription, the drug will be listed under Pharmacy Expenses Not Covered.

Generic and brand-name drugs on the PDL will be placed in any tier based on evidence relating to clinical effectiveness, cost, and total health-care value. Changes to the PDL may be made up to six times per calendar year.

The BSA Medical Plan reserves the right to cover or cease coverage for a prescription drug at any time during the calendar year based on evidence relating to clinical effectiveness, availability of over-the-counter drugs with the same ingredient(s), cost, and total health-care value.

The PDL and the list of participating pharmacies are available on the UnitedHealthcare website at www.myuhc.com. You can also call UnitedHealthcare Member Services at 800-632-3203.

If your physician writes a prescription for a generic drug, the drug will be filled as written. If the prescription is written for a brand-name drug, but the physician does not indicate “dispense as written” (meaning “do not substitute”), and there is a generic equivalent available, then it will be filled with the generic equivalent. If a generic equivalent is not available, the applicable copay will apply.

Prescriptions not filled through a local in-network pharmacy or through the mail-order program will not be covered. (The only exception is for those who live outside the United States, including Japan, Germany, the Virgin Islands, and Puerto Rico.)

Co-Insurance

A 20 percent co-insurance (not subject to deductible) will apply to preventive drugs on the Core Preventive Drug List for participants in the High Deductible Health Plan.

Notification/Prior Authorization

Notification or Prior Authorization requires your doctor to provide additional information about why you are taking your medication in order to determine if you will receive benefit coverage. This is based on uses listed in the U.S. Food and Drug Administration (FDA) approved medication labeling and other clinical criteria.

To begin this process:

1. Talk to your doctor and ask him or her to go online to www.optumrx.com. If they click on Healthcare Professionals and then Prior Authorizations, they can submit an online notification/prior authorization request.

2. Once OptumRx has reviewed the information, they will send you and your doctor a letter to let you know if the medication is covered under the pharmacy benefit.
If you have the HDHP with HSA, and your physician writes a prescription for 17 tablets for a 34-day supply at a local pharmacy and the cost of the prescription is $150, under the Half Tablet Program, your cost would be $75.

### UnitedHealthcare Half Tablet Program

The voluntary half tablet program could help reduce your prescription medication cost by your using double-strength tablets split in half. This program includes only those medications deemed appropriate for pill splitting, based on established clinical criteria. Here are some examples of medications that meet this requirement:

<table>
<thead>
<tr>
<th>Condition/Therapeutic Class</th>
<th>Medications Available in the Half Tablet Program</th>
<th>Current Dosage</th>
<th>Tablet Strength to Split</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hypertension (High Blood Pressure) ACE Inhibitors</strong></td>
<td>moexipril (Univasc)</td>
<td>7.5mg</td>
<td>Use 1/2 of 15mg</td>
</tr>
<tr>
<td></td>
<td>perindopril (Aceon)</td>
<td>2mg, 4mg</td>
<td>Use 1/2 of 4mg, 8mg</td>
</tr>
<tr>
<td></td>
<td>trandolapril (Mavik)</td>
<td>1mg, 2mg</td>
<td>Use 1/2 of 2mg, 4mg</td>
</tr>
<tr>
<td><strong>Hypertension (High Blood Pressure) Angiotensin Receptor Blockers (ARBs)</strong></td>
<td>Atacand</td>
<td>4mg, 8mg, 16mg</td>
<td>Use 1/2 of 8mg, 16mg, 32mg</td>
</tr>
<tr>
<td></td>
<td>Benicar</td>
<td>20mg</td>
<td>Use 1/2 of 40mg</td>
</tr>
<tr>
<td></td>
<td>valsartan (Diovan)</td>
<td>40mg, 80mg, 160mg</td>
<td>Use 1/2 of 80mg, 160mg, 320mg</td>
</tr>
<tr>
<td></td>
<td>irbesartan (Avapro)</td>
<td>75mg, 150mg</td>
<td>Use 1/2 of 150mg, 300mg</td>
</tr>
<tr>
<td></td>
<td>losartan (Cozaar)</td>
<td>25mg, 50mg</td>
<td>Use 1/2 of 50mg, 100mg</td>
</tr>
<tr>
<td><strong>High Cholesterol</strong></td>
<td>atorvastatin (Lipitor)</td>
<td>10mg, 20mg, 40mg</td>
<td>Use 1/2 of 20mg, 40mg, 80mg</td>
</tr>
<tr>
<td></td>
<td>Crestor</td>
<td>5mg, 10mg, 20mg</td>
<td>Use 1/2 of 10mg, 20mg, 40mg</td>
</tr>
<tr>
<td></td>
<td>pravastatin (Pravachol)</td>
<td>10mg, 20mg, 40mg</td>
<td>Use 1/2 of 20mg, 40mg, 80mg</td>
</tr>
<tr>
<td></td>
<td>simvastatin (Zocor)</td>
<td>5mg, 10mg, 20mg, 40mg</td>
<td>Use 1/2 of 10mg, 20mg, 40mg, 80mg</td>
</tr>
<tr>
<td><strong>Depression/Mental Health</strong></td>
<td>Abilify</td>
<td>5mg, 10mg, 15mg</td>
<td>Use 1/2 of 10mg, 20mg, 30mg</td>
</tr>
<tr>
<td></td>
<td>escitalopram (Lexapro)</td>
<td>5mg, 10mg</td>
<td>Use 1/2 of 10mg, 20mg</td>
</tr>
<tr>
<td></td>
<td>Pexeva</td>
<td>10mg, 20mg</td>
<td>Use 1/2 of 20mg, 40mg</td>
</tr>
<tr>
<td></td>
<td>sertraline (Zoloft)</td>
<td>25mg, 50mg</td>
<td>Use 1/2 of 50mg, 100mg</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>pioglitazone (Actos)</td>
<td>15mg</td>
<td>Use 1/2 of 30mg</td>
</tr>
</tbody>
</table>

If you and your doctor agree that this program is appropriate for you, and your medication meets established clinical criteria, he or she can phone in or fax a new prescription to your preferred local pharmacy or the mail-order pharmacy. Your doctor will write a prescription for twice the dosage and half the quantity of your current prescription. The pharmacist will then dispense the appropriate quantity (for example, 17 tablets for a 34-day supply at local or 45 tablets for a 90-day supply at mail) with instructions for using half a tablet per day.

An example of this is that your physician writes a prescription for 17 tablets for a 34-day supply at a local pharmacy. If the local pharmacy copay is $30 for that specific drug, under the Half Tablet Program, the copay would be only $15 under the traditional PPO plan.

If you have the HDHP with HSA, and your physician writes a prescription for 17 tablets for a 34-day supply at a local pharmacy and the cost of the prescription is $150, under the Half Tablet Program, your cost would be $75.

### To Receive Local Pharmacy Benefits

To receive benefits from a participating network pharmacy, present your UnitedHealthcare ID card along with your prescription. Your prescription will be filled for the appropriate copay.

If you will be traveling and need an early refill, ask your pharmacist to call for an early refill authorization.
To Receive Mail-Order Benefits

For mail-order prescriptions, you should complete a mail order form. You may get one at www.myuhc.com or http://bsabenefits.mercerhrs.com, or by calling 855-842-6337.

Ask your physician to prescribe a 90-day supply of needed medications plus refills. To ensure prompt processing, be sure the physician's name, patient's name, and exact daily dosage are clearly indicated. If you now take medication, ask your physician for a new prescription. Your prescription will be filled for the exact amount up to the 90-day supply. It is important that your prescription be written for a 90-day supply.

Your prescriptions are sent by first-class mail or by UPS. The package will include instructions for ordering additional prescriptions and refills. Please allow 21 days for delivery.

If you need to begin the medication immediately and do not already have some from a previous prescription, ask your doctor for two prescriptions: one for a 34-day supply that you fill at a local participating network pharmacy and the other for up to a 90-day supply that you mail order.

Select Designated Pharmacy

With prescription drug costs on the rise, certain high-cost medications are now a part of the Select Designated Pharmacy program designed to help you save money on your medications. If you are filling one of these high-cost medications through your local retail pharmacy, you will receive a letter advising that you could save money by taking a lower-cost alternative and continuing to fill at your local pharmacy.

If you would rather continue taking your current medication, you can refill it through the mail-order pharmacy, where you will get the convenience of a three-month supply at a reduced co-pay. You will be responsible for the full cost of your medication if you choose to continue filling at your local retail pharmacy without moving to a lower-cost alternative.

Mail-Order Prescription Drug Refills

If you qualify for a refill on a prescription previously filled, you can order a refill by completing the order envelope returned to you with your original order. Enclose the refill label(s) with your copay for each prescription and mail in the envelope provided.

For your convenience, you may also request refill orders by calling 855-842-6337. Please have your prescription number and credit card ready when you call. These credit cards are accepted:
- American Express
- Discover
- MasterCard
- Visa

If you will be traveling and need an early refill, call 855-842-6337 and request a vacation override.

Also, you may order your refill online at www.myuhc.com.

Specialty Pharmacy Benefits

Specialty drugs are generally high-cost, self-injectable biotechnology drugs used to treat patients with certain conditions such as hepatitis C, multiple sclerosis, rheumatoid arthritis, and some forms of cancer. The UnitedHealthcare Specialty Pharmacy Management Program helps us contain the cost for these drugs by providing a pharmacy that is focused on the purchase and distribution of only these drugs.

Please contact UnitedHealthcare at 888-739-5820 to begin using the Specialty Pharmacy Program.

Pharmacy Expenses Covered

- FDA-approved contraceptive methods for women are covered at 100 percent without a copay, coinsurance, or deductible when filled at a network pharmacy. (Please contact UnitedHealthcare at 800-632-3203 for a current list of approved contraceptive methods provided at no cost to you.)
- Federal Legend Drugs (any medicinal substance that the federal Food, Drug, and Cosmetic Act requires to be labeled “Caution—Federal Law prohibits dispensing without prescription.”)
• Drugs that require a prescription under state law but not under federal law
• Compound drugs (drugs that have more than one ingredient. At least one of the ingredients has to be a Federal Legend Drug or a drug that requires a prescription under state law.)
• Injectable drugs, including but not limited to epinephrine (EpiPen), Imitrex, glucagon, and insulin
• Insulin syringes with needles
• Drugs and other medicines used and specifically prescribed for a particular sickness
• Blood and urine test strips
• Drugs that treat erectile dysfunction
• Prenatal vitamins containing 1 milligram of folic acid
• Vitamin supplements containing fluoride for children under age 12
• Tretinoin (Retin-A) and related products for people through age 29 (can also be covered with proof of medical necessity approved by UnitedHealthcare pharmacy management)
• Oral contraceptives including contraceptive patch
• DepoProvera, diaphragms, and cervical caps
• Ketone tablets and test strips
• Lancets and lancet devices
• Insulin pump supplies
• Nonlegend drugs as required by the Affordable Care Act.

Pharmacy Expenses Not Covered
• Drugs that are not covered health services, including any drugs given in connection with a service or supply that is not a covered health service
• Over-the-counter drugs that do not require a prescription order by federal or state law before being dispensed unless otherwise listed as covered in Pharmacy Expenses Covered
• Any prescription drug that does not provide a cost or total health-care value that is equivalent to an available over-the-counter or prescription drug that contains the same prescription ingredient or is determined by pharmacy experts to be of equal clinical effectiveness
• Drugs labeled “Caution—Limited by Federal Law to investigational use”

Appealing a Pharmacy Determination

If your ongoing treatment of a specific medical condition requires the use of a non-covered prescription drug and you have had adverse reactions to similar medications, your prescribing physician may request an appeal from UnitedHealthcare.

To request an appeal, your doctor should submit a letter to UnitedHealthcare at the address below and include information about the medical condition that requires the non-covered drug and the length of projected use.

UnitedHealthcare Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

If your appeal is approved, you will be able to fill the prescription at your local network pharmacy or through mail order.
WHEN TRAVELING OUTSIDE THE UNITED STATES

You are covered under the BSA Medical Plan when traveling outside the United States. When paying for medical bills in another country, pay in U.S. currency, if possible, and request that the medical bill be written in English, and billed in U.S. dollars. Contact your physician or UnitedHealthcare's Member Services as soon as reasonably possible.

HOW THE MEDICAL PLANS OPERATE

It is important to understand how the BSA Medical Plan works and how it may affect you. In an ever-changing environment, the information also may change. Contact UnitedHealthcare if you have questions after reading the information in this benefits handbook or other materials.

Further information is available from UnitedHealthcare at www.myuhc.com or from Member Services at 800-632-3203 on Monday through Friday from 8 a.m. to 8 p.m. in your time zone. You can also contact the BSA Benefits Center at 800-444-4416 on Monday through Friday from 9 a.m. to 6 p.m., Central Standard Time or at http://bsabenefits.mercerhrs.com.

- The BSA and UnitedHealthcare do not provide medical services or make treatment decisions. The BSA medical plan is self-funded, and UnitedHealthcare administers the health benefit plan in which you are enrolled. That means:
  - UnitedHealthcare makes decisions about whether the health benefit plan you are enrolled in will reimburse you for care that you may receive.
  - UnitedHealthcare does not decide what care you need or receive. You and your physician make those decisions.
- The BSA or UnitedHealthcare may enter into arrangements where other entities carry out some of the administrative duties under the plan, but those entities must operate consistently with the plan.
- UnitedHealthcare may use individually identifiable information about you to help you (and you alone) learn about procedures, products, or services that you may find valuable.

- UnitedHealthcare contracts with physicians and other health-care professionals. UnitedHealthcare's credentialing process confirms public information about their licenses and credentials, but does not ensure the quality of the services provided.
- Physicians and other health-care professionals in UnitedHealthcare's networks are independent contractors, not employees or agents. The BSA and UnitedHealthcare do not control nor have a right to control your physician's treatment plan.
- UnitedHealthcare may enter into cost-savings agreements with physicians or other health-care professionals. UnitedHealthcare encourages physicians and other health-care professionals in its network to disclose the nature of those arrangements with you. If they do not, you are encouraged to talk to your physicians and other health-care professionals about these arrangements.
- UnitedHealthcare encourages physicians to talk with you about medical care you or your physician thinks might be valuable.
- UnitedHealthcare will use individually identifiable information about you as permitted by law, including in its operations and research. UnitedHealthcare will use anonymous data for commercial purposes, including research.

Who Pays What?

Each year you are required to give information about any other plans covering you or your dependents when you file a claim. If the primary carrier (other carrier) pays the same amount or more than the BSA Medical Plan, no payment will be made by the BSA Medical Plan. If the primary carrier pays less than the BSA Medical Plan, then eligible expenses will be considered up to the allowable benefit under the BSA Medical Plan.

Which Plan Is Primary (While Employed)?

These rules are used to determine which plan is primary and which is secondary if you or your covered dependent are covered under two group plans. They are always used in the following order:

1. A plan that does not have a coordination of benefits provision is primary to a plan that does have a coordination of benefits provision.
2. A plan that covers the employee is primary to a plan that covers the same person as a dependent.

3. If the other plan contains a coordination of benefits provision, the primary carrier is determined as follows:
   - If the patient is a BSA or local council employee or a retiree and is not covered by Medicare, the BSA Medical Plan is the primary carrier and pays its usual benefits first.
   - If the patient is employed by the other employer, the other plan is the primary carrier and pays its usual benefits first.

4. If the patient is a dependent child, the plan covering the parent whose birthday comes earliest in the year (without regard to year of birth) is the primary carrier.

5. If the patient is a dependent child and both parents have the same birthday, the plan that has covered one of the parents for the longest time is the primary carrier.

6. If the dependent child is covered under two or more plans of divorced or separated parents, the following rules will be used to determine which plan is primary:
   - The plan of the parent with custody is primary to the plan of the parent without custody.
   - If the parent with custody has re-married, the order of payment is:
     A. The plan of the parent with custody pays benefits first.
     B. The plan of the stepparent with custody pays benefits next.
     C. The plan of the parent without custody pays benefits next.
     D. The plan of the stepparent without custody pays benefit next.
     - If there is no court decree and the child's parents have joint custody, then the plan covering the parent whose birthday comes earliest in the year (without regard to year of birth) is the primary carrier.

7. If, in the case of divorce or separation, a court decree assigns one parent financial responsibility for the medical, dental, or other health expenses of the dependent child, and if the plan that covers the parent who has financial responsibility knows the specific terms of the court decree, it is primary to any other plan that covers that dependent child.

8. A plan that covers a person as an employee who is not laid off or retired, or as a dependent of that employee, is primary to any plan that also covers the person as a laid-off or retired employee, or as a dependent of that employee. If the other plan does not have a rule for laid-off or retired employees similar to this rule, this rule will not apply.

9. If none of the above rules applies, the plan that has covered the person for the longest time is primary to all other plans.

### RECOVERY AND REIMBURSEMENT RIGHTS

The BSA Medical Plan will be subrogated to you or your dependent's right of recovery against any person or insurer in connection with injuries sustained by you or your dependent. The BSA Medical Plan may exercise this right to the extent of the benefits provided under the BSA Medical Plan on account of those injuries. The plan's rights shall be a first priority lien, to be paid from any settlement or judgment before any other claim for damages, regardless of whether the injured person is fully compensated (“made whole”) by such settlement or judgment.

The BSA Medical Plan also will have a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is in addition to the BSA Medical Plan's subrogation right, but only to the extent of the benefits provided under the BSA Medical Plan.

The BSA Medical Plan's subrogation and reimbursement rights apply to any recoveries made by or on behalf of you or your dependent as a result of the injuries sustained, including:

- Payments made directly by or on behalf of a third party or its insurer
- Any payment, settlement, judgment, or arbitration award paid by an insurer under any policyholder's automobile or homeowner's insurance policy (including any “no fault,” uninsured, or underinsured motorist coverage)
• Any other payment from any source designed or intended to compensate you or your dependent for injuries for which a third party may be liable as the result of its negligence or alleged negligence, its strict liability or otherwise
• Any workers' compensation award or settlement

Neither you nor your dependent may incur any expenses on behalf of the BSA Medical Plan in pursuit of its subrogation and reimbursement rights. In particular, no court costs or attorney's fees may be deducted from the BSA Medical Plan's recovery without the prior expressed written consent of the BSA Medical Plan or its representative.

By enrolling in the BSA Medical Plan, you and your dependents agree to cooperate fully with the BSA Medical Plan to help it exercise these rights. If full cooperation is withheld, you must reimburse the BSA Medical Plan for all costs and expenses, including attorneys' fees, incurred by the plan in enforcing these rights.

Claims

HEALTH STATEMENTS

Each month in which UnitedHealthcare processes at least one claim for you or a covered dependent, you will receive a health statement in the mail. Health statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered dependents online, you may do so at www.myuhc.com. You may also discontinue receipt of paper health statements by selecting that option on that site.

FILING A CLAIM

If you use an in-network physician, specialist, or facility, UnitedHealthcare pays them directly. If an in-network physician, specialist, or facility bills you for any covered services, contact UnitedHealthcare. However, you are responsible for any copays and/or coinsurance at the time of service or when you receive a bill from the physician, specialist, or facility.

If you choose to use an out-of-network physician, specialist, or facility for covered services, you are responsible for requesting payment from UnitedHealthcare. You must file the claim in a format that contains all of the information required, as described below. You are responsible for meeting the annual deductible, paying the copays and/or coinsurance amount, and paying any amount that exceeds reasonable and customary charges and/or plan limits. Payment is at the time of service or when you receive a bill from the physician, specialist, or facility.

Time to File

You must submit a request for payment of benefits within one year after the date of service. If an out-of-network health-care professional submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you do not provide this information to UnitedHealthcare within one year of the date of service, benefits for that health service will be denied or reduced.

Required Information

When you request payment of benefits from UnitedHealthcare, you must provide all of the following information:
• Your name and address
• The patient's name, age, and relationship to you
• Your member number and group number as printed on your ID card
• An itemized bill from your health-care professional that includes the following:
  — Patient diagnosis
  — Date(s) of service
  — Procedure code(s) and descriptions of service(s) rendered
  — Charge for each service rendered
  — Provider of service name, address, and tax identification number
  — The date the injury or sickness began
• A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

Mail claims to:

UnitedHealthcare
PO. Box 30555
Salt Lake City, UT 84130-0555

**Payment of Benefits**

UnitedHealthcare will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

- The health-care professional notifies UnitedHealthcare that your signature is on file, assigning benefits directly to that health-care professional.
- You make a written request for the out-of-network health-care professional to be paid directly at the time you submit your claim.

This plan will always be secondary to medical payment coverage or personal injury protection (PIP) coverage under any auto liability or no-fault insurance policy.

**POST-SERVICE CLAIMS**

Post-service claims are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from UnitedHealthcare within 30 days of receipt of the claim, as long as all needed information was provided with the claim. UnitedHealthcare will notify you within this 30-day period if more information is needed to process the claim. UnitedHealthcare may request a one-time extension not longer than 15 days and put your claim on “pending” status until all information is received.

Once notified of the extension, you have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, UnitedHealthcare will notify you of the denial within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

**PRE-SERVICE CLAIMS**

Pre-service claims require notification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from UnitedHealthcare within 15 days of receipt of the claim. If you filed a pre-service claim improperly, UnitedHealthcare will notify you of the improper filing and how to correct it within five days after the pre-service claim was received.

If more information is needed to process the pre-service claim, UnitedHealthcare will notify you of the information needed within 15 days after the claim was received. UnitedHealthcare also may request a one-time extension not longer than 15 days and put your claim on “pending” status until all information is received. Once notified of the extension, you have 45 days to provide this information. If all information needed is received within the 45-day time frame, UnitedHealthcare will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

**URGENT CARE CLAIMS**

Urgent care claims require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize a patient’s life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of the patient’s medical condition, could cause severe pain. You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for benefits. In these situations:

- You will receive notice of the benefit determination (whether adverse or not) in writing or electronically within 72 hours after UnitedHealthcare receives all necessary information, taking into account the seriousness of the patient’s condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.
• If you filed an urgent care claim improperly, UnitedHealthcare will notify you of the improper filing and how to correct it within 72 hours after the claim was received. If more information is needed to process the claim, UnitedHealthcare will notify you of the information needed within 72 hours after the claim was received. You then have 48 hours after receiving notice that additional information is required to provide that information.

You will be notified of a determination no later than 72 hours after:
• UnitedHealthcare’s receipt of the requested information, or
• The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If UnitedHealthcare denies your urgent care claim, you must appeal the adverse benefit determination no later than 180 days after receiving the adverse benefit determination. UnitedHealthcare must notify you of the appeal decision within 72 hours after receiving the appeal.

IF A CLAIM IS DENIED OR BENEFITS ARE REDUCED

If your question or concern is about a benefit determination, you may informally contact Member Services before requesting a formal appeal. If the Member Services representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described under “Filing a Claim,” you may appeal it as described below, without first informally contacting Member Services. If you first informally contact Member Services and later wish to request a formal appeal in writing, you should contact Member Services and request an appeal. If you request a formal appeal, a Member Services representative will give you the appropriate address of UnitedHealthcare.

If you are appealing an urgent care claim denial, please refer to “Urgent Care Claim Appeals” below and contact Member Services immediately at 800-632-3203. Member Services representatives are available to take your call between 8 a.m. and 8 p.m., Monday through Friday in your time zone.

Appeals

APPELLING A CLAIM DETERMINATION

If you wish to appeal a denied pre-service request for benefits, post-service claim, or a rescission of coverage, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:
• The patient’s name and the identification number from the ID card
• The date(s) of medical service(s)
• The health-care professional’s name
• The reason you disagree with the denial
• Any documentation or other written information to support your request for claim payment

CONCURRENT CARE CLAIMS

If an ongoing course of treatment was previously approved, and your request to extend the treatment is an urgent care request for benefits as defined in the previous section, your request will be decided within 24 hours. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service time frames, whichever applies.
The request should be sent to:

UnitedHealthcare Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

Appeal Process

As part of the appeals process, you are entitled to:

• Submit written comments, documents, records, and other information relating to the claim for benefits whether or not submitted in connection with your initial claim.
• Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your claim if it:
  — Was relied upon in making the benefit determination
  — Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record, or other information was relied upon in making the benefit determination
  — Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  — Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
• A review that takes into account all comments, documents, records, and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.
• A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination nor by that person's subordinate.
• A review in which the named fiduciary consults with a health-care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug, or other item is experimental).
• The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.
• In the case of a claim for urgent care, an expedited review process in which:
  — You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination.
  — All necessary information, including the plan's benefit determination on review, will be transmitted between the plan and you by telephone, facsimile, or other available similarly prompt method.
• You will also be provided, free of charge, any new or additional evidence considered, relied upon, or generated by the plan or at the plan's direction in connection with your claim. This material, if any, will be provided to you as soon as possible and sufficiently in advance of the deadline for the determination of the appeal to give you an opportunity to respond prior to the deadline.

Appeal Determinations

UnitedHealthcare will provide you with a notification of any adverse benefit determination, which will set forth:

• The specific reason(s) for the adverse benefit determination
• References to the specific plan and/or summary plan description provisions on which the benefit determination is based
• A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary
• A description of the plan's internal appeal and external review procedures that may be available to you and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination
• Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.
• If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request

• If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim

• Sufficient information to identify the claim, including the date of service, the provider, the claim amount (if applicable), the diagnosis, treatment and denial codes and their meanings, and the standard, if any, used for deciding the claim

• The availability of health insurance consumer assistance or a Public Health Service ombudsman, including contact information, to assist you in seeking plan benefits

You will be provided written or electronic notification of decision on your appeal as follows:

For appeals of pre-service claims, the first-level appeal will be conducted, and you will be notified by UnitedHealthcare of the decision within 15 days from receipt of a request for appeal of a denied claim. The second-level appeal will be conducted, and you will be notified by UnitedHealthcare of the decision within 15 days from receipt of a request for review of the first-level appeal decision.

For appeals of post-service claims, the first level appeal will be conducted, and you will be notified by UnitedHealthcare of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted, and you will be notified by UnitedHealthcare of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent care claims, see “Urgent Care Claim Appeals.”

If you are not satisfied with the first-level appeal decision of UnitedHealthcare, you have the right to request a second-level appeal from UnitedHealthcare as the plan administrator. You must submit your second-level appeal request to UnitedHealthcare within 60 days from the receipt of the first-level appeal decision.

For pre-service and post-service claim appeals, the Boy Scouts of America has delegated to UnitedHealthcare the exclusive right to interpret and administer the provisions of the plan. UnitedHealthcare’s decisions are conclusive and binding. There is not an appeal to the Boy Scouts of America.

Please note that UnitedHealthcare’s decision is based only on whether benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Urgent Care Claim Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your physician should call UnitedHealthcare as soon as possible. UnitedHealthcare will provide you with a written or electronic determination within 24 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent care claim appeals, the Boy Scouts of America has delegated to UnitedHealthcare the exclusive right to interpret and administer the provisions of the plan. UnitedHealthcare’s decisions are conclusive and binding. There is not an appeal to the Boy Scouts of America.

External Review Program

If a final determination to deny benefits is made, you may choose to participate in our external review program. This program only applies if the decision is based on:

• Clinical reasons
• The exclusion for experimental, investigational, or unproven services
• As otherwise required by applicable law

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after you exhaust the appeals process noted above and you receive an unfavorable decision, or if UnitedHealthcare fails to respond to your appeal within the applicable time frames.
You may request an independent review of the adverse benefit determination. Neither you nor UnitedHealthcare will be able to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. You, your treating physician or an authorized designated representative may request an independent review by contacting UnitedHealthcare Member Services at 800-632-3203 or by sending a written request to the address on your identification card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a covered health service under the BSA Medical Plan. The independent review organization (IRO) has been contracted by UnitedHealthcare and has no material affiliation or interest with UnitedHealthcare or Boy Scouts of America. UnitedHealthcare will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

As part of the appeals process, you are entitled to:

- Submit written comments, documents, records, and other information relating to the claim for benefits whether or not submitted in connection with your initial claim.
- Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record, or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- A review that takes into account all comments, documents, records, and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination nor by that person's subordinate.
- A review in which the named fiduciary consults with a health-care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug, or other item is experimental).
  - The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.
  - In the case of a claim for urgent care, an expedited review process in which:
    - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination.
    - All necessary information, including the plan's benefit determination on review, will be transmitted between the plan and you by telephone, facsimile, or other available similarly prompt method.
  - You will also be provided, free of charge, any new or additional evidence considered, relied upon, or generated by the plan or at the plan's direction in connection with your claim. This material, if any, will be provided to you as soon as possible and sufficiently in advance of the deadline for the determination of the appeal to give you an opportunity to respond prior to the deadline.
The reviewer’s decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and UnitedHealthcare with the reviewer’s decision, a description of the reviewer’s qualifications, and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the BSA Medical Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the plan. If the final independent review decision is that payment or referral will not be made, the plan will not be obligated to provide benefits for the service or procedure.

Contact UnitedHealthcare Member Services at 800-632-3203 for more information about your appeal rights and the independent review process.

Limitation of Action

You cannot bring any legal action against Boy Scouts of America or the claims administrator to recover reimbursement until 90 days after (1) you have properly submitted a request for reimbursement as described in this section and (2) all required reviews of your claim have been completed. If you want to bring a legal action against Boy Scouts of America or the claims administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Boy Scouts of America or the claims administrator.

You cannot bring any legal action against Boy Scouts of America or the claims administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Boy Scouts of America or the claims administrator, you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against Boy Scouts of America or the claims administrator.

Appealing Eligibility and Enrollment Determinations

In accordance with the Employee Retirement Income Security Act (ERISA), section 503, the BSA has established and maintains reasonable procedures governing filing for benefits, notification of benefit determinations, and appeal of adverse benefit determinations.

Appeals by Plan Participants

The BSA appeal procedures ensure:

- Participants shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and
- there will be a full and fair review of the appeal.

Under the appeal process:

- The participant shall have the opportunity to submit written comments, documents, records, and other information relating to the appeal request.
- The participant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant’s claim for benefits.
- The review will take into account all comments, documents, records, and other information submitted by the participant relating to the appeal.

As part of the appeal process, participants are entitled to:

- Submit written comments, documents, records, and other information relating to the appeal.
- Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the appeal.
These procedures allow a participant to appeal any determination not related to claim payment, including a denial for enrollment in the plan or a change in the benefit election for themselves or their eligible dependents.

Participants wishing to file an appeal must do so in writing, providing information on the eligibility or enrollment request that was denied, including any accompanying documentation that supports their request for appeal.

Appeal requests may be submitted by:

- U.S. Postal Service mail to:
  HR Compensation and Benefits
  SUM 288
  1325 W. Walnut Hill Lane
  Irving, TX 75038
- Fax to 972-580-2194
- Email to scouting2health@scouting.org

**Notice and Timing of Appeal Determination**

Participants will receive written notification at their home address of the determination made by the Benefits Committee within 60 days of receipt of the request for review by the Benefits Committee. Due to special circumstances, an extension of up to 60 days may occur. Written notice of the extension shall be furnished to the participant prior to the termination of the initial 60-day period.

In the case of an adverse determination on appeal, a written notice of denial will include:

- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provisions on which the benefit determination is based.
- A description of the plan’s internal appeal procedure and the time limits applicable, including a statement of your right to bring a civil action under ERISA after receiving an adverse benefit determination.
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.

**Limitation of Action**

A participant cannot bring legal action against Boy Scouts of America until 90 days after they have properly submitted a request for appeal and all required reviews have been completed.

**Your Rights**

**ERISA INFORMATION AND NOTICE OF RIGHTS**

If you participate in the BSA Medical Plan, you are entitled to certain rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Refer to the Legal Notices chapter for more information.

**WOMEN’S HEALTH AND CANCER RIGHTS**

Your BSA Medical Plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). For more information, call UnitedHealthcare at 800-632-3203.

**LEGAL INFORMATION**

**Right to Amend the Plan**

All benefits under the BSA Medical Plan are funded by the Boy Scouts of America. The BSA has a contract with UnitedHealthcare to process benefit claims and to provide certain other services under the plan. Benefits under this plan will be paid only if the plan administrator decides in its discretion that the applicant is entitled to them. The BSA reserves the right to make revisions to, or terminate, the plan at any time. If you have any questions, please contact the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com. Please refer to the Legal Notices chapter for the Boy Scouts of America “Privacy of Your Information” policy and the “Notice of Privacy Policies” as required under the Health Insurance Portability and Accountability Act (HIPAA).
## 2016 Monthly Premiums

### ACTIVE EMPLOYEE

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*2016 incentive rates are earned by employees and covered spouses who completed health activities specified in the Personal Rewards Program.

All rates are subject to change upon provision of written notice.
# 2016 Monthly Premiums

**EMPLOYEE ON LONG-TERM DISABILITY; NOT ON MEDICARE**

This coverage is no longer available for those who are age 65 or over.

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<td>$777.00</td>
<td></td>
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<tr>
<td>Self, Medicare spouse, &amp; 2+ children</td>
<td>$915.00</td>
<td>$853.00</td>
<td></td>
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</tr>
</tbody>
</table>
2016 Monthly Premiums

RETIREE OR SURVIVOR NOT ON MEDICARE

Retirement on or before Dec. 1, 2004
OR
Retirement on or after Jan. 1, 2005,
with at least 20 years of benefit-eligible service

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
<th>HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retiree</td>
<td>BSA</td>
</tr>
<tr>
<td>Self or spouse or child</td>
<td>$518.00</td>
<td>$786.00</td>
</tr>
<tr>
<td>Self &amp; non-Medicare spouse</td>
<td>$1,060.00</td>
<td>$1,611.00</td>
</tr>
<tr>
<td>Self or spouse or child + 1 child</td>
<td>$613.00</td>
<td>$929.00</td>
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<tr>
<td>Self &amp; 2+ children</td>
<td>$726.00</td>
<td>$1,103.00</td>
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<tr>
<td>Self, non-Medicare spouse, &amp; 1 child</td>
<td>$1,156.00</td>
<td>$1,755.00</td>
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<td>Self, non-Medicare spouse, &amp; 2+ children</td>
<td>$1,269.00</td>
<td>$1,926.00</td>
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<tr>
<td>Self &amp; Medicare spouse</td>
<td>$611.00</td>
<td>$926.00</td>
</tr>
<tr>
<td>Self, Medicare spouse, &amp; 1 child</td>
<td>$706.00</td>
<td>$1,070.00</td>
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<tr>
<td>Self, Medicare spouse, &amp; 2+ children</td>
<td>$819.00</td>
<td>$1,243.00</td>
</tr>
</tbody>
</table>

RETIREE OR SURVIVOR ON MEDICARE

This coverage is no longer available for those who are age 65 or over.

Retirement on or before Dec. 1, 2004
OR
Retirement on or after Jan. 1, 2005,
with at least 20 years of benefit-eligible service

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retiree</td>
</tr>
<tr>
<td>Self or spouse or child</td>
<td>$199.00</td>
</tr>
<tr>
<td>Self &amp; non-Medicare spouse</td>
<td>$720.00</td>
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<td>$295.00</td>
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<tr>
<td>Self &amp; 2+ children</td>
<td>$409.00</td>
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<tr>
<td>Self, non-Medicare spouse, &amp; 1 child</td>
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<td>Self, non-Medicare spouse, &amp; 2+ children</td>
<td>$932.00</td>
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<tr>
<td>Self &amp; Medicare spouse</td>
<td>$399.00</td>
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<tr>
<td>Self, Medicare spouse, &amp; 1 child</td>
<td>$514.00</td>
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<tr>
<td>Self, Medicare spouse, &amp; 2+ children</td>
<td>$609.00</td>
</tr>
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</table>
# 2016 Monthly Premiums

## RETIREE OR SURVIVOR NOT ON MEDICARE

Retirement on or after Jan. 1, 2005, with at least 10 but less than 20 years of benefit-eligible service

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
<th>HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retiree</td>
<td>BSA</td>
</tr>
<tr>
<td>Self or spouse or child</td>
<td>$911.00</td>
<td>$393.00</td>
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<tr>
<td>Self &amp; non-Medicare spouse</td>
<td>$1,866.00</td>
<td>$805.00</td>
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<tr>
<td>Self or spouse or child + 1 child</td>
<td>$1,077.00</td>
<td>$465.00</td>
</tr>
<tr>
<td>Self &amp; 2+ children</td>
<td>$1,278.00</td>
<td>$551.00</td>
</tr>
<tr>
<td>Self, non-Medicare spouse, &amp; 1 child</td>
<td>$2,034.00</td>
<td>$877.00</td>
</tr>
<tr>
<td>Self, non-Medicare spouse, &amp; 2+ children</td>
<td>$2,232.00</td>
<td>$963.00</td>
</tr>
<tr>
<td>Self &amp; Medicare spouse</td>
<td>$1,074.00</td>
<td>$463.00</td>
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<tr>
<td>Self, Medicare spouse, &amp; 1 child</td>
<td>$1,241.00</td>
<td>$535.00</td>
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<tr>
<td>Self, Medicare spouse, &amp; 2+ children</td>
<td>$1,440.00</td>
<td>$622.00</td>
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</tbody>
</table>

## RETIREE OR SURVIVOR ON MEDICARE

This coverage is no longer available for those who are age 65 or over.

Retirement on or after Jan. 1, 2005, with at least 10 but less than 20 years of benefit-eligible service

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
<th>HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retiree</td>
<td>BSA</td>
</tr>
<tr>
<td>Self or spouse or child</td>
<td>$349.00</td>
<td>$149.00</td>
</tr>
<tr>
<td>Self &amp; non-Medicare spouse</td>
<td>$1,261.00</td>
<td>$541.00</td>
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<tr>
<td>Self or spouse or child + 1 child</td>
<td>$515.00</td>
<td>$221.00</td>
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<tr>
<td>Self or spouse &amp; 2+ children</td>
<td>$716.00</td>
<td>$307.00</td>
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<tr>
<td>Self, non-Medicare spouse, &amp; 1 child</td>
<td>$1,428.00</td>
<td>$612.00</td>
</tr>
<tr>
<td>Self, non-Medicare spouse, &amp; 2+children</td>
<td>$1,628.00</td>
<td>$699.00</td>
</tr>
<tr>
<td>Self &amp; Medicare spouse</td>
<td>$698.00</td>
<td>$298.00</td>
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<tr>
<td>Self, Medicare spouse, &amp; 1 child</td>
<td>$898.00</td>
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<tr>
<td>Self, Medicare spouse, &amp; 2+ children</td>
<td>$1,065.00</td>
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### 2016 COBRA MONTHLY PREMIUMS

#### ACTIVE EMPLOYEES

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
<th>HDHP</th>
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</thead>
<tbody>
<tr>
<td>Self</td>
<td>$661.98</td>
<td>$566.44</td>
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<tr>
<td>Self &amp; spouse</td>
<td>$1,322.94</td>
<td>$1,174.36</td>
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<tr>
<td>Self &amp; 1 child</td>
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<td>$809.20</td>
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<tr>
<td>Self &amp; 2+ children</td>
<td>$1,189.32</td>
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<tr>
<td>Self, spouse, &amp; 1 child</td>
<td>$1,588.14</td>
<td>$1,418.14</td>
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<tr>
<td>Self, spouse, &amp; 2+ children</td>
<td>$1,852.32</td>
<td>$1,662.94</td>
</tr>
<tr>
<td>Per child</td>
<td>$264.18</td>
<td>$242.76</td>
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</table>

#### EMPLOYEE ON LONG-TERM DISABILITY; NOT ON MEDICARE

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
<th>HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>$613.02</td>
<td>$559.98</td>
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<tr>
<td>Self &amp; spouse</td>
<td>$1,273.98</td>
<td>$1,167.90</td>
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<tr>
<td>Self &amp; 1 child</td>
<td>$877.20</td>
<td>$802.74</td>
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<tr>
<td>Self &amp; 2+ children</td>
<td>$1,140.36</td>
<td>$1,045.50</td>
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<td>Self, spouse, &amp; 1 child</td>
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<td>$1,411.68</td>
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<tr>
<td>Self, spouse, &amp; 2+ children</td>
<td>$1,803.36</td>
<td>$1,656.48</td>
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<tr>
<td>Per child</td>
<td>$264.18</td>
<td>$242.76</td>
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</table>

#### EMPLOYEE ON LONG-TERM DISABILITY; ON MEDICARE

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>$613.02</td>
</tr>
<tr>
<td>Self &amp; non-Medicare spouse</td>
<td>$1,273.98</td>
</tr>
<tr>
<td>Self &amp; 1 child</td>
<td>$877.20</td>
</tr>
<tr>
<td>Self &amp; 2+ children</td>
<td>$1,140.36</td>
</tr>
<tr>
<td>Self, non-Medicare spouse, &amp; 1 child</td>
<td>$1,539.18</td>
</tr>
<tr>
<td>Self, non-Medicare spouse, &amp; 2+ children</td>
<td>$1,803.36</td>
</tr>
<tr>
<td>Self &amp; Medicare spouse</td>
<td>$1,273.98</td>
</tr>
<tr>
<td>Self, Medicare spouse &amp; 1 child</td>
<td>$1,539.18</td>
</tr>
<tr>
<td>Self, Medicare spouse &amp; 2+ children</td>
<td>$1,803.36</td>
</tr>
<tr>
<td>Per child</td>
<td>$264.18</td>
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</table>
## Retiree Not On Medicare

<table>
<thead>
<tr>
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<th>Traditional</th>
<th>HDHP</th>
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</thead>
<tbody>
<tr>
<td>Self</td>
<td>$1,330.08</td>
<td>$1,224.00</td>
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<tr>
<td>Self &amp; non-Medicare spouse</td>
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</tr>
<tr>
<td>Self &amp; 1 child</td>
<td>$1,572.84</td>
<td>$1,447.38</td>
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<tr>
<td>Self &amp; 2+ children</td>
<td>$1,865.58</td>
<td>$1,716.66</td>
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<tr>
<td>Self, non-Medicare spouse, &amp; 1 child</td>
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<td>$2,731.56</td>
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<td>Self, non-Medicare spouse, &amp; 2+ children</td>
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<tr>
<td>Self &amp; Medicare spouse</td>
<td>$1,567.74</td>
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<tr>
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<td>$1,666.68</td>
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<tr>
<td>Self, Medicare spouse, &amp; 2+ children</td>
<td>$2,103.24</td>
<td>$1,934.94</td>
</tr>
<tr>
<td>Per child</td>
<td>$242.76</td>
<td>$223.38</td>
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</table>

## Retiree On Medicare

<table>
<thead>
<tr>
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<th>Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>$507.96</td>
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<tr>
<td>Self &amp; non-Medicare spouse</td>
<td>$1,838.04</td>
</tr>
<tr>
<td>Self &amp; 1 child</td>
<td>$750.72</td>
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<tr>
<td>Self &amp; 2+ children</td>
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<tr>
<td>Self, non-Medicare spouse, &amp; 1 child</td>
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<tr>
<td>Self, non-Medicare spouse, &amp; 2+ children</td>
<td>$2,373.54</td>
</tr>
<tr>
<td>Self &amp; Medicare spouse</td>
<td>$1,015.92</td>
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<tr>
<td>Self, Medicare spouse, &amp; 1 child</td>
<td>$1,308.66</td>
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<tr>
<td>Self, Medicare spouse, &amp; 2+ children</td>
<td>$1,551.42</td>
</tr>
<tr>
<td>Per child</td>
<td>$242.76</td>
</tr>
</tbody>
</table>

## Dental Assistance Plan

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Self</td>
<td>$34.68</td>
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<tr>
<td>Self &amp; spouse</td>
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</tr>
<tr>
<td>Self &amp; 1 child</td>
<td>$68.34</td>
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<tr>
<td>Self &amp; 2+ children</td>
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<td>$96.90</td>
</tr>
<tr>
<td>Self, spouse, &amp; 2+ children</td>
<td>$129.54</td>
</tr>
<tr>
<td>Per child</td>
<td>$33.66</td>
</tr>
</tbody>
</table>

## Vision Care Plan

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>$11.30</td>
</tr>
<tr>
<td>Self &amp; spouse</td>
<td>$18.11</td>
</tr>
<tr>
<td>Self &amp; 1 child</td>
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<tr>
<td>Self &amp; 2+ children</td>
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<tr>
<td>Self, spouse, &amp; 1 child</td>
<td>$31.19</td>
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<tr>
<td>Self, spouse, &amp; 2+ children</td>
<td>$31.19</td>
</tr>
<tr>
<td>Per child</td>
<td>$7.19</td>
</tr>
</tbody>
</table>
CHOICE PLUS

Plans
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Under the Choice Plus medical plan options, you have the freedom to choose either a network or an out-of-network provider each time you seek medical care, except for preventive services and United Resource Network, which are covered in network only.

**Copay** is when you pay a specific amount for a visit to a physician or for a prescription.

**Coinsurance** is when you pay a specific percentage of the total cost of the service or product.

**Deductible** is the amount of eligible expenses that must be incurred before benefits are payable.

### Choice Plus Plans

Only coinsurance, copays, and deductibles apply to the out-of-pocket maximum, while non-notification decrease and charges exceeding eligible, reasonable, and customary do not.

**Deductible** (Must be met annually before coinsurance applies.)

- **Individual**
  - In Network: $2,500
  - Out of Network: $10,000

- **Family**
  - In Network: $5,000
  - Out of Network: $20,000

**Out-of-Pocket Maximum**

- **Individual**
  - In Network: $2,500
  - Out of Network: $10,000

- **Family**
  - In Network: $5,000
  - Out of Network: $20,000

**Coinsurance**

- **Individual**
  - 20% after deductible

- **Family**
  - 40% after deductible

**Lifetime Maximum**

- **Traditional PPO**
  - In Network: N/A
  - Out of Network: N/A

- **HDHP With HSA**
  - In Network: N/A
  - Out of Network: N/A

### Physician Office Visits

- **PCP Office Visit**
  - $30

- **Specialist Office Visit**
  - $40

- **Outpatient Therapy**
  - $40

- **Chiropractic Care**
  - $40

- **Virtual Visits**
  - $40

- **Urgent Care Center**
  - $50

**Preventive Care (Effective Sept, 1, 2010)**

- **0% (not subject to deductible)**
- **Not covered**

**Inpatient/Outpatient Lab and X-Ray**

- **Inpatient Hospital**
  - Per admission, including maternity stays (semi-private room and board, anesthesia, medications, supplies, inpatient lab and X-ray)
  - **First 5 days:** $150 copay per day plus deductible plus 20% of the balance. Days 6+: 20%
  - **First 5 days:** $150 copay per day plus deductible plus 40% of the balance. Days 6+: 0%

  - **Physician fees for inpatient surgery**
    - 20%
    - 40%

  - **Physician visits in hospital**
    - 20%
    - 40%

- **Emergency Room (copay does not apply if admitted)**
  - 20%
  - 40%

**Mental Health and Chemical Dependency**

- **Outpatient facility**
  - $30
  - 40%
  - 0%
  - 20%

- **Inpatient hospital charges and supplies**
  - Same as for inpatient hospital
  - $30, first visit only
  - 40%
  - 0%

- **Outpatient care**
  - Same as for inpatient hospital
  - 20%
  - 40%
  - 0%

- **Intermediate care**
  - Same as for inpatient hospital
  - 20%

- **Outpatient care**
  - Same as for inpatient hospital
  - $30
  - 40%
  - 0%

### Traditional PPO

You Pay:

- **In Network**
  - Does not apply to out of network.
  - Does not apply to in network.

- **Out of Network**
  - Does not apply to out of network.
  - Does not apply to in network.

### HDHP With HSA

You Pay:

- **In Network**
  - Does not apply to out of network.
  - Does not apply to in network.

- **Out of Network**
  - No out-of-pocket maximum.
<table>
<thead>
<tr>
<th>Prescription Medication</th>
<th>$50 annual deductible per person</th>
<th>$2,600 or $5,200 annual deductible for individual or family (medical and drug combined)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local (up to a 34-day supply)</td>
<td>Traditional PPO</td>
<td>HDHP With HSA</td>
</tr>
<tr>
<td>Tier 1 Copay</td>
<td>$7.00</td>
<td></td>
</tr>
<tr>
<td>Tier 2 Coinsurance</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Minimum Copay</td>
<td>$30.00</td>
<td></td>
</tr>
<tr>
<td>Maximum Copay</td>
<td>$60.00</td>
<td></td>
</tr>
<tr>
<td>Tier 3 Coinsurance</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Minimum Copay</td>
<td>$50.00</td>
<td></td>
</tr>
<tr>
<td>Maximum Copay</td>
<td>$100.00</td>
<td></td>
</tr>
<tr>
<td>Mail Order (up to a 90-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 Copay</td>
<td>$14.00</td>
<td></td>
</tr>
<tr>
<td>Tier 2 Coinsurance</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Minimum Copay</td>
<td>$60.00</td>
<td></td>
</tr>
<tr>
<td>Maximum Copay</td>
<td>$120.00</td>
<td></td>
</tr>
<tr>
<td>Tier 3 Coinsurance</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Minimum Copay</td>
<td>$100.00</td>
<td></td>
</tr>
<tr>
<td>Maximum Copay</td>
<td>$200.00</td>
<td></td>
</tr>
<tr>
<td>Medications on the Preventive Drug List*</td>
<td>20% (not subject to deductible)</td>
<td></td>
</tr>
<tr>
<td>Specialty Pharmacy</td>
<td>Must use UnitedHealthcare Specialty Pharmacy</td>
<td></td>
</tr>
</tbody>
</table>

* The Preventive Drug List is available online at www.myuhc.com, on MyBSA/HR Gateway, and on www.mercerhrs.com/scouting2health.
In-Network Benefits

You may access the list of Choice Plus physicians, specialists, and facilities through UnitedHealthcare's website at www.myuhc.com. You may also request a list from United Healthcare Member Services by calling 800-632-3203.

Primary care physicians (PCPs) include general practitioners, family practitioners, internists, pediatricians, or obstetrician/gynecologists. (See the Glossary for PCP definition.)

IN-NETWORK DEDUCTIBLES

The calendar-year deductible below is the amount you pay in covered expenses each year before the plans begin to pay benefits for the HDHP. The Traditional PPO Plan includes covered items that are not subject to a deductible. If two or more family members are injured in the same accident, only one individual deductible must be met for all covered expenses related to the accident.

The family deductible can be met collectively by two or more family members provided one family member has met the individual deductible.

Traditional PPO Plan
• $1,250 individual deductible.
• $2,500 family deductible.

High Deductible Health Plan With Health Savings Account
• $2,600 individual deductible.
• $5,200 family deductible.

Note: The year-to-date deductible amount met will be carried over if an employee terminates employment and rehires in the same calendar year.

OUT-OF-NETWORK DEDUCTIBLES

If you use an out-of-network physician, specialist, or facility, a calendar-year deductible must first be met. After the deductible has been met, covered expenses will be paid at 60 percent (Traditional PPO Plan) or 80 percent (High Deductible Health Plan), subject to eligible, reasonable, and customary charges. The calendar-year deductible is the amount you pay in covered expenses each year before the plan begins to pay benefits.

The family deductible can be met collectively by two or more family members provided one family member has met the individual deductible.

Traditional PPO Plan
• $2,500 individual deductible.
• $5,000 family deductible.

Out-of-Network Benefits

If for any reason an out-of-network physician, specialist, or facility is used, the plan will pay a percentage of the eligible, reasonable, and customary charges after the deductible has been met. No benefits are payable if an out-of-network physician, specialist, or facility is used for preventive health care.

IN-NETWORK OUT-OF-POCKET MAXIMUMS

In-network coinsurance, copays, and deductibles apply toward the out-of-pocket maximum. Charges exceeding eligible, reasonable, and customary; out-of-network coinsurance; out-of-network deductible, and non-notification penalty do not apply toward the in-network deductible or out-of-pocket maximum.

The family out-of-pocket maximum can be met collectively by two or more family members provided one family member has met the individual out-of-pocket maximum.

Certain eligible benefits will be payable at 100 percent after the individual or family out-of-pocket maximum is reached each calendar year. There is not a maximum lifetime benefit.

Traditional PPO Plan
• $2,500 individual out-of-pocket maximum.
• $5,000 family out-of-pocket maximum.

High Deductible Health Plan With Health Savings Account
• $2,600 individual out-of-pocket maximum.
• $5,200 family out-of-pocket maximum.
• When you meet the deductible under the High Deductible Health Plan, you also meet the out-of-pocket maximum. Benefits are then payable at 100 percent.
Early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration

Your physician may recommend additional services based on your family or medical history. The examples of preventive medical care listed below provide a guide to what is considered a covered preventive health service:

- One routine physical exam per calendar year, including diagnostic tests and immunizations
- Child preventive care services given in connection with routine pediatric care, including immunizations:
  - From birth but less than 12 months old: four visits per calendar year
  - From 12 months but less than 24 months old: three visits per calendar year
  - From 24 months to the end of dependent eligibility; one visit per calendar year
- Tuberculosis Intradermal Mantoux test
- Breastfeeding support and counseling from trained providers
- Contraceptive services approved by the Food and Drug Administration to include barrier methods, hormonal methods, implanted devices, sterilization procedures,

**Preventive Health Care Benefits**

Preventive health care is covered only when in-network physicians, specialists, or facilities are used. Preventive care services provided on an outpatient basis at a physician’s office, an alternate facility, or a hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration

Your physician may recommend additional services based on your family or medical history. The examples of preventive medical care listed below provide a guide to what is considered a covered preventive health service:

- One routine physical exam per calendar year, including diagnostic tests and immunizations
- Child preventive care services given in connection with routine pediatric care, including immunizations:
  - From birth but less than 12 months old: four visits per calendar year
  - From 12 months but less than 24 months old: three visits per calendar year
  - From 24 months to the end of dependent eligibility; one visit per calendar year
- Tuberculosis Intradermal Mantoux test
- Breastfeeding support and counseling from trained providers
- Contraceptive services approved by the Food and Drug Administration to include barrier methods, hormonal methods, implanted devices, sterilization procedures,
patient education, and counseling (Please contact UnitedHealthcare at 800-632-3203 for a current list of approved contraceptive methods provided at no cost to you.)

- Domestic and interpersonal violence screening and counseling for women
- Gestational diabetes screening for women at high risk of developing gestational diabetes
- Human Immunodeficiency Virus (HIV) screening and counseling
- Human Papillomavirus (HPV) DNA testing every three years for women at high risk
- Sexually Transmitted Infections (STI) counseling
- Multiple well-woman visits if needed to obtain all necessary recommended preventive services, depending on a woman’s health status, health needs, and other risk factors

MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Network providers are responsible for following notification requirements for mental health and substance use disorder inpatient services, including partial hospitalization/day treatment and services at a residential treatment facility. For a scheduled admission, the Network provider must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as is reasonably possible for non-scheduled admission, including emergency admissions.

When benefits are provided out-of-network, you are responsible for providing pre-service notification for the services outlined above. If you fail to notify the Mental Health/Substance Use Disorder administrator as required, benefits will be reduced to 50 percent of all eligible expenses.

Inpatient and Intermediate Services

Pre-service notification is required when benefits are provided for these services:

- Inpatient services (including partial hospitalization/day treatment and services at a residential treatment facility)
- Intensive outpatient program treatment
- Outpatient electro-convulsive treatment
- Psychological testing
- Extended outpatient treatment visits beyond 45 to 50 minutes in duration, with or without medication management.

The plan will only pay for treatment of the diagnoses that are identified in the current edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders. Benefits include detoxification from abusive chemicals or substances when necessary to protect your health. The American Psychiatric Association’s website is [www.apa.org](http://www.apa.org).

If United Behavioral Health determines that an inpatient stay is required, it is covered on a semi-private room (a room with two or more beds) basis. At the sole discretion of United Behavioral Health, two sessions of intermediate care (such as partial hospitalization) may be provided in lieu of one inpatient day.

Alternate levels of care are paid out of the inpatient benefit using the standard substitution of benefits ratio. One day of inpatient care is equivalent to the following:

<table>
<thead>
<tr>
<th>Treatment Site</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential treatment</td>
<td>1.5 days = 1 inpatient day</td>
</tr>
<tr>
<td>Day treatment/partial hospitalization</td>
<td>2 days = 1 inpatient day</td>
</tr>
<tr>
<td>Intensive outpatient</td>
<td>5 days = 1 inpatient day</td>
</tr>
<tr>
<td>Transitional care</td>
<td>10 days = 1 inpatient day</td>
</tr>
</tbody>
</table>

Inpatient Treatment

In Network

- **Traditional PPO Plan.** After the in-network deductible has been satisfied, you pay a copay of $150 per day for the first five days of each stay plus 20 percent of the balance, and for days six-plus, 20 percent; or a copay of $75 per day for the first five days of each intermediate care hospital stay plus 20 percent of the balance, and for days six-plus, 20 percent.

- **High Deductible Health Plan With Health Savings Account.** You pay 100 percent of covered charges until you meet the annual deductible. After the in-network deductible is met, benefits are paid at 100 percent.
Out of Network

- **Traditional PPO Plan.** After the out-of-network deductible has been satisfied, you pay a copay of $150 per day for the first five days of each stay plus 40 percent of the balance, and for days six-plus, 40 percent; or a copay of $75 per day for the first five days of each intermediate care hospital stay plus 40 percent of the balance, and for days six-plus, 40 percent.

- **High Deductible Health Plan With Health Savings Account.** You pay 100 percent of covered charges until you meet the annual deductible. After the out-of-network deductible is met, the plan pays 80 percent of covered charges up to reasonable and customary limits.

**Outpatient Services**

The plan covers mental health and substance use disorder services received on an outpatient basis in a provider’s office or at an alternate facility, including the following:

- Mental health/substance use disorder evaluations and assessment
- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy)
- Crisis intervention
- Psychological testing

Referrals to a mental health/substance use disorder provider are at the sole discretion of United Behavioral Health, is responsible for coordinating all your care. Contact United Behavioral Health at 800-788-5614 for authorization prior to receiving outpatient mental health and substance use disorder services.

**In Network**

- **Traditional PPO Plan.** $30 copay.

- **High Deductible Health Plan With Health Savings Account.** You pay 100 percent of covered charges until you meet the deductible. After the deductible has been satisfied, the plan pays 100 percent of covered charges.

**Out of Network**

- **Traditional PPO Plan.** 40 percent of covered expenses, after the deductible has been satisfied.

- **High Deductible Health Plan With Health Savings Account.** You pay 100 percent of covered charges until you meet the annual deductible. After the out-of-network deductible is met, the plan pays 80 percent of covered charges up to reasonable and customary limits.

**Special Mental Health Programs and Services**

Special programs and services that are contracted under the mental health/substance use disorder administrator may become available to you as part of your mental health/substance use disorder services benefit. The mental health/substance use disorder services benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, partial hospitalization/day treatment, intensive outpatient treatment, outpatient, or a transitional care category of benefit use. Special programs or services provide access to services beneficial in treating your mental illness or substance use disorder, which may not otherwise be covered under the BSA Medical Plan. You must be referred to such programs through the mental health/substance use disorder administrator, who is responsible for coordinating your care, or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the covered person and is not mandatory.

**Emergency Care**

When emergency care is required to treat mental health or substance use disorder, United Behavioral Health should be notified within two days of the emergency care being given. If it is not possible to call United Behavioral Health within two days, the call must be made as soon as is reasonably possible.

**IF YOUR PLAN CHANGES**

If a covered member’s plan changes from the Options PPO network to the Choice Plus network during a calendar year, any charges applied to the Options PPO out-of-network deductible and out-of-pocket maximum will apply toward the Choice Plus out-of-network deductible and out-of-pocket maximum. Any charges applied to the Options PPO in-network deductible and out-of-pocket maximum will apply toward the Choice Plus in-network deductible and out-of-pocket maximum.
### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>Network: $1,250 Individual / $2,500 Family Non-Network: $2,500 Individual / $5,000 Family / Per calendar year. Does not apply to copays, pharmacy drugs, and services listed below as “No Charge”.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes, Prescription Drugs - Network: $50 Individual Deductible Non-Network: Not Covered</td>
<td>You must pay all of the costs for these services up to the specific <strong>deductible</strong> amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Medical: Network: $2,500 Individual / $5,000 Family Non-Network: $5,000 Individual / $10,000 Family Prescription Drugs - Network: $2,500 Individual / $5,000 Family Prescription Drugs Non-Network: Not Covered</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td><strong>Premiums</strong>, balanced-billed charges, health care this plan doesn’t cover, penalties for failure to obtain pre-notification for services.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>This policy has no overall annual limit on the amount it will pay each year.</td>
<td>The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes, this plan uses <strong>network providers</strong>. If you use a <strong>non-network provider</strong> your cost may be more. For a list of <strong>network providers</strong>, see <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-800-632-3203.</td>
<td>If you use a network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network <strong>provider</strong> for some services. Plans use the term network, <strong>preferred</strong>, or participating for <strong>providers</strong> in their <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the <strong>specialist</strong> you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes</td>
<td>Some of the services this plan doesn’t cover are listed on Page 5. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-800-632-3203 or visit us at www bsabenefits mercerhrs com. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www dol gov/ebsa/pdf/SBCUniformGlossary pdf or call the number above to request a copy.

Coverage Period: 01/01/2016-12/31/2016

Coverage for: Employee/Family | Plan Type: PS1
Choice Plus Traditional Plan

Coverage Period: 01/01/2016-12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Employee/Family | Plan Type: PS1

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
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<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 Copay/visit</td>
<td>40% Coinsurance After Deductible</td>
<td>Virtual Visit - In network $40 copay per visit by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.</td>
</tr>
<tr>
<td>provider’s office or clinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40 Copay/visit</td>
<td>40% Coinsurance After Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$40 Copay/visit</td>
<td>40% Coinsurance After Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coinsurance After Deductible</td>
<td>40% Coinsurance After Deductible</td>
<td>Prior Authorization required for out of network sleep studies or benefits reduced to 50%</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% Coinsurance After Deductible</td>
<td>40% Coinsurance After Deductible</td>
<td>Prior Authorization required for out of network or benefits reduced to 50%</td>
</tr>
</tbody>
</table>
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2016-12/31/2016

**Coverage for:** Employee/Family | **Plan Type:** PS1

<table>
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<tr>
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<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1 - Your Lowest-Cost Option</td>
<td>Retail: $7 Copay After $50 Deductible Mail Order: $14 Copay After $50 Deductible</td>
<td>Retail: Not Covered</td>
<td>Retail is limited to 34 days supply, and mail order 90 days</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Your Midrange-Cost Option</td>
<td>Retail: 25% Coinsurance After $50 Deductible Mail Order: 25% Coinsurance After $50 Deductible</td>
<td>Retail: Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Your Highest-Cost Option</td>
<td>Retail: 35% Coinsurance After $50 Deductible Mail Order: 35% Coinsurance After $50 Deductible</td>
<td>Retail: Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Additional High-Cost Option</td>
<td>Retail: N/A Mail Order: N/A</td>
<td>Retail: Not Covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% Coinsurance After Deductible</td>
<td>40% Coinsurance After Deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance After Deductible</td>
<td>40% Coinsurance After Deductible</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room services</td>
<td>$200 Copay/visit</td>
<td>$200 Copay/visit</td>
<td>Prior Authorization required within 48 hrs if admitted to a non-network facility, or paid at 50%</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No Charge</td>
<td>No Charge</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 Copay/visit</td>
<td>40% Coinsurance After Deductible</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$150 Copay per day for the first 5 days of admission, 20% Coinsurance After Deductible</td>
<td>40% Coinsurance After Deductible</td>
<td>Non-network requires Prior Authorization or 50% coinsur.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% Coinsurance After Deductible</td>
<td>40% Coinsurance After Deductible</td>
<td>None</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [www.myuhc.com](http://www.myuhc.com).
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2016-12/31/2016

**Coverage for:** Employee/Family | **Plan Type:** PS1

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<tr>
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<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental/Behavioral health outpatient services</td>
<td>$30 Copay/visit</td>
<td>40% Coinsurance After Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$150 Copay per day for the first 5 days of admission, 20% Coinsurance After Deductible</td>
<td>40% Coinsurance After Deductible</td>
<td>Non-network requires Prior Authorization or 50% coinsur.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$30 Copay/visit</td>
<td>40% Coinsurance After Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$150 Copay per day for the first 5 days of admission, 20% Coinsurance After Deductible</td>
<td>40% Coinsurance After Deductible</td>
<td>Non-network requires Prior Authorization or 50% coinsur.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>20% Coinsurance After Deductible</td>
<td>40% Coinsurance After Deductible</td>
<td>Your Cost in this Category includes physician delivery charges. Routine Prenatal care is covered at no cost.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$150 Copay per day for the first 5 days of admission, 20% Coinsurance After Deductible</td>
<td>40% Coinsurance After Deductible</td>
<td>Your cost for inpatient services only. For physician delivery charges, see Pre/Post Natal. Prior Authorization is required if length of stay is greater than 48 hrs or 72 hrs c-sect, and for out of network or paid at 50%</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2016-12/31/2016  
**Choice Plus Traditional Plan**  
**Coverage for:** Employee/Family | Plan Type: PS1

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>20% Coinsurance After Deductible</td>
<td>40% Coinsurance After Deductible</td>
<td>240 visits per calendar yr IN &amp; Out of network services comb. Prior Authorization needed for Out Of Network or 50% coins.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$40 Copay/visit</td>
<td>40% Coinsurance After Deductible</td>
<td>Pulmonary, Occupational, Physical &amp; Speech have 30 visit per cal yr each. Cardiac has 20 visit limit, in and out of network comb.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>$150 Copay per day for the first 5 days of admission, 20% Coinsurance After Deductible</td>
<td>40% Coinsurance After Deductible</td>
<td>365 days per Life Time max IN and out of network comb. Prior Authorization required for out of network or 50% coins.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% Coinsurance After Deductible</td>
<td>40% Coinsurance After Deductible</td>
<td>Prior Authorization is needed if over $1000 when using an out of network provider or payable at 50%</td>
</tr>
<tr>
<td>Hospice service</td>
<td>20% Coinsurance After Deductible</td>
<td>40% Coinsurance After Deductible</td>
<td>Non-network requires Prior Authorization or 50% coinsur.</td>
</tr>
</tbody>
</table>

### If you need help recovering or have other special health needs

- **Eye exam**  
  - Not Covered  
  - Not Covered  
  - Not Covered

- **Glasses**  
  - Not Covered  
  - Not Covered  
  - Not Covered

- **Dental check-up**  
  - Not Covered  
  - Not Covered  
  - Not Covered

### Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child routine vision exam (i.e. refraction)
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care limitations may apply
- Private-duty nursing limitations may apply
- Routine foot care limitations may apply
- Hearing aids limitations may apply
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-722-2667. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us at 1-800-632-3203 or visit [www.myuhc.com](http://www.myuhc.com).

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:
- Spanish (Español): Para obtener asistencia en Español, llame al 1-800-632-3203.
- Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-632-3203.
- Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-800-632-3203.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

---

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
</tr>
<tr>
<td><strong>Plan pays</strong> $5,660</td>
</tr>
<tr>
<td><strong>Patient pays</strong> $1,880</td>
</tr>
</tbody>
</table>

**Sample care costs:**
- Hospital charges (mother) $2,700
- Routine obstetric care $2,100
- Hospital charges (baby) $900
- Anesthesia $900
- Laboratory tests $500
- Prescriptions $200
- Radiology $200
- Vaccines, other preventive $40

**Total** $7,540

**Patient pays:**
- Deductibles $1,270
- Copays $150
- Coinsurance $310
- Limits or exclusions $150

**Total** $1,880

<table>
<thead>
<tr>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays</strong> $3,600</td>
</tr>
<tr>
<td><strong>Patient pays</strong> $1,800</td>
</tr>
</tbody>
</table>

**Sample care costs:**
- Prescriptions $2,900
- Medical Equipment and Supplies $1,300
- Office Visits and Procedures $700
- Education $500
- Laboratory tests $100
- Vaccines, other preventive $100

**Total** $5,400

**Patient pays:**
- Deductibles $1,200
- Copays $20
- Coinsurance $0
- Limits or exclusions $80

**Total** $1,800
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example Show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

**Does the Coverage Example predict my own care needs?**

✓ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

**Does the Coverage Example predict my future expenses?**

✓ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-632-3203 or visit us at www.bsabenefits.mercerhrs.com. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf. Or call the number above to request a copy.
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>Network: $2,600 Individual / $5,200 Family Non-Network: $5,200 Individual / $10,400 Family / Per calendar year. Does not apply to services listed below as “No Charge”.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No, there are no other <strong>deductibles</strong>.</td>
<td>You don’t have to meet <strong>deductibles</strong> for specific service, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Is there an out-of-pocket limit on my expenses?</strong></td>
<td>Medical- Network: $2,600 Individual / $5,200 Family Non-Network: Unlimited Individual / Unlimited Family</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td><strong>Premiums</strong>, balanced-billed charges, health care this plan doesn’t cover, penalties for failure to obtain pre-notification for services.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td><strong>Is there an overall annual limit on what the plan pays?</strong></td>
<td>This policy has no overall annual limit on the amount it will pay each year.</td>
<td>The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.</td>
</tr>
<tr>
<td><strong>Does this plan use a network of providers?</strong></td>
<td>Yes, this plan uses network providers. If you use a non-network provider, your cost may be more. For a list of network providers, see <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-800-632-3203.</td>
<td>If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td><strong>Do I need a referral to see a specialist?</strong></td>
<td>No</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td><strong>Are there services this plan doesn’t cover?</strong></td>
<td>Yes</td>
<td>Some of the services this plan doesn’t cover are listed on Page 6. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-800-623-3203 or visit us at www.bsabenefits.mercerhrs.com. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [http://www.dol.gov/ebia/pdf/SBCUniformGlossary.pdf](http://www.dol.gov/ebia/pdf/SBCUniformGlossary.pdf) or call the number above to request a copy.
**Choice Plus HDHP**

**Coverage Period:** 01/01/2016-12/31/2016

**Coverage for:** Employee/Family | Plan Type: PS1

### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Virtual Visit - In network 100% co-insurance after deductible per visit by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-Ins may apply.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Cost Share applies for only Manipulative (Chiropractic) Care. 30 vis per cal year INN/OON comb Prior-Authorization required for Out of Network or 50% coins</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Includes preventive health services specified in the health care reform law. Not covered Out of Network.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Prior Authorization required for non-network sleep studies or benefits reduced to 50%</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Prior Authorization required for out of network or benefits reduced to 50%</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your Cost If You Use a Network Provider</td>
<td>Your Cost If You Use a Non-network Provider</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Your Lowest-Cost Option</td>
<td>Retail: 0% Coinsurance After Deductible Mail Order: 0% Coinsurance After Deductible</td>
<td>Retail: Not Covered</td>
<td>Plan pays 100% after deductible. Out of network not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Your Midrange-Cost Option</td>
<td>Retail: 0% Coinsurance After Deductible Mail Order: 0% Coinsurance After Deductible</td>
<td>Retail: Not Covered</td>
<td>Plan pays 100% after deductible. Out of network not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Your Highest-Cost Option</td>
<td>Retail: 0% Coinsurance After Deductible Mail Order: 0% Coinsurance After Deductible</td>
<td>Retail: Not Covered</td>
<td>Plan Pays 100% after deductible. Out of network not covered.</td>
</tr>
<tr>
<td>Tier 4 - Additional High-Cost Option</td>
<td></td>
<td>Retail: N/A Mail Order: N/A</td>
<td>Retail: N/A Mail Order: N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>0% Coinsurance After Deductible</td>
<td>0% Coinsurance After Deductible</td>
<td>Non-Emerg not covered. Prior-Authorization required for Out of network w/in 48 hr or paid at 50%</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>0% Coinsurance After Deductible</td>
<td>0% Coinsurance After Deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Non-network requires prior-authorization or 50% coinsur.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>None</td>
</tr>
</tbody>
</table>

More information about [prescription drug coverage](#) is available at [www.myuhc.com](http://www.myuhc.com).
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** Employee/Family | **Plan Type:** PS1

**Coverage Period:** 01/01/2016-12/31/2016

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental/Behavioral health outpatient services</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>The Employee Assistance Program offers up to 6 visits at no cost. Non-network requires prior-authorization or 50% coinsur.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Non-network requires prior-authorization or 50% coinsur.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>The Employee Assistance Program offers up to 6 visits at no cost.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Non-network requires prior-authorization or 50% coinsur.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Your cost in this category includes physician delivery charges. Newborns must be added to the plan within 30 days of birth. Routine Pre-natal care covered at no cost.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Your cost for inpatient services only. For physician delivery charges, see pre-post natal care. Prior Authorization needed if stay is longer than 48 hrs or 72 hrs c-section, or 50% coinsurance</td>
</tr>
</tbody>
</table>
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2016-12/31/2016

**Plan Type:** PS1

<table>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home health care</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>240 visits cal yr INN/OON comb. Prior Authorization required for Out Of Network or 50% coins</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Pulmonary, Occupational, Physical &amp; Speech have 30 visit each and Cardiac has 20 visits, per cal yr limit, in and out of network comb.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Prior Authorization required out of network or if greater than $1000 or 50% coins</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Prior Authorization required out of network or if greater than $1000 or 50% coins</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Non-network requires prior-authorization or 50% coinsur.</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child dental check-up
- Child glasses
- Child routine vision exam (i.e. refraction)
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care limitations may apply
- Hearing aids limitations may apply
- Private-duty nursing limitations may apply
- Routine foot care limitations may apply
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-877-722-2667. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us at 1-800-632-3203 or visit www.myuhc.com.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
• Spanish (Español): Para obtener asistencia en Español, llame al 1-800-632-3203.
• Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-632-3203.
• Chinese (中文): 如果您需要中文的帮助，请拨打这个号码 1-800-632-3203.
• Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-632-3203.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**Having a baby** (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,370
- **Patient pays:** $170

<table>
<thead>
<tr>
<th>Sample care costs:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

- **Deductibles:** $20
- **Copays:** $0
- **Coinsurance:** $0
- **Limits or exclusions:** $150
- **Total:** $170

**Managing type 2 diabetes** (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,720
- **Patient pays:** $2,680

<table>
<thead>
<tr>
<th>Sample care costs:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

- **Deductibles:** $2,600
- **Copays:** $0
- **Coinsurance:** $0
- **Limits or exclusions:** $80
- **Total:** $2,680

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example Show

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✓ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✓ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-623-3203 or visit us at www.bsabenefits.mercerhrs.com. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf Or call the number above to request a copy.
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options ppo plans

Under the Options PPO medical plan, you and your covered dependents may see any physician, specialist, or facility in or out of the Options PPO network, except for United Resource Network. The Options PPO coverage is only available in a few geographic areas where UnitedHealthcare’s Choice Plus network is not fully developed.

Copay is when you pay a specific amount for a visit to a physician or for a prescription.

Coinsurance is when you pay a specific percentage of the total cost of the service or product.

Deductible is the amount of eligible expenses that must be incurred before benefits are payable.

<table>
<thead>
<tr>
<th>Options PPO Plans</th>
<th>Traditional PPO</th>
<th>HDHP With HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In Network</td>
<td>Out of Network</td>
</tr>
<tr>
<td></td>
<td>You Pay:</td>
<td>You Pay:</td>
</tr>
<tr>
<td>Deductible (Must be met annually before coinsurance applies.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Does not apply to out of network.</td>
<td>Does not apply to out of network.</td>
</tr>
<tr>
<td></td>
<td>$1,250</td>
<td>$1,250</td>
</tr>
<tr>
<td>Family</td>
<td>$2,500</td>
<td>$2,500</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2,500</td>
<td>$2,500</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Physician Office Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP Office Visit</td>
<td>$30</td>
<td>$30</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>Outpatient Therapy</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>Virtual Visits</td>
<td>$40</td>
<td>N/A</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Preventive Care (Not subject to deductible)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient/Outpatient Lab and X-Ray</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>MRI’s and CAT Scans</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient Facility/Ambulatory Surgical Center</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Per admission, including maternity stays (semi-private room and board, anesthesia, medications, supplies, inpatient lab and x-ray)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician fees for inpatient surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician visits in hospital</td>
<td></td>
</tr>
<tr>
<td>Emergency Room (copay does not apply if admitted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance (emergency)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance (nonemergency)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal Office Visits</td>
<td>$30, first visit only</td>
<td>$30, first visit only</td>
</tr>
<tr>
<td></td>
<td>Physician delivery fee, outpatient lab and x-ray</td>
<td></td>
</tr>
<tr>
<td>Mental Health and Chemical Dependency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital charges and supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient facility</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

First 5 days: $150 copay per day plus deductible plus 20% of the balance. Days 6+: 20% of the balance. Days 6+: 20% of the balance. Days 6+: 20% of the balance. Days 6+: 20% of the balance.

First 5 days: $75 copay per day plus deductible plus 20% of the balance. Days 6+: 20% of the balance. Days 6+: 20% of the balance. Days 6+: 20% of the balance. Days 6+: 20% of the balance.

First 5 days: $150 copay per day plus deductible plus 20% of the balance. Days 6+: 20% of the balance. Days 6+: 20% of the balance. Days 6+: 20% of the balance.
<table>
<thead>
<tr>
<th>Prescription Medication</th>
<th>$50 annual deductible per person</th>
<th>$2,600 or $5,200 annual deductible for individual or family (medical and drug combined)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local (up to a 34-day supply)</strong></td>
<td>Traditional PPO</td>
<td>HDHP With HSA and Medicare Supplement</td>
</tr>
<tr>
<td><strong>Tier 1 Copay</strong></td>
<td>$7.00</td>
<td></td>
</tr>
<tr>
<td><strong>Tier 2 Coinsurance</strong></td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Minimum Copay</td>
<td>$30.00</td>
<td></td>
</tr>
<tr>
<td>Maximum Copay</td>
<td>$60.00</td>
<td></td>
</tr>
<tr>
<td><strong>Tier 3 Coinsurance</strong></td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Minimum Copay</td>
<td>$50.00</td>
<td></td>
</tr>
<tr>
<td>Maximum Copay</td>
<td>$100.00</td>
<td></td>
</tr>
<tr>
<td><strong>Mail Order (up to a 90-day supply)</strong></td>
<td></td>
<td>Plan pays 100% after individual or family deductible is met.</td>
</tr>
<tr>
<td><strong>Tier 1 Copay</strong></td>
<td>$14.00</td>
<td></td>
</tr>
<tr>
<td><strong>Tier 2 Coinsurance</strong></td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Minimum Copay</td>
<td>$60.00</td>
<td></td>
</tr>
<tr>
<td>Maximum Copay</td>
<td>$120.00</td>
<td></td>
</tr>
<tr>
<td><strong>Tier 3 Coinsurance</strong></td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Minimum Copay</td>
<td>$100.00</td>
<td></td>
</tr>
<tr>
<td>Maximum Copay</td>
<td>$200.00</td>
<td></td>
</tr>
<tr>
<td><strong>Medications on the Preventive Drug List</strong>*</td>
<td></td>
<td>20% (not subject to deductible)</td>
</tr>
<tr>
<td><strong>Specialty Pharmacy</strong></td>
<td></td>
<td>Must use UnitedHealthcare Specialty Pharmacy</td>
</tr>
</tbody>
</table>

* The Preventive Drug List is available online at www.myuhc.com, on MyBSA/HR Gateway, and on www.mercerhrs.com/scouting2health.
In-Network Benefits
You may access the list of Options PPO physicians, specialists, and facilities through UnitedHealthcare's website at or www.myuhc.com. You may also request a list from UnitedHealthcare Member Services by calling 800-632-3203.

Primary care physicians (PCPs) include general practitioners, family practitioners, internists, pediatricians, or obstetrician/gynecologists. (See the glossary for PCP definition.)

IN-NETWORK DEDUCTIBLES
The calendar-year deductible below is the amount you pay in covered expenses each year before the plan begins to pay benefits for the HDHP. The Traditional PPO Plan includes covered items that are not subject to a deductible. If two or more family members are injured in the same accident, only one individual deductible must be met for all covered expenses related to the accident.

The family deductible can be met collectively by two or more family members provided one family member has met the individual deductible.

Traditional PPO Plan
• $1,250 individual deductible.
• $2,500 family deductible.

High Deductible Health Plan With Health Savings Account
• $2,600 individual deductible.
• $5,200 family deductible.

Note: The year-to-date deductible amount met will be carried over if an employee terminates employment and rehires in the same calendar year.

IN-NETWORK OUT-OF-POCKET MAXIMUMS
In-network coinsurance, copays, and deductibles apply toward the out-of-pocket maximum. Charges exceeding eligible, reasonable, and customary; out-of-network coinsurance; out-of-network deductible, and non-notification penalty do not apply toward the in-network deductible or out-of-pocket maximum.

The family out-of-pocket maximum can be met collectively by two or more family members provided one family member has met the individual out-of-pocket maximum.

Certain eligible benefits will be payable at 100 percent after the individual or family out-of-pocket maximum is reached each calendar year. There is not a maximum lifetime benefit.

These out-of-pocket maximums for in-network benefits will apply each calendar year.

Traditional PPO Plan
• $2,500 individual out-of-pocket maximum.
• $5,000 family out-of-pocket maximum.

High Deductible Health Plan With Health Savings Account
• $2,600 individual out-of-pocket maximum.
• $5,200 family out-of-pocket maximum.
• When you meet the deductible under the High Deductible Health Plan, you also meet the out-of-pocket maximum. Benefits are then payable at 100 percent.

Out-Of-Network Benefits
If for any reason an out-of-network physician, specialist, or facility is used, charges exceeding reasonable and customary limits are the responsibility of the plan participant and not paid by the plan.

OUT-OF-NETWORK DEDUCTIBLES
If you use an out-of-network physician, specialist, or facility, a calendar-year deductible must first be met. After the deductible has been met, covered expenses will be paid at 80 percent for both the Traditional PPO Plan and the High Deductible Health Plan With Health Savings Account, subject to eligible, reasonable, and customary charges. The calendar-year deductible is the amount you pay in covered expenses each year before the plan begins to pay benefits.

The family deductible can be met collectively by two or more family members provided one family member has met the individual deductible.
Preventive care services provided on an outpatient basis at a physician's office, an alternate facility, or a hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration

Your physician may recommend additional services based on your family or medical history. The examples of preventive medical care listed below provide a guide to what is considered a covered preventive health service:

- One routine physical exam per calendar year, including diagnostic tests and immunizations
- Child preventive care services given in connection with routine pediatric care, including immunizations:
  - From birth but less than 12 months old: four visits per calendar year
  - From 12 months but less than 24 months old: three visits per calendar year
  - From 24 months to the end of dependent eligibility; one visit per calendar year
- Tuberculosis Intradermal Mantoux test
- Family planning services:
  - Diaphragm fitting with instructions

Traditional PPO Plan
- $1,250 individual deductible.
- $2,500 family deductible.

High Deductible Health Plan With Health Savings Account
- $2,600 individual deductible.
- $5,200 family deductible.

The calendar-year deductible does not apply to preventive care.

OUT-OF-NETWORK OUT-OF-POCKET MAXIMUMS

Out-of-network coinsurance and deductibles apply toward the out-of-pocket maximum. Non-notification penalty; charges exceeding eligible, reasonable, and customary; in-network coinsurance; and in-network deductible do not apply toward the out-of-network out-of-pocket maximum.

The family out-of-pocket maximum can be met collectively by two or more family members provided one family member has met the individual out-of-pocket maximum.

Certain eligible benefits will be payable at 100 percent after the individual or family out-of-pocket maximum is reached each calendar year for the Traditional PPO plan. The High Deductible Health Plan with Health Savings Account has no out-of-network out-of-pocket maximum. There is not a maximum lifetime benefit.

These out-of-pocket maximums for out-of-network benefits will apply each calendar year.

Traditional PPO Plan
- $2,500 individual out-of-pocket.
- $5,000 family out-of-pocket.

High Deductible Health Plan With Health Savings Account
- There is no out-of-pocket maximum.
- You pay 20 percent after out-of-network deductible is satisfied.
— Insertion and removal of intrauterine device
— Chromosome testing
• Breastfeeding support and counseling from trained providers
• Contraceptive services approved by the Food and Drug Administration to include barrier methods, hormonal methods, implanted devices, sterilization procedures, patient education, and counseling (Please contact UnitedHealthcare at 800-632-3203 for a current list of approved contraceptive methods provided at no cost to you.)
• Domestic and interpersonal violence screening and counseling for women
• Gestational diabetes screening for women at high risk of developing gestational diabetes
• Human Immunodeficiency Virus (HIV) screening and counseling
• Human Papillomavirus (HPV) DNA testing every three years for women at high risk
• Sexually Transmitted Infections (STI) counseling
• Multiple well-woman visits if needed to obtain all necessary recommended preventive services, depending on a woman’s health status, health needs, and other risk factors

MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

You are responsible for following notification requirements for mental health and substance use disorder inpatient services, including partial hospitalization/day treatment and services at a residential treatment facility for both in-network and out-of-network facilities. For a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as is reasonably possible for non-scheduled admission, including emergency admissions. If you fail to notify the Mental Health/Substance Use Disorder Administrator, as required, benefits will be reduced to 50 percent of eligible expenses.

Inpatient and Intermediate Services

Pre-service notification is required when benefits are provided for these services:

• Inpatient services (including partial hospitalization/day treatment and services at a residential treatment facility)
• Intensive outpatient program treatment
• Outpatient electro-convulsive treatment
• Psychological testing
• Extended outpatient treatment visits beyond 45 to 50 minutes in duration, with or without medication management.

The plan will only pay for treatment of diagnoses identified in the current edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders. Benefits include detoxification from abusive chemicals or substances when necessary to protect your health. The American Psychiatric Association’s website is www.apa.org.

If United Behavioral Health determines that an inpatient stay is required, it is covered on a semi-private room (a room with two or more beds) basis. At the sole discretion of United Behavioral Health, two sessions of intermediate care (such as partial hospitalization) may be provided in lieu of one inpatient day.

Alternate levels of care are paid out of the inpatient benefit using the standard substitution of benefits ratio. One day of inpatient care is equivalent to the following:

<table>
<thead>
<tr>
<th>Treatment Site</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential treatment</td>
<td>1.5 days = 1 inpatient day</td>
</tr>
<tr>
<td>Day treatment/partial hospitalization</td>
<td>2 days = 1 inpatient day</td>
</tr>
<tr>
<td>Intensive outpatient</td>
<td>5 days = 1 inpatient day</td>
</tr>
<tr>
<td>Transitional care</td>
<td>10 days = 1 inpatient day</td>
</tr>
</tbody>
</table>

Inpatient Treatment

In Network

• Traditional PPO plan. After the in-network deductible has been satisfied, you pay a copay of $150 per day for the first five days of each stay plus 20 percent of the balance, and for days six-plus, 20 percent; or a copay of $75 per day for the first five days of each intermediate care hospital stay plus 20 percent of the balance, and for days six-plus, 20 percent.

• High Deductible Health Plan With Health Savings Account. After the in-network deductible has been satisfied, the plan pays 100 percent of covered charges.
Out of Network

- Traditional PPO plan. After the out-of-network deductible has been satisfied, you pay a copay of $150 per day for the first five days of each stay plus 20 percent of the balance, and for days six-plus, 20 percent; or a copay of $75 per day for the first five days of each intermediate care hospital stay plus 20 percent of the balance, and for days six-plus, 20 percent.

- High Deductible Health Plan With Health Savings Account. You pay 100 percent of covered charges until you meet the annual deductible. After the annual deductible is met, the plan pays 80 percent of covered charges up to reasonable and customary limits.

### Outpatient Services

The plan covers mental health and substance use disorder services received on an outpatient basis in a provider’s office or at an alternate facility, including the following:

- Mental health/substance use disorder evaluations and assessment
- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy)
- Crisis intervention
- Psychological testing

Referrals to a mental health/substance use disorder provider are at the sole discretion of United Behavioral Health, which is responsible for coordinating all your care. Contact United Behavioral Health at 800-788-5614 for authorization prior to receiving outpatient mental health and substance use disorder services.

### In Network

- Traditional PPO Plan. You pay $30 copay.
- High Deductible Health Plan With Health Savings Account. You pay 100 percent. After the deductible has been satisfied, the plan pays 80 percent of covered charges.

### Out of Network

- Traditional PPO Plan. You pay $30 copay.
- High Deductible Health Plan With Health Savings Account. You pay 100 percent. After the deductible has been satisfied, the plan pays 80 percent of covered charges up to reasonable and customary limits.

### Special Mental Health Programs and Services

Special programs and services that are contracted under the mental health/substance use disorder administrator may become available to you as part of your mental health/substance use disorder services benefit. The mental health/substance use disorder services benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, partial hospitalization/day treatment, intensive outpatient treatment, outpatient, or a transitional care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your mental illness or substance use disorder, which may not otherwise be covered under the BSA Medical Plan. You must be referred to such programs through the mental health/substance use disorder administrator, who is responsible for coordinating your care, or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the covered person and is not mandatory.

### Emergency Care

When emergency care is required to treat a mental health or substance use disorder, United Behavioral Health should be notified within two days of the emergency care being given. If it is not possible to call United Behavioral Health within two days, the call must be made as soon as is reasonably possible.

### IF YOUR PLAN CHANGES

If a covered member’s plan changes from the Choice Plus network to the Options PPO network during a calendar year, any charges applied to the Choice Plus out-of-network deductible and out-of-pocket maximum will apply toward the Options PPO out-of-network deductible and out-of-pocket maximum. Any charges applied to the Choice Plus in-network deductible and out-of-pocket maximum will apply toward the Options PPO in-network deductible and out-of-pocket maximum.
<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>Network: $1,250 Individual / $2,500 Family</td>
<td>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</td>
</tr>
<tr>
<td></td>
<td>Non-Network: $1,250 Individual / $2,500 Family / Per calendar year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does not apply to copays, pharmacy drugs, and services listed below as “No Charge”.</td>
<td></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes, Prescription Drugs - Network: $50 Individual Deductible</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td></td>
<td>Non-Network: Not Covered</td>
<td></td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Medical- Network: $2,500 Individual / $5,000 Family</td>
<td>The out-of-pocket limit is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td></td>
<td>Non-Network: $2,500 Individual / $5,000 Family</td>
<td></td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balanced-billed charges, health care this plan doesn’t cover, penalties for failure to obtain pre-notification for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>This policy has no overall annual limit on the amount it will pay each year.</td>
<td>The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes, this plan uses network providers. If you use a non-network provider, your cost may be more. For a list of network providers, see <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-800-632-3203.</td>
<td>If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes</td>
<td>Some of the services this plan doesn’t cover are listed on Page 6. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-632-3203 or visit us at www.bsabenefits.mercerhrs.com. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number above to request a copy.
**Options PPO Traditional Plan**

**Coverage Period:** 01/01/2016-12/31/2016

**Coverage for:** Employee/Family  |  **Plan Type:** PPO

---

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.

- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)

- This plan may encourage you to use network providers by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

---

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 Copay/visit</td>
<td>No Charge</td>
<td>Virtual Visit - In network $40 copay per visit by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40 Copay/visit</td>
<td>20% Coinsurance</td>
<td>Cost Share applies for only Manipulative (Chiropractic) Care. 30 visits per calendar yr in &amp; out of network comb. Prior Authorization is required for Out of network or 50% coins</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$40 Copay/visit</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/immunization</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Includes preventive health services specified in the health care reform law.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Prior Authorization required for non-network Sleep Studies, or benefits reduced to 50%</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Prior Authorization required for out of network or benefits reduced to 50%</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** Employee/Family  |  **Plan Type:** PPO

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>If you need drugs to treat your illness or condition</th>
<th>Summary of Benefits and Coverage: What this Plan Covers &amp; What it Costs</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1 - Your Lowest-Cost Option</strong></td>
<td>Retail: $7 Copay After $50 Deductible Mail Order: $14 Copay After $50 Deductible</td>
<td>Retail: Not Covered</td>
<td>Retail allows a 34 days supply. Mail order 90 days</td>
</tr>
<tr>
<td><strong>Tier 2 - Your Midrange-Cost Option</strong></td>
<td>Retail: 25% Coinsurance After $50 Deductible Mail Order: 25% Coinsurance After $50 Deductible</td>
<td>Retail: Not Covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>Tier 3 - Your Highest-Cost Option</strong></td>
<td>Retail: 35% Coinsurance After $50 Deductible Mail Order: 35% Coinsurance After $50 Deductible</td>
<td>Retail: Not Covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>Tier 4 - Additional High-Cost Option</strong></td>
<td>Retail: N/A Mail Order: N/A</td>
<td>Retail: Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>

*More information about prescription drug coverage is available at [www.myuhc.com](http://www.myuhc.com).*

### If you have outpatient surgery

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Facility fee (e.g., ambulatory surgery center)</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility fee</strong></td>
<td>20% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Physician/surgeon fees</strong></td>
<td>20% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

### If you need immediate medical attention

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Emergency room services</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room services</td>
<td>$200 Copay/visit</td>
<td>$200 Copay/visit</td>
<td></td>
<td>Prior Authorization required within 48 hours if admitted to an out of network facility or paid at 50%. ER visits are only covered for True Emergencies.</td>
</tr>
</tbody>
</table>

### If you have a hospital stay

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Facility fee (e.g., hospital room)</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>$150 Copay per day for the first 5 days of admission, 20% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Non-network requires Prior Authorization or 50% coinsur.</td>
<td></td>
</tr>
<tr>
<td>Physician/surgeon fee</td>
<td>20% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

### Coverage Period: 01/01/2016-12/31/2016

**Coverage for:** Employee/Family | **Plan Type:** PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$30 Copay/visit</td>
<td>No Charge</td>
<td>The Employee Assistance Program offers up to 6 visits at no cost.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$150 Copay per day for the first 5 days of admission, 20% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Non-network requires prior authorization or 50% coinsur.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$30 Copay/visit</td>
<td>No Charge</td>
<td>The Employee Assistance Program offers up to 6 visits at no cost.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$150 Copay per day for the first 5 days of admission, 20% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Non-network requires prior authorization or 50% coinsur.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>20% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Your cost in this category includes physician delivery charges. Routine Prenatal visits are covered at no cost.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$150 Copay per day for the first 5 days of admission, 20% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Your cost for inpatient services only. For physician delivery charges, see pre/postnatal care. Authorize if out of network or if stay exceeds 48 or 72 hrs c-sect or 50% coinsur.</td>
</tr>
</tbody>
</table>
## Options PPO Traditional Plan

**Coverage Period:** 01/01/2016-12/31/2016

### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** Employee/Family | **Plan Type:** PPO

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>20% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>240 visits cal yr in and out of network comb. Prior authorization needed for out of network or 50% coins</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$40 Copay/visit</td>
<td>No Charge</td>
<td>Pulmonary, Occupational, Physical &amp; Speech each have 30 visit per cal yr limit and cardiac has 20 visit limit, in and out of network comb.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Non-covered</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>$150 Copay per day for the first 5 days of admission, 20% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>365 days per Life Time INN and Out Of Network comb. Prior Authorization required for out of network or 50% coins</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Prior Authorization is needed for out of network providers if the charge is &gt;$1,000 or paid at 50%</td>
</tr>
<tr>
<td>Hospice service</td>
<td>20% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Non-network requires Prior Authorization or 50% coinsur.</td>
</tr>
</tbody>
</table>

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow.

Your Grievance and Appeals Rights:

For questions about your rights, this notice, or assistance, you can contact us at 1-800-632-3203 or visit www.myuhc.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.”

Language Access Services:

- Chinese (Mandarin): If you need Chinese help, please dial 1-800-632-3203.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-632-3203.

### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child dental check-up
- Child glasses
- Child routine vision exam (i.e. refraction)
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

#### Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care limitations may apply
- Private-duty nursing limitations may apply
- Routine foot care limitations may apply
- Hearing aids limitations may apply
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (877) 722-2667. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us at 1-800-632-3203 or visit www.myuhc.com.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-800-632-3203.
- Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-632-3203.
- Navajo (Dine): Dinék'ehgo shika at'ohwol ninisingo, kwiiijgo holne’ 1-800-632-3203.

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To see examples of how this plan might cover costs for a sample medical situation, see the next page.
About these Coverage Examples:
These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,660
- **Patient pays:** $1,880

**Sample care costs:**
- Hospital charges (mother): $2,700
- Routine obstetric care: $2,100
- Hospital charges (baby): $900
- Anesthesia: $900
- Laboratory tests: $500
- Prescriptions: $200
- Radiology: $200
- Vaccines, other preventive: $40

**Total:** $7,540

**Patient pays:**
- **Deductibles:** $1,270
- **Copays:** $150
- **Coinsurance:** $310
- **Limits or exclusions:** $150

**Total:** $1,880

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,600
- **Patient pays:** $1,800

**Sample care costs:**
- Prescriptions: $2,900
- Medical Equipment and Supplies: $1,300
- Office Visits and Procedures: $700
- Education: $300
- Laboratory tests: $100
- Vaccines, other preventive: $100

**Total:** $5,400

**Patient pays:**
- **Deductibles:** $1,200
- **Copays:** $520
- **Coinsurance:** $0
- **Limits or exclusions:** $80

**Total:** $1,800
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example Show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-632-3203 or visit us at www.bsabenefits.mercerhrs.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf. Or call the number above to request a copy.
**Options PPO HDHP**

**Coverage Period:** 01/01/2016-12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** Employee/Family  |  **Plan Type:** PPO

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### Important Questions | Answers | Why this Matters:
--- | --- | ---

| What is the overall deductible? | Network: $2,600 Individual / $5,200 Family Non-Network: $2,600 Individual / $5,200 Family / Per calendar year. Does not apply to services listed below as “No Charge”. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. |

| Are there other deductibles for specific services? | No, there are no other deductibles. | You don’t have to meet deductibles for specific service, but see the chart starting on page 2 for other costs for services this plan covers. |

| Is there an out-of-pocket limit on my expenses? | Medical- Network: $2,600 Individual / $5,200 Family Non-Network: Unlimited Individual / Unlimited Family | The out-of-pocket limit is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses. Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |

| What is not included in the out-of-pocket limit? | Premiums, balanced-billed charges, health care this plan doesn’t cover, penalties for failure to obtain pre-notification for services. | The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits. |

| Is there an overall annual limit on what the plan pays? | This policy has no overall annual limit on the amount it will pay each year. | |

| Does this plan use a network of providers? | Yes, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see www.myuhc.com or call 1-800-632-3203. | If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |

| Do I need a referral to see a specialist? | No | You can see the specialist you choose without permission from this plan. |

| Are there services this plan doesn’t cover? | Yes | Some of the services this plan doesn’t cover are listed on Page 6. See your policy or plan document for additional information about excluded services. |

---

**Questions:** Call **1-800-632-3203** or visit us at **1-800-444-4416**. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call the number above to request a copy.

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Options PPO HDHP

Coverage Period: 01/01/2016-12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Employee/Family | Plan Type: PPO

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

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<td>Primary care visit to treat an injury or illness</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Virtual Visit - In network 100% coinsurance after deductible per visit by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.</td>
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<tr>
<td></td>
<td>Specialist visit</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Cost Share applies for only Manipulative (Chiropractic) Care. 30 visits cal year INN &amp; Out Of Network comb. Prior Auth if Out Of Network provider paid at 50%</td>
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<td></td>
<td>Preventive care/ screening/immunization</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Includes preventive health services specified in the health care reform law.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Prior Authorization required for non-network sleep studies or benefits reduced to 50%</td>
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<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Prior Authorization required for Non-network or benefits reduced to 50%</td>
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### Options PPO HDHP

**Coverage Period:** 01/01/2016-12/31/2016

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

#### Coverage for: Employee/Family | Plan Type: PPO

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<td>Retail: 0% Coinsurance After Deductible&lt;br&gt;Mail Order: 0% Coinsurance After Deductible</td>
<td>Retail: Not Covered</td>
<td>None</td>
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<td></td>
<td>Tier 2 - Your Midrange-Cost Option</td>
<td>Retail: 0% Coinsurance After Deductible&lt;br&gt;Mail Order: 0% Coinsurance After Deductible</td>
<td>Retail: Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Your Highest-Cost Option</td>
<td>Retail: 0% Coinsurance After Deductible&lt;br&gt;Mail Order: 0% Coinsurance After Deductible</td>
<td>Retail: Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Additional High-Cost Option</td>
<td>Retail: N/A&lt;br&gt;Mail Order: N/A</td>
<td>Retail: N/A&lt;br&gt;Mail Order: N/A</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room services</td>
<td>0% Coinsurance After Deductible</td>
<td>0% Coinsurance After Deductible</td>
<td>Prior-Auth required within 48 hours if admitted to a non-network facility or payment will be at 50%. ER visits are ONLY covered if a True Emergency.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>0% Coinsurance After Deductible</td>
<td>0% Coinsurance After Deductible</td>
<td>Prior Authorization required for Non Emergency air transportation. Out of network penalty is reduction in benefits to 50%.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Non-network requires prior-authorization or 50% coinsur.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>None</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [www.myuhc.com](http://www.myuhc.com).
Options PPO HDHP

Coverage Period: 01/01/2016-12/31/2016

Coverage for: Employee/Family | Plan Type: PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Employee Assistance Program offers up to 6 visits at no cost.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health inpatient services</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Non-network providers require Prior Authorization or 50% coinsur.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Substance use disorder outpatient services</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Employee Assistance Program offers up to 6 visits at no cost.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Substance use disorder inpatient services</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Non-network providers require Prior Authorization or 50% coinsur.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Your cost in this category includes physician delivery charges. Routine Prenatal care covered at no charge.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Delivery and all inpatient services</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Your cost for inpatient services only. For physician delivery charges, see pre-postnatal care. Prior Authorization if stay is longer than 48 or 72 hrs e-sector or benefits reduced to 50% coinsur.</td>
</tr>
</tbody>
</table>
## Coverage Period: 01/01/2016-12/31/2016

### Summary of Benefits and Coverage:

#### What this Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use a Non-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>240 visits per cal year INN &amp; Out Of Network comb. Prior Auth needed if Out Of Netwk provider paid at 50%</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Pulmonary, Occupational, Physical &amp; Speech each have 30 visit and Cardiac has 20 visits, per cal yr limit, in and out of network comb.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>365 days lifetime comb in/out of ntwk. Prior-Auth required for Out of Ntwk provider or paid at 50%</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Prior Authorization is needed if Out of Network provider and the cost is &gt;$1000 or paid at 50%</td>
<td></td>
</tr>
<tr>
<td>Hospice service</td>
<td>0% Coinsurance After Deductible</td>
<td>20% Coinsurance After Deductible</td>
<td>Non-network requires prior-authorization or 50% coinsur.</td>
<td></td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Bariatric Surgery
- Child dental check-up
- Child glasses
- Child routine vision exam (i.e. refraction)
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

#### Other Covered Services

- Chiropractic care limitations may apply
- Hearing aids limitations may apply
- Private-duty nursing limitations may apply
- Routine foot care limitations may apply

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**If you need help recovering or have other special health needs**

**If your child needs dental or eye care**

Eye exam: Not Covered
Glasses: Not Covered
Dental check-up: Not Covered

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**Language Access Services:**

- Spanish (Español): Para obtener asistencia en Español, llame al 1-800-632-3203.
- Chinese: To see examples of how this plan might cover costs for a sample medical situation, see the next page.
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-877-722-2667. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us at 1-800-632-3203 or visit www.myuhc.com.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
- Spanish (Español): Para obtener asistencia en Español, llame al 1-800-632-3203.
- Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-632-3203.
- Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiiijgo holne’ 1-800-632-3203.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
About these Coverage Examples:
These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.
Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
</tr>
<tr>
<td><strong>Plan pays</strong> $7,370</td>
</tr>
<tr>
<td><strong>Patient pays</strong> $170</td>
</tr>
<tr>
<td><strong>Sample care costs:</strong></td>
</tr>
<tr>
<td><strong>Hospital charges (mother)</strong> $2,700</td>
</tr>
<tr>
<td><strong>Routine obstetric care</strong> $2,100</td>
</tr>
<tr>
<td><strong>Hospital charges (baby)</strong> $900</td>
</tr>
<tr>
<td><strong>Anesthesia</strong> $900</td>
</tr>
<tr>
<td><strong>Laboratory tests</strong> $500</td>
</tr>
<tr>
<td><strong>Prescriptions</strong> $200</td>
</tr>
<tr>
<td><strong>Radiology</strong> $200</td>
</tr>
<tr>
<td><strong>Vaccines, other preventive</strong> $40</td>
</tr>
<tr>
<td><strong>Total</strong> $7,540</td>
</tr>
<tr>
<td><strong>Patient pays:</strong></td>
</tr>
<tr>
<td><strong>Deductibles</strong> $20</td>
</tr>
<tr>
<td><strong>Copays</strong> $0</td>
</tr>
<tr>
<td><strong>Coinsurance</strong> $0</td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong> $150</td>
</tr>
<tr>
<td><strong>Total</strong> $170</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays</strong> $2,720</td>
</tr>
<tr>
<td><strong>Patient pays</strong> $2,680</td>
</tr>
<tr>
<td><strong>Sample care costs:</strong></td>
</tr>
<tr>
<td><strong>Prescriptions</strong> $2,900</td>
</tr>
<tr>
<td><strong>Medical Equipment and Supplies</strong> $1,300</td>
</tr>
<tr>
<td><strong>Office Visits and Procedures</strong> $700</td>
</tr>
<tr>
<td><strong>Education</strong> $500</td>
</tr>
<tr>
<td><strong>Laboratory tests</strong> $100</td>
</tr>
<tr>
<td><strong>Vaccines, other preventive</strong> $100</td>
</tr>
<tr>
<td><strong>Total</strong> $5,400</td>
</tr>
<tr>
<td><strong>Patient pays:</strong></td>
</tr>
<tr>
<td><strong>Deductibles</strong> $2,600</td>
</tr>
<tr>
<td><strong>Copays</strong> $0</td>
</tr>
<tr>
<td><strong>Coinsurance</strong> $0</td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong> $80</td>
</tr>
<tr>
<td><strong>Total</strong> $2,680</td>
</tr>
</tbody>
</table>
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example Show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

- Yes. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-632-3203 or visit us at 1-800-444-4416. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf Or call the number above to request a copy.
HEALTH SAVINGS ACCOUNTS (HSA)
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What Is a Health Savings Account?

An HSA is a tax-advantaged bank account that can be used to pay for qualified health expenses incurred by you or your eligible dependents. An HSA is available only to those participating in a medical plan that is qualified by the Internal Revenue Service (IRS) as a high-deductible plan such as the BSA High Deductible Health Plan With an HSA (HDHP). Because the Traditional PPO plan is not qualified as a high-deductible medical plan, participants in this plan may not open or contribute to an HSA.

The health savings account is not an employer-sponsored benefit, but the BSA has arranged with UnitedHealthcare and OptumHealth Bank to provide you access to an HSA as an opportunity for you and the BSA to set aside money so that you can pay out-of-pocket health-care expenses tax-free—expenses such as deductibles, co-insurance and other kinds of health-care services like glasses and dental work for yourself, your spouse, and/or your eligible dependents. (A list of qualified medical expenses is available in Publication 502 found at www.irs.gov.) The money accumulated in the account, whether deposited by you, the BSA, or anyone else, is yours to keep, so even if you leave your job your account goes with you.

How the HSA Works

The concept of an HSA is rather simple. As a participant in a qualified high-deductible medical plan, federal rules allow you to open an account that can be funded by you, your employer, or anyone else and not be taxed on those contributions to the account. Using your bank-issued HSA debit card, you may then spend money from the account tax-free on qualified medical expenses incurred by you or your tax dependents. While the money in the account is yours, money you spend from the account on anything other than qualified health expenses becomes subject to taxes and a federal penalty.

HSA Eligibility

You are eligible to open and contribute to an HSA only if all of the following are true:

• You are enrolled in the HDHP or another qualified high-deductible medical plan.
• You are not covered by any other health plan (such as your spouse’s health plan) that is not a high-deductible medical plan.
• You are not enrolled in Medicare benefits.
• You are not enrolled in TRICARE or TRICARE for Life.
• You are not able to be claimed as a dependent on someone else’s tax return.
• You are not enrolled in a health-care Flexible Spending Account (FSA). If you are, it must be a limited-purpose FSA, meaning it can reimburse only those expenses not covered under another benefit plan such as dental or vision.

In addition, your eligibility to open an HSA account is governed under the PATRIOT Act, which requires banks to confirm applicants meet certain qualifications specified by federal law, such as citizenship and residency, before an account can be approved.

Opening an HSA

You may apply for an HSA if you are enrolled in the HDHP. You are not required to open an HSA, but doing so can reduce your overall health-care costs due to the tax savings available. At the time you make your initial or annual enrollment benefit elections on the BSA Benefits Center website at http://bsabenefits.mercerhrs.com, and after electing the HDHP, you will be taken to a Web page to apply for an HSA through OptumHealth Bank.

If you do not apply for an HSA at the time you elect to participate in the HDHP, you can return to the BSA Benefits Center website to open an account by going to the link for “Health/Life Status Change” at the top of the page. You can then select the link for “HSA Contribution” to complete your application.
You may open an HSA with any banking institution that offers the accounts; however, if you wish to fund your account from payroll deductions and be eligible to receive any available annual contribution from the BSA, you should apply with OptumHealth Bank through the BSA Benefits Center website. Simply follow the instructions, determine whether you wish to make contributions to your account, and submit your application. You may contact the BSA Benefits Center at 800-444-4416 if you have any questions regarding your HSA or the application process.

Once you have completed the application, the BSA Benefits Center will forward your information to OptumHealth Bank to begin processing your application. If approved, a welcome kit will be mailed to your home address within approximately two weeks. Also, in two separate unmarked mailings, you will receive a debit card(s) and a Personal Identification Number assigned by the bank to access your HSA online.

If your application is not approved, you will receive notification from OptumHealth Bank. Additional information may be requested in order to continue processing your application. Once your account has been opened, you will receive a welcome kit, debit card(s), and PIN as described. If you do not receive a welcome kit or notification from OptumHealth Bank, you may call the BSA Benefits Center or call OptumHealth Bank directly at 800-791-9361 (and select option 1).

Contributions to an HSA

Each year, the BSA will determine how much, if any, contribution will be made to your OptumHealth Bank HSA on your behalf as long as you are participating in the HDHP. For 2016, the BSA will make a single contribution of $500 to your HSA if you open your account on or before June 30, 2016. If you open an account between July 1 and December 31, 2016, the BSA will contribute $250 to your account.

The IRS sets limits on how much can be contributed to an HSA each year. The maximum amount that may be contributed to your HSA for the 2016 tax year is $3,350 for single coverage and $6,750 for family coverage, with an additional $1,000 catch-up contribution for employees age 55 and older. The BSA deposit, your payroll deductions, direct deposits, or deposits from any other source all count toward your maximum contribution for the 2016 tax year. You can elect to make, change, or stop payroll deductions into your HSA on the BSA Benefits Center website at www.bsabenefits.mercerhrs.com or by calling the Benefits Center at 800-444-4416. Your instructions will be communicated to your payroll department, which will make your changes at the next payroll closing date following receipt of your instructions.

When determining how much to contribute to an HSA, consider whether you want to contribute just enough to your HSA to cover anticipated costs for the year; contribute up to the HDHP’s single or family deductible amounts; or contribute the maximum amount allowed by the IRS to take full advantage of tax savings.

Note: Tax-free deposits can only be made to your HSA if you are actively participating in the HDHP or in another qualified high-deductible medical plan. However, once deposited, the money is yours to spend even if you stop participating in a high-deductible medical plan. For this reason, many participants use the HSA as a tax-free savings account to prepare for medical expenses into retirement.

Using an HSA to Pay for Health Expenses

Before you receive care:

- Confirm that the health services, supplies, or drugs you will be purchasing are qualified health expenses that can be paid from your HSA (generally, if the services or supplies are covered by the plan, they are qualified health expenses; refer to IRS Publication 502 for a list of qualified health expenses).
- Know approximately how much you will be responsible for paying the provider (if in-network, this will be based on the negotiated amount the provider has agreed to charge).
- Know how much in out-of-pocket expenses you have paid toward your annual deductible and how much remains to be paid before you meet your deductible.
- Know the balance of your HSA funds available to spend.
At the point of care:

- Inform your doctor or other health-care providers of your participation in a high-deductible medical plan.
- You can pay the cost of services using your HSA debit card as long as there is a sufficient balance available.
- Provided you have not met your deductible and out-of-pocket maximum under the HDHP, the amount you are responsible for paying the provider is the in-network rate negotiated with UnitedHealthcare.
- If you or the provider are not certain of the amount you are responsible for paying, ask your provider to bill you after filing your claim so that network discounts can be applied and you can avoid overpaying for the service.
- Keep your receipts and compare them to the explanation of benefits (EOB) that will be provided after your claim is processed. If you paid more or less than the amount shown on the EOB, you will need to work with the provider to settle the difference.
- If you do not have a sufficient balance in your HSA, you are still responsible for charges until you meet your deductible.
- If you pay the provider from a source of funds other than your HSA, you can still receive a tax advantage for those costs by reimbursing yourself from the HSA once you have a sufficient balance, or you may deduct qualified health expenses at the time you file your personal tax return for the year you incurred the expense(s).

**What Happens to the Money If I Don’t Use It?**

If you do not use all the funds in your HSA by the end of the plan year (December 31), the money will roll over to the next plan year. You can continue to contribute to the HSA in the succeeding plan years as long as you are participating in the HDHP, increasing your HSA account balance each year. If you leave the BSA, you can take the funds in your HSA with you.

**Following is an example of how Mark uses his HSA to pay for health-care expenses:**

Mark is single and elected employee-only coverage in the High Deductible Health Plan (HDHP). He has a $2,500 in-network annual deductible with the plan paying 100 percent for covered charges once he meets the deductible.

In addition to the $500 deposited by the BSA, Mark elected to make $2,736 in annual contributions from his semimonthly paycheck (or $114 per pay period pre-tax deduction) to his OptumHealth Bank HSA to help pay for his qualified health-care costs (prescriptions, doctor visits, labs, X-rays, etc.) This gives Mark a tax savings of $22.80 per paycheck, or $547.20, per year if his tax rate is 20 percent. Plus the $500 provided by the BSA, Mark has just saved $1,047.20 for the year!

Mark's first expenses for the year were incurred in January for prescription drugs and he paid the full cost from his HSA. In early February, he went for his annual physical and paid nothing since the plan pays 100 percent for preventive care. However, shortly afterward Mark was injured and needed X-rays, an MRI, and physical therapy, which cost more than he had available in his HSA.

Since the total covered charges for treating his injury were not enough to cause Mark to meet his deductible, he was responsible for the full cost of the health-care services he received. The providers offered to bill him and receive payment as he made further deposits to his HSA, but Mark chose to pay for the care and reimburse himself from the HSA at a later date.

**OTHER EXPENSES YOU CAN PAY WITH AN HSA**

Qualified health expenses are not limited to expenses covered by the HDHP. Other expenses that may qualify include:
- Out-of-pocket expenses for dental or vision that are not paid by a dental or vision plan
- Over-the-counter medication if prescribed by your doctor
- COBRA premiums for yourself or your tax dependents
- Medicare Part B premiums
- Long-term care coverage
- Other expenses listed in Publication 502
Using his BSA Vision plan, Mark went for his annual vision exam and purchased a new pair of glasses. The vision benefit paid most of his expenses, but since his remaining out-of-pocket costs are qualified health expenses, Mark chose to pay those costs from his HSA. Please note these expenses are not covered HDHP expenses so they do not apply toward his HDHP deductible.

With limited expenses anticipated for the remainder of the year, his remaining balance and contributions to his HSA will roll over to be used in the next plan year.

**Beneficiary Designation**

You will need to log in to [www.myuhc.com](http://www.myuhc.com) and download a beneficiary form for your HSA account, then follow the instructions on the form. If you do not designate a beneficiary, your HSA funds will go to your legal spouse. If you are not married at the time of your death, the funds will go to your estate.

**Interest and Fees**

OptumHealth Bank charges a number of fees for services that can be reviewed online at [www.myuhc.com](http://www.myuhc.com). Since all of these fees with the exception of one are easily avoided based on choices you make in managing your account, fees will be deducted from your HSA balance, if incurred. However, the one exception is a $1 monthly service fee charged to accounts with an average monthly balance below $500. Because this fee is not easily avoided, particularly for new account holders, the BSA has arranged with OptumHealth Bank to pay this fee on behalf of account holders.

Your HSA may earn interest at competitive, tiered rates. Interest is paid monthly and rates can vary. Log in to your account at [www.myuhc.com](http://www.myuhc.com) to confirm the interest rate that applies to your account.

**Investment Opportunities**

Once your account reaches a minimum $2,000 balance, you have the option to begin investing a portion of your savings in mutual funds. Note: Funds you choose to invest do not remain in your account to pay for medical expenses. If you want to use invested funds to pay for medical expenses, you will have to transfer them back to your HSA.

**Reporting to the IRS**

You are responsible for saving receipts and keeping track of expenses paid from your HSA account in case you need to prove to the IRS that distributions from the HSA were for qualified health-care expenses.

**State Tax Information**

States can choose to follow the federal tax treatment guidelines for HSA accounts or establish their own. Eligible HSA contributions are not taxed by most states, but they are taxed in Alabama, California, and New Jersey. Please consult your tax adviser or state department of revenue for more information.

**Withdrawals After Age 65 or Upon Becoming Disabled**

After you turn 65 or become entitled to Medicare benefits, you may withdraw money from your HSA for non-medical purposes without penalty. The withdrawal is treated as retirement income and is subject to normal income tax. (The same holds true if you become disabled before age 65.)
Managing Your HSA

Log in to your account through myuhc.com to:

- Check monthly statements
- Pay bills to health-care providers
- View and export transactions
- Download account forms
- Find your current interest rate
- Arrange to make deposits from another bank account into your HSA
- Manage investment activity
- Get tax information
- Use HSA calculators

Customer Service

Contact OptumHealth Bank Customer Service at 800-791-9361 from 8 a.m. to 8 p.m. Eastern, Monday through Friday, with questions about your HSA account. If you call before or after these business hours, an automated system can give you information about your balance and last five transactions.
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SPECIAL MEDICAL PROGRAMS

(Active Employees Only)
Employee Assistance Plan

The Employee Assistance Plan (EAP) provides free, confidential assistance with a variety of personal or workplace concerns, ranging from stress, depression, conflicts at work, and grief to legal or financial issues. The EAP is administered by United Behavioral Health (UBH), which also manages the mental health and substance use disorder treatment for the BSA Medical Plan.

ELIGIBILITY

Any active employee and his/her eligible dependents who are eligible to be enrolled in the BSA Medical Plan are eligible for the EAP. This includes anyone who has continuation of medical coverage through COBRA. This does not include retirees, survivors, anyone receiving a benefit from the BSA Long-Term Disability Plan or the BSA Long-Term Disability Executive Plan, or any other plan participant who is not an active employee of the BSA or a local council.

BENEFITS

The EAP is available 24 hours a day, seven days a week. You may call the EAP at 800-788-5614 (TTY/TDD 800-8429489) any time you feel that a problem is more than you can handle alone. You will be connected immediately to an EAP specialist, who is a master’s-level clinician experienced in helping people identify the nature of their concerns and in finding the right resources to address them. After you receive an assessment of your needs, concerns, or issues, your EAP specialist will refer you to a local resource or a health-care professional who has experience dealing with your issue or problem. Additional information may be found at the UBH website www.liveandworkwell.com (access code 136003).

You will also receive a “certification” number that authorizes you to schedule an initial assessment with your local health-care professional. The call or the appointment will cost you nothing. Each person covered under the BSA Medical Plan as defined under the “Eligibility” section above is eligible for up to six appointments per calendar year at no cost.

After the free initial assessment, you and your health-care professional may determine that longer-term care is needed beyond your EAP. In this case, the sessions will be covered according to the BSA Medical Plan.

SERVICES

Expert Counseling. Professional counselors are available to provide an objective viewpoint and expert guidance. You can have on-the-spot advice over the phone or a referral to work with a counselor face-to-face.

Legal Assistance. Advice for landlord/tenant issues, personal injury, bankruptcy, and other concerns. Services include free phone consultations with licensed attorneys, a free referral to a local attorney plus a 30-minute face-to-face consultation at no charge, and a 25 percent discount on additional legal services. Family mediation services are also available.

Financial Services. Free, unlimited phone consultations with certified financial planners about debt management, taxes, investing, and other related topics. Also included are credit card debt and budget assistance programs.

CONFIDENTIALITY

The care you receive through the EAP is confidential. UBH provides information only to the health-care professional who delivers your treatment. In addition, UBH and your health-care professional will not disclose any information to anyone without explicit written instructions from you, except where required within federal and state guidelines.

UBH’s quality behavioral health-care services ensure that you and your covered family members will always receive the assistance that meets your needs, regardless of where you live, work, or travel.

WHEN BENEFITS END

Benefits under the EAP automatically end on the day the coverage under the BSA Medical Plan ends, including continuation of coverage through COBRA.
Your Rights

ERISA INFORMATION AND NOTICE OF RIGHTS

If you participate in the BSA Employee Assistance Program, you are entitled to certain rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Refer to the Legal Notices chapter for more information.

CONTINUATION OF COVERAGE (COBRA)

Boy Scouts of America is required to offer continuation of coverage in certain cases as a result of Public Law 99272, Title X, Consolidated Omnibus Budget Reconciliation Act (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Refer to the Legal Notices chapter for more information.

LEGAL INFORMATION

Privacy Notice

Please refer to the Legal Notices chapter for the Boy Scouts of America “Privacy of Your Information” policy and the “Notice of Privacy Policies” as required under the Health Insurance Portability and Accountability Act (HIPAA).

Personal Health Support

UnitedHealthcare provides a program called Personal Health Support that is designed to encourage personalized, efficient care for you and your covered dependents.

Personal Health Support nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse—referred to as a Personal Health Support Nurse—to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support nurse will provide you with his or her phone number so you can call him or her with questions about your conditions, or your overall health and well-being.

Personal Health Support nurses will provide a variety of services to help you and your covered family members receive appropriate medical care. Program components and notification requirements are subject to change without notice. As of the publication of this SPD, the Personal Health Support program includes:

- Admission counseling: For upcoming inpatient hospital admissions with certain conditions, a Treatment Decision Support nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- Inpatient care advocacy: If you are hospitalized, a nurse will work with your physician to make sure you are getting the care you need and that your physician's treatment plan is being carried out effectively.
- Readmission management: This program serves as a bridge between the hospital and your home if you are at high risk of being readmitted. After leaving the hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- Risk management: Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
If you do not receive a call from a Personal Health Support nurse but feel you could benefit from any of these programs, please call 800-632-3203.

**REQUIREMENTS FOR NOTIFYING PERSONAL HEALTH SUPPORT**

There are some network benefits for which you are responsible for notifying Personal Health Support. However, network providers, except in the Options PPO, are generally responsible for notifying Personal Health Support before they provide these services to you.

When you choose to receive covered health services from non-network providers, you are responsible for notifying Personal Health Support before you receive these covered health services. In many cases, your non-network benefits will be reduced if Personal Health Support is not notified.

The services that require Personal Health Support notification are:

- Ambulance (nonemergent air and ground)
- BRCA testing (breast cancer susceptibility)
- Clinical trials
- Congenital heart disease services
- Dental services treatment is covered only for accidental damage or injury and removal of any bony impacted teeth requiring general anesthetic and performed by an oral surgeon that is not covered by dental insurance.
- Durable medical equipment for items that will cost more than $1,000 to purchase or rent
- Home health care
- Hospice care (inpatient)
- Hospital inpatient stay, including emergency admission
- Lab, X-ray, and major diagnostics—CT and PET scans, MRI, MRA, and nuclear medicine
- Maternity care that is expected to continue beyond either:
  - 48 hours for the mother and newborn child following a vaginal delivery, or
  - 96 hours for the mother and newborn child following a cesarean section delivery
- Reconstructive procedures
- Rehabilitation services (chiropractic)
- Scopic procedures
- Skilled nursing facility/inpatient rehabilitation facility services
- Surgery (outpatient)—diagnostic catheterization, electrophysiology implant, sleep apnea surgeries
- Therapeutics (outpatient)—dialysis, intensity modulated radiation therapy, MR-guided focused ultrasound
- Transplantation services

**CONTACTING PERSONAL HEALTH SUPPORT IS EASY.** Simply call 800-632-3203.

**SPECIAL NOTE REGARDING MEDICARE**

If you are enrolled in Medicare, and Medicare pays benefits before the plan, you are not required to notify Personal Health Support before receiving covered health services. Since Medicare pays benefits first, the plan will pay benefits second as described in the Medicare Supplement section.

**NON-NOTIFICATION PENALTY**

Benefits are reduced to 50 percent if you or your covered dependent do not call Personal Health Support as required. This reduction is called a non-notification penalty. A non-notification penalty applies to each stay, surgical procedure, or treatment plan.

The 50 percent non-notification penalty would apply to the Choice Plus out-of-network providers and the Options PPO in-network and out-of-network providers.

**APPEALS**

You or your covered dependent can appeal a decision by calling Personal Health Support.

If you, your covered dependent, or the physician does not agree with Personal Health Support’s decision, it can be appealed.
targets specific conditions as well as the treatments and procedures for those conditions. It offers:

- Access to accurate, objective, and relevant health-care information
- Coaching by a nurse through decisions in your treatment and care
- Expectations of treatment
- Information on high quality providers and programs

Conditions for which this program is available include:

- Back pain
- Knee and hip replacement
- Prostate disease
- Prostate cancer
- Benign uterine conditions
- Breast cancer

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact 800-632-3203.

**Disease Management Program**

If you have been diagnosed with or are at risk for developing certain chronic medical conditions, you may be eligible to participate in a disease management program at no cost to you. The heart failure and coronary artery disease/diabetes and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, and recommended exams and medications.
- Access to educational and self-management resources on a consumer website.

**EMERGENCY CARE**

When emergency care is required and results in a stay, you or your covered dependent (or that person's representative or physician) must call Personal Health Support within 48 hours of the date the stay begins, or as soon as reasonably possible.

A working day is a business day of the employer. It does not include Saturday, Sunday, or a state or federal holiday. If it is not reasonably possible to call Personal Health Support within 48 hours, Personal Health Support must be notified as soon as reasonably possible.

When the emergency care has ended, however, Personal Health Support must be called before any additional services that require notification are received.

Benefits are subject to the non-notification penalty if Personal Health Support is not called as shown above. The non-notification penalty applies to each stay.

The amount of the non-notification penalty is shown under the “Non-notification Penalty” section. The amount of the non-notification penalty will never be more than the amount of the covered expenses.

**Treatment Decision Support**

In order to help you make informed decisions about your health care, UnitedHealthcare has a voluntary program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions. It offers:

- Access to accurate, objective, and relevant health-care information
- Coaching by a nurse through decisions in your treatment and care
- Expectations of treatment
- Information on high quality providers and programs

Conditions for which this program is available include:

- Back pain
- Knee and hip replacement
- Prostate disease
- Prostate cancer
- Benign uterine conditions
- Breast cancer

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact 800-632-3203.
There is no obligation to use recommended providers or facilities and no charge for the consulting services received from your participation in this program.

For more information, call 866-936-6002 or visit www.myoptumhealthcomplexmedical.com.

myuhc.com

UnitedHealthcare’s member website, www.myuhc.com, provides information at your fingertips anywhere and anytime you have access to the Internet. Certainly myuhc.com opens the door to a wealth of health information and convenient self-service tools to meet your needs.

Health Information

With myuhc.com you can:

- Research a health condition and treatment options to get ready for a discussion with your physician
- Search for network providers available through the online provider directory
- Access all of the content and wellness topics from Optum NurseLine including Live Nurse Chat 24 hours a day, seven days a week
- Complete a health assessment to identify health habits you can improve, learn about healthy lifestyle techniques, and access health improvement resources

Self-Service Tools

Visit myuhc.com and:

- Use the Prescription Drug Pricing tool in the tools section of the “Benefits & Coverage” tab to calculate your costs for formulary prescriptions you or your family fill;
- Use the Estimate Health Care Costs tool to find out what your costs may be for a procedure or test your doctor orders;
- Make real-time inquiries into the status and history of your claims;
- View eligibility and plan benefit information, including copays and annual deductibles;
- Use the hospital comparison tool to compare hospitals in your area on various patient safety and quality measures;
- View and print all of your Explanation of Benefits (EOBs) online; and

- Toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - Education about the specific disease and condition
  - Medication management and compliance
  - Behavior modification and encouragement from an online coach
  - Preparation and support for upcoming physician visits
  - Review of psychosocial services and community resources
  - Caregiver status and in-home safety
  - Use of mail-order pharmacy and in-network providers

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact UnitedHealthcare at 800-632-3203.

Complex Medical Conditions

The OptumHealth Care Solutions Complex Medical Conditions program provides specialized consulting services to enrolled employees and dependents. The program includes educational information so you can make informed decisions about your care, and clinical consulting by nurse case managers who can answer questions about your treatment options and provide help finding a healthcare provider that is right for you.

This UHC program focuses on the following areas of concern:

- Organ transplants
- Cancer
- Congenital heart disease
- Neonatology
- Infertility
- Pregnancy

An opportunity for the disease management nurse to work with your physician to ensure that you are receiving the appropriate care.

Examples of support topics include:

- Education about the specific disease and condition
- Medication management and compliance
- Behavior modification and encouragement from an online coach
- Preparation and support for upcoming physician visits
- Review of psychosocial services and community resources
- Caregiver status and in-home safety
- Use of mail-order pharmacy and in-network providers

With myuhc.com you can:

- Research a health condition and treatment options to get ready for a discussion with your physician
- Search for network providers available through the online provider directory
- Access all of the content and wellness topics from Optum NurseLine including Live Nurse Chat 24 hours a day, seven days a week
- Complete a health assessment to identify health habits you can improve, learn about healthy lifestyle techniques, and access health improvement resources

Self-Service Tools

Visit myuhc.com and:

- Use the Prescription Drug Pricing tool in the tools section of the “Benefits & Coverage” tab to calculate your costs for formulary prescriptions you or your family fill;
- Use the Estimate Health Care Costs tool to find out what your costs may be for a procedure or test your doctor orders;
- Make real-time inquiries into the status and history of your claims;
- View eligibility and plan benefit information, including copays and annual deductibles;
- Use the hospital comparison tool to compare hospitals in your area on various patient safety and quality measures;
- View and print all of your Explanation of Benefits (EOBs) online; and
• Order a new or replacement ID card, print a temporary ID card, or check on an ID card request.

Registering on myuhc.com

If you have not already registered as a myuhc.com subscriber, simply go to myuhc.com and click on “Register Now.” Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Health Improvement Plan

You can start a health improvement plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:
• Nutrition
• Exercise
• Weight management
• Stress
• Smoking cessation
• Diabetes
• Heart health

To help keep you on track with your health improvement plan and online coaching, you’ll also receive personalized messages and reminders—BSA’s way of helping you meet your health and wellness goals.

Naturally Slim

The Naturally Slim web-based education program focuses on one of the primary issues that lead to metabolic syndrome—our eating habits. Through this 10-week online program, you have the opportunity to learn more about and decrease your risk factors for metabolic syndrome, lose weight, and look and feel better. This program was developed by studying people who were “naturally slim,” and coincidentally had fewer risk factors for metabolic syndrome, to determine what they did to maintain an ideal weight throughout their lives. Key program features include:
• Improving the health of those most at risk for metabolic syndrome.
• Focusing on weight loss and maintenance. Participants learn to eat sensibly, identify personal eating habits, make wise choices, recognize the differences between true hunger and psychological hunger, understand how hydration habits influence hunger, and practice ways to minimize fat storage.
• Learning how exercise, stress, and your environment affect weight loss.
• Learning how to develop a lifestyle of eating the foods you like while improving your health and losing weight.

Program completion requirements include:
• Completing a minimum of eight out of the 10 weekly online video sessions.
• Committing to participate actively in the program.

The program is offered on a voluntary basis and there is no cost to you as long as you complete the program requirements. If you do not meet the completion requirements listed above within the timeframe specified for your class, you will be required to pay $150 towards the cost of the program through a series of three payroll deductions. The BSA takes health improvement seriously and we ask you to do the same.

Optum® NurseLine℠

Optum NurseLine is a service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Simply call 866-529-1680. NurseLine nurses can provide health information for routine or urgent health concerns such as:
• A recent diagnosis;
• A minor sickness or injury;
• Men’s, women’s, and children’s wellness;
• How to take prescription drugs safely;
• Self-care tips and treatment options;
• Healthy living habits; or
• Any other health related topic.

Live Nurse Chat

With NurseLine, you also have access to nurses online. To use this service, log onto www.myuhc.com and click “Live Nurse Chat” in the top menu bar. You’ll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day,
seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

**Note:** If you have a medical emergency, call 911 instead of logging onto [www.myuhc.com](http://www.myuhc.com).

**Healthy Pregnancy Program**

If you are pregnant and enrolled in the BSA Medical Plan, you can get valuable educational information and advice by calling 800-411-7984 or online at [www.healthy-pregnancy.com](http://www.healthy-pregnancy.com). This program offers:

- Maternity nurses on duty 24 hours a day;
- A free copy of the *Healthy Pregnancy Guide*;
- A phone call from a maternity nurse halfway through your pregnancy to see how things are going;
- A phone call from a nurse approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations, and more; and
- A copy of an available publication, for example, *Healthy Baby Book*, which focuses on the first two years of life.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of pregnancy. You can enroll at any time, up to your 34th week. To enroll, call 800-632-3203.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you may have.

**UnitedHealth Premium℠ Program**

UnitedHealthcare designates network physicians and facilities as UnitedHealth Premium Program physicians or facilities for certain medical conditions. Being a network physician or facility is not the same as being a Premium Program physician or facility. Physicians and facilities are evaluated on two levels—quality and efficiency of care. The UnitedHealth Premium Program was designed to:

- Help you make informed decisions on where to receive care
- Provide you with decision support resources
- Give you access to physicians and facilities across areas of medicine that have met UnitedHealthcare’s quality and efficiency criteria

For details on the UnitedHealth Premium Program, including how to locate a UnitedHealth Premium physician or facility, log onto [www.myuhc.com](http://www.myuhc.com) or call 800-632-3203.

**Sherpa (Support for Cancer Patients)**

Sherpa is a UnitedHealthcare program that offers a designated customer service team to help enrolled cancer patients with non-clinical issues such as insurance questions and claims, while providing advocacy and empathy along the way. The goal of the Sherpa program is to provide cancer patients with assistance in navigating a health care system that is complicated and can be difficult to understand.

There is no formal enrollment process for Sherpa. When a claim is filed showing that you or your family member is undergoing active cancer treatment, they will be identified by the system as eligible for this free program.

The next time the eligible person (or their family member) calls UnitedHealthcare Customer Service, the call is automatically routed to a Sherpa agent, who will introduce the program and explain its free services.

Sherpa is available to cancer patients early in the treatment cycle and continues to provide support throughout their treatment. Sherpa offers the following services to eligible UnitedHealthcare participants:

- A designated customer service team to help resolve questions or issues
- Appointment scheduling assistance to better fit the patient’s schedule
- Setting up conference calls with clinical and claim experts, if needed

There is no charge for utilizing the Sherpa program and its services.
Personal Rewards Program

What is Personal Rewards?

The BSA believes the health of our employees and their families is important, and we want to build and maintain a culture of health and wellness within the BSA organization. To help us reach that goal, the BSA has partnered with UnitedHealthcare to offer employees and their spouses enrolled in the health insurance plan the opportunity to participate in a wellness program called Personal Rewards.

Personal Rewards encourages employees and their spouses to become aware of their health and will help them learn how to improve it. It also allows employees to earn discounts on health insurance premiums.

What do I have to do to participate?

Eligible employees and spouses participating in Personal Rewards complete two health actions to receive the premium discount:

- An annual preventive exam. Don’t forget to take the Provider Notification Form to your appointment for your doctor to complete.

- Four biometric screening measurements. Body mass index (BMI), LDL cholesterol, fasting blood sugar, and blood pressure, which are recorded on the Provider Notification Form.

Once the Provider Notification Form is complete, participants upload or fax it to UnitedHealthcare so the successful completion of their biometric screening can be recorded.

Participants receive credit for their annual preventive exam when their provider files a claim for the office visit. Note: The claim must be filed as preventive.

Where can I get help with the Personal Rewards program?

Employees can get more information about Personal Rewards by calling UnitedHealthcare Customer Service at 877-818-5826, on MyBSA/HR Gateway, or on www.mercerhrs.com/scouting2health.

QuitPower

This UnitedHealthcare program is designed to help end a person’s dependence on nicotine.

How does it work? This six month program offers:

- Up to eight weeks of over-the-counter nicotine replacement therapy (patches or gum);

- Telephone access to a dedicated coach with eight scheduled coaching sessions;

- Information that will help you identify and voice common reasons why quit attempts fail;

- Educational articles, quizzes and progress tracking tools designed to provide support throughout the program.

To enroll in the QuitPower program or for more information, contact UnitedHealthcare at 877-784-8797 or at www.uhccoaching.com/quitpower.
The BSA Medicare Supplement Plan is self-funded and administered by UnitedHealthcare. A self-funded plan means just that: we fund the plan ourselves. The premiums you and your employer pay for those benefit plans are placed into a BSA account specifically for each plan. Claims and a small amount of administrative cost are then paid from that account. This plan coordinates with and provides a supplemental benefit to Medicare.

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**Eligibility**

Effective Jan. 1, 2011, the BSA Medical Plan will no longer provide Medicare Supplement Plan benefits for any of the following who are age 65 or over:

- BSA retirees
- BSA retirees’ dependents
- Long-Term Disability Plan participants
- Long-Term Disability Plan participants’ dependents
- Other surviving dependents

In order to be eligible for the BSA Medicare Supplement Plan, you must be a retiree, a survivor, a long-term disability plan participant or the dependent of a retiree, a survivor, or a long-term disability plan participant enrolled in or eligible to enroll in the BSA Medical Plan that is under the age of 65. You must also be enrolled in both Medicare Parts A and B and not enrolled in a Medicare prescription drug plan or other Medicare supplement plan.

If you fail to enroll for both Medicare Parts A and B, your coverage under the BSA Medical Plan will end the date you became eligible for Medicare Parts A and B. If you enroll in a Medicare prescription drug plan, a nontraditional Medicare plan, or other Medicare supplement plan, including but not limited to TRICARE for Life, Medicare Advantage plans, or any type of Medicare HMO, your coverage under the BSA Medical Plan will end the date the other coverage is effective. The BSA Benefits Center must be notified when such an enrollment occurs.

If your coverage in the BSA Medical Plan has been canceled, you may not re-enroll unless you qualify for a special enrollment period as defined on page 7 of the Medical Plans chapter. Survivors are not eligible for the special enrollment period and will not be eligible to re-enroll at a later date, regardless of the reason the BSA coverage was canceled.

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**Benefits**

Expenses must be eligible under Medicare in order to be eligible under the plan, except for those listed on page 112. When a physician, specialist, or facility chooses not to provide services through the Medicare program, Medicare does not pay any amount for the services and neither does the BSA Medicare Supplement Plan.

Benefits are determined from the [Explanation of Medicare Benefits (EOMB)](#), which shows the amount Medicare paid. All EOMBs must be sent to UnitedHealthcare. After Medicare has paid, the plan will pay 80 percent of covered expenses after you satisfy the calendar-year deductible. You are responsible for the remaining portion of covered expenses for the remainder of that calendar year. Covered expenses greater than $5,000 will be paid at 100 percent.

**MEDICARE PART A**

- As of January 1, 2015, the Medicare Part A deductible for inpatient hospital expenses is $1,260 for the first 60 days.*
- The daily amount not covered by Medicare from day 61 through day 90 of hospitalization is $315 per day.*
- The 60-day Medicare lifetime reserve:
  - As of January 1, 2015, if the 60-day lifetime reserve is elected, the BSA Medicare Supplement Plan pays the daily amount not covered by Medicare, up to $630 per day.*
  - After the elected 60-day lifetime reserve has been used up, the BSA Medicare Supplement Plan pays full covered expenses (semi-private).
- Room and board charges (semi-private room and ancillary charges not covered by Medicare) in hospitals not approved by Medicare, provided the hospital is a legally constituted hospital.

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*Subject to change.
The calendar-year deductible is the amount you pay in covered expenses each year (not including prescriptions) before the plan pays benefits.

- $150 individual deductible.
- $300 family deductible. (Can be met collectively by two or more family members.)

There is a $50 prescription deductible per person, per calendar year.

Prescriptions must be filled through the UnitedHealthcare pharmacy benefit program. Refer to Pharmacy Program on page 23.

Filing a Claim

If you are in the Medicare Supplement Plan (Indemnity), all claims must be submitted to Medicare first. This is your physician’s responsibility. You are responsible for meeting the annual deductible, paying the coinsurance amount, and paying any amount that exceeds reasonable and customary charges and/or plan limits.

After your claim has been considered by Medicare and you have received your EOMB, it is your responsibility to ensure that the claim is submitted to UnitedHealthcare for consideration. Be sure to include your Social Security number and the group number (136003).

If you do not wish to submit your EOMBs to UnitedHealthcare, you may participate in the Medicare crossover process. It allows Medicare to automatically forward Part B and durable medical equipment claims to UnitedHealthcare once Medicare has paid their portion. It is available to anyone enrolled in the BSA Medicare Supplement Plan as long as that plan is the only other coverage besides Medicare. This process does not apply to Medicare Part A or prescription drug expenses.

An enrollment form is included on page 114. This enrollment form must be completed and returned to the address at the upper left hand side of the form for the process to become effective. Do not send it to the Boy Scouts of America or the BSA Benefits Center. You can verify that the automated crossover is in place when you receive an EOMB showing your claim has been forwarded.
to your secondary insurance carrier. Until this message appears on your EOMB, it is important that you or your physician continue to file claims directly with UnitedHealthcare.

If you provide written authorization to allow direct payment to a physician, all or a portion of any eligible expenses due to a physician may be paid directly to the physician instead of being paid to you. UnitedHealthcare will not reimburse third parties who have purchased or been assigned benefits by physicians or other health-care professionals.

A claim transmittal form can be found at http://bsabenefits.mercerhrs.com, under Benefits Resources. Make copies of the form as needed, or request additional forms by contacting the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com.

As indicated on your medical ID card, send completed claim forms to:

UnitedHealthcare
P.O. Box 30555
Salt Lake City, UT 84130-0555

**TIME TO FILE**

For Medicare claims, you must submit a request for payment of benefits within one year after the date of service or the date Medicare issues your EOMB, whichever is later. This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.
I have the BSA Medicare Supplement Plan and want to participate in the Medicare crossover process.

**Retiree/Surviving Spouse:**

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<thead>
<tr>
<th>Name</th>
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<tr>
<td>Soc. Sec. # - - - Date of Birth / /</td>
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<tr>
<td>Address</td>
<td></td>
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<tr>
<td>City State* Zip</td>
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</table>

(Enter the Medicare Claim # as it appears on your red, white, & blue Medicare Health Insurance Card.)

**Spouse (only if enrolled in the Medicare Supplement Plan):**

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<th>Name</th>
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<td>Soc. Sec. # - - - Date of Birth / /</td>
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<td>Medicare Claim # - - - - - - - - - - -</td>
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</tbody>
</table>

(Enter the Medicare Claim # as it appears on your red, white, & blue Medicare Health Insurance Card.)

* If you live part-time in other states during the year where you might incur medical expenses, please indicate these additional states below (maximum of two additional states):

<table>
<thead>
<tr>
<th>Additional State 1:</th>
<th>Additional State 2:</th>
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**UnitedHealthcare**

A UnitedHealth Group Company

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medicare supplement plan
DENTAL ASSISTANCE

Plan
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INTENTIONALLY
LEFT BLANK.
The BSA Dental Assistance Plan is self-funded and administered by MetLife Insurance Company. A self-funded plan means just that: we fund the plan ourselves. The premiums you and your employer pay for those benefit plans are placed into a BSA account specifically for each plan. Claims and a small amount of administrative cost are then paid from that account.

Eligibility

FOR EMPLOYEES

If you were hired or rehired on or before May 31, 2004, and are in a regular position scheduled to work 21 hours or more per week year-round with the BSA or a local council, you and your eligible dependents are eligible to enroll.

If you were hired or rehired on or after June 1, 2004, and are in a regular position scheduled to work 30 hours or more per week year-round with the BSA or a local council, you and your eligible dependents are eligible to enroll.

If you were hired or rehired in any position scheduled to work less than 30 hours per week year-round, you are eligible to enroll under the following circumstances:

- You were hired or rehired on or before Nov. 1, 2014, and you actually worked 30 or more hours per week on average in the 12-month period from Nov. 1, 2014, through Oct. 31, 2015. In this event, you are eligible Jan. 1, 2016. Your eligibility continues for the next 12 calendar months and will end Dec. 31, 2016, unless you have continued to work an average of 30 or more hours per week.

- If you were hired or rehired after Nov. 1, 2014, and you actually worked 30 or more hours per week on average in the 12 calendar months following the month you were hired. In this event, you are eligible the first day of the calendar month following 13 full months of employment. Your eligibility continues for the next 12 calendar months and will end unless you have continued to work an average of 30 or more hours per week.

Enrollment must be completed within 30 days from the date of your initial eligibility. Coverage will then be effective from the date of your initial eligibility. If you and/or your eligible dependents do not enroll within 30 days from the date of eligibility, your next enrollment opportunity will occur during the next annual enrollment period or if a special enrollment period applies. Refer to the Special Enrollment Periods and Annual Enrollment Period sections on pages 7 and 6, respectively.

FOR DEPENDENTS

Eligible dependents include:

- Your spouse (If your spouse is a BSA or local council employee, he or she must be enrolled as an employee, not as a dependent.)
- For the purposes of the plan, “spouse” is the person to whom you are legally married and does not include a person who is a husband or a wife by reason of a common-law marriage.
- Your children (and stepchildren) from birth to the last day of the month in which they turn age 26, including:
  - Children you have legally adopted (including a child for whom legal adoption proceedings have been started)
  - Children of whom you have legal custody
  - Children for whom you are required to provide coverage as part of a divorce decree, if otherwise eligible

If you are required by a Qualified Medical Child Support Order (QMCSO), as defined in the Employee Retirement Income Security Act of 1974 (ERISA), as amended, to provide health benefits coverage for your children, you may enroll them. Proof of the support order may be requested at any time.

Note: A person cannot be covered as a dependent of more than one employee under this plan.

It is your responsibility to notify the BSA Benefits Center within 30 days of the date a dependent is no longer eligible. You may reach the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com. Benefits will be canceled effective the date the dependent was no longer eligible. Any changes in your premium will be effective at the next pay period or billing period. If notice is provided after 30 days of the date a dependent is no longer eligible, benefits will still be canceled effective the date the dependent was no longer eligible; however, no premiums will be refunded.
FOR CHILDREN 26 AND OLDER

At the end of the month in which dependent children turn age 26, they are no longer eligible for benefits under this plan, unless they are unmarried, unable to be self-supportive because of mental or physical handicap, and dependent mainly on you for support. A request to continue coverage for such a dependent child must be submitted to MetLife at least 30 days before the dependent's coverage would otherwise end due to age.

MetLife will review the medical evidence supporting such incapacity and dependency and determine whether the continuation is approved or not. If approved, MetLife may need to review the medical evidence and dependency each year in order for coverage to continue. They may also require proof of continuing eligibility at any time.

FOR RETIREEs

If your retirement date was on or before Dec. 1, 2004, and you met the definition of retiree in the Glossary, dental coverage will be continued upon your retirement from the BSA or a local council.

If your retirement date was on or after Jan. 1, 2005, you meet the definition of retiree in the glossary, and you have at least 10 years of service (defined by the years of employment that were eligible for BSA benefits), you may continue your dental coverage upon your retirement from the BSA or a local council.

You may enroll yourself and/or any eligible dependents if you qualify and request coverage per the provisions described in the “Changing Coverage” section.

Retirees cannot enroll during the annual enrollment period.

FOR SURVIVORS OF EMPLOYEES/RETIREEs

Coverage under this plan will continue for those who meet the definition of survivor (in the glossary) of an employee or retiree whose date of death was on or after Dec. 31, 2004.

Coverage under this plan will continue for those who meet the definition of survivor (in the glossary) of an employee or retiree whose date of death was on or after Jan. 1, 2005, and who had at least 10 years of service (defined by the years of employment that were eligible for BSA benefits).

Survivors may continue only the coverage in effect at the time of the employee's or retiree's death. The survivor will not be responsible for the remainder of the month in which the employee or retiree died, plus one full month of premiums.

The annual enrollment period does not apply to survivors.

FOR RETIREES AND SURVIVORS

You may cancel coverage at any time by contacting the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com. Coverage will be canceled effective the first of the next month, provided that your request is made on or before the fifth business day, unless you specifically request a later date (effective the first day of a month). A request made on or after the sixth business day will be effective the first of the month following the next month.

REQUIRED CONTRIBUTIONS

Premiums for elected benefits must be paid by the employee and employer in self-funded plans. The employer may not make contributions on the employee's behalf. The employee may make their contributions toward premiums through payroll deduction.

Premiums will be considered past due if not paid by the last day of the month for which they are owed. Failure to make timely payment of premiums within 60 days or more will cause the employee's benefits to end, and they will be offered COBRA for the eligible benefit plans that were canceled due to non-payment of premium.
Enrollment

HOW TO ENROLL

To enroll, call the BSA Benefits Center at 800-444-4416 or log onto http://bsabenefits.mercerhrs.com within 30 days of the date you become eligible. Coverage will then be effective on your eligibility date. If you and/or your eligible dependents do not enroll within the first 30 days of your eligibility, your dental plan election will default to the employee only level of coverage and your next enrollment opportunity will occur if a special enrollment period applies or during an annual enrollment period. Refer to the “Special Enrollment Periods” and “Annual Enrollment Period” sections.

ANNUAL ENROLLMENT PERIOD (FOR EMPLOYEES ONLY)

There will be an annual enrollment period each year. During this annual enrollment period, you may add or cancel coverage for yourself and/or any eligible dependents for any reason.

TWO YEAR ENROLLMENT LOCK

Once enrolled, the employee and/or dependent must remain enrolled for two full calendar years unless a qualifying life event occurs.

CHANGING COVERAGE (FOR EMPLOYEES AND RETIREES ONLY)

If you are enrolled in another dental insurance plan, you may be able to enroll in the BSA Dental Assistance Plan if you request enrollment within 30 days of when that other coverage ends. The specific requirements for this type of enrollment are described below.

You and/or your dependents do not need to elect COBRA continuation coverage to request special enrollment.

An enrollment period is available for you and/or your dependents if the following conditions are all met:

- You and/or your dependents were covered under another group dental plan.
- Your and/or your dependents’ other coverage has been under a COBRA continuation provision and that other coverage has been exhausted or your or your dependents’ other coverage has not been under a COBRA continuation provision and either that other coverage has terminated as a result of loss of eligibility (including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment); or employer contributions toward that other coverage have terminated. This is true even if you and/or your dependent continue to receive coverage under the prior plan and pay the amounts previously paid by the employer.
- Loss of eligibility for an individual also includes loss of group dental maintenance organization (DMO) coverage because the individual no longer lives or works in the DMO service area and has no other benefit option available; loss of coverage because the individual incurs a claim that would exceed a lifetime limit on all benefits; and loss of coverage because the plan no longer offers benefits to a class of individuals that includes you and/or your dependents.
  - You may request enrollment no later than 30 days after the date of the exhaustion of coverage described above or the termination of coverage or employer contributions described above, whichever is applicable.

If these conditions are met, enrollment will be effective on the first day the other coverage ends.

If other coverage was terminated for cause, or because required contributions were not paid on a timely basis, then you are not eligible to enroll in the BSA Dental Assistance Plan.

If you get married while you are enrolled in the BSA Dental Assistance Plan, you may enroll your new spouse and stepchildren during the 30 days following your marriage. Enrollment in these circumstances will be effective on the date of marriage.
If you acquire a new dependent by birth, legal adoption, or placement for adoption while you are enrolled in the BSA Dental Assistance Plan, you may enroll your new dependent during the 30 days following the birth, legal adoption, or placement for adoption. Enrollment in these circumstances will be effective on the date of birth, legal adoption, or placement for adoption. You must add your new dependent even if your coverage tier is employee, spouse, and two or more children. Coverage is not automatic for newborns.

You may cancel coverage for yourself or covered dependents if you have a life event as described in the Premium Only Plan under Section 125 of the Internal Revenue Code. (See the 125 Plan chapter.) These provisions will apply even if you are not enrolled in the Premium Only Plan.

You acknowledge that the information that you have provided is accurate and complete to the best of your knowledge. This information may be investigated and verified, and is subject to the eligibility provisions of the plans. You further acknowledge that if any of this information is found to be false or misleading, you may be required to reimburse the plans for monies spent as a result of any false or misleading statements, and if coverage is through current employment, any false or misleading statements may subject you to discipline, up to and including termination of your employment.

WHEN COVERAGE ENDS

Your dental coverage will terminate on the earliest date on which any of the following occurs:

- When your employment ends. If it is due to retirement from the BSA or a local council, see the applicable provision.
- When you retire from the BSA or a local council as defined in the glossary but you are not eligible to continue benefits into retirement as defined under the “Eligibility” section.
- When the employee or dependent ceases to be eligible for benefits, as defined under the “Eligibility” section.
- When your death occurs. Your dependents may continue benefits as survivors, as defined in the “Eligibility” section and/or as defined in the glossary.
- When you do not make the required contribution for the plan benefits. Coverage will end on the date through which you made your last contribution.
- When the plan ends in whole or in part.

COVERAGE AFTER BENEFITS END

No benefits are payable for dental expenses incurred by a covered person after the dental expense benefits for that person end except as listed below. This applies even if benefits for dental services have been predetermined. However, benefits for dental expenses incurred for you or your covered dependents for the following services will be paid after dental expense benefits end:

- For a prosthetic device, if the dentist prepared the abutment teeth and made impressions while dental expense benefits for you or your covered dependent were in effect and the device is installed within 31 days after the date the dental expense benefits end.
- For a crown, if the dentist prepared the tooth for the crown while the dental expense benefits for you or your covered dependent were in effect and the crown is installed within 31 days after the date the dental expense benefits end.
- For root canal therapy, if the dentist opened the tooth while the dental expense benefits for you or your covered dependent were in effect and the treatment is finished within 31 days after the date the dental expense benefits end.
**Dental Plan Overview**

**PREFERRED DENTIST PROGRAM (PDP)**

The Preferred Dentist Program (PDP) is a network of dental providers available to anyone enrolled in the BSA Dental Assistance Plan. When you use a PDP dentist or dental specialist, you can save money because services are provided at a reduced cost through a negotiated fee schedule, which results in lower out-of-pocket expenses to you. The PDP lets you select any participating or non-participating dentist at the time of treatment—you do not have to choose a dentist at the time of enrollment. You are free to continue using your current dentist even if he or she is not in the PDP network. Reimbursement utilizing out-of-network dentists is based upon reasonable and customary charges.

In-network dentists must meet MetLife’s strict credentialing standards and comply with any ongoing utilization and claim review processes, and standards for education, licensing, and practice history in order to participate in the network. These dentists agree to accept network-negotiated fee schedules in exchange for the potential of a larger, more stable patient base. In-network dentists are subject to review of the care and services they provide to help ensure continued quality care for you and your covered dependents.

To obtain a list of PDP dentists in your area, call MetLife at 800-942-0854 or log on to www.metlife.com/mybenefits.

**BENEFITS**

Benefits will be limited to a maximum of $1,500 in any calendar year for you or your covered dependent. This applies to type I, II, and III expenses.

**DEDUCTIBLES**

Type I expenses ........................................ None

Type II and Type III combined expenses ........ $50

*Preventive and periodontal treatment combined cannot exceed the maximum total of four treatments per year.

Type IV expenses (orthodontia) ................. None

Family .................................................. $150

The family deductible is met when you and your covered dependents have any combination of Type II and/or Type III covered expenses of $150. A maximum of $50 will be counted per dependent toward the family deductible.

**DENTAL EXPENSES COVERED**

**Type I expenses.** Payable at 100 percent of the negotiated PDP fee with no deductible:

- Oral exams (maximum two per calendar year).
- Preventive treatment*: cleaning and scaling of teeth (oral prophylaxis) not more than twice in a calendar year.
- Periodontal treatment*: deep cleaning, scaling of teeth, and root planing not more than four treatments in a calendar year, less two regular cleanings.
- X-rays, including full-mouth X-rays, not more than once every 60 months. Bitewing X-rays are covered not more than once in a calendar year.
- Topical fluoride treatment for a covered person under 14 years of age not more than once in a calendar year.
- Space maintainers for a covered person under 14 years of age.
- Sealants for a covered dependent child under 19 years of age, once every 60 months; permanent first and second molars only.

**Type II expenses.** Payable at 80 percent of the negotiated PDP fee after deductible:

- Fillings—amalgam, silicate, plastic, porcelain, or composite fillings to restore injured or decayed teeth.
- Extractions.
- Root canal therapy.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth including scaling, root planing, and periodontal surgery.
- Oral surgery, except as specified under Dental Expenses Not Covered.
- Administration of anesthetics in connection with oral surgery, extractions, or other covered dental services, as medically necessary.
- Denture repairs.
- Prescription drugs when needed in connection with a covered dental expense procedure.
- Repair of crowns, inlays, onlays, or bridgework.
- Surgical removal of impacted teeth.
- Dental root resection, apicoectomy.

**Type III expenses.** Payable at 50 percent of the negotiated PDP fee after deductible:  
- Those services needed to replace one or more natural teeth that are lost while dental expense benefits for the covered person are in effect. For example:  
  — Installation of fixed bridgework for the first time  
  — Installation of a partial or full removable denture for the first time  
  — Replacement of an existing removable denture or fixed bridgework if it is needed because of the loss of one or more natural teeth after the existing denture or bridgework is installed; or if it is needed because the existing denture or bridgework can no longer be used and was installed at least five years prior to its replacement  
  — Replacement of an existing temporary full denture with a new permanent full denture when the existing denture cannot be made permanent and the permanent denture is installed within 12 months after the existing denture was installed  
  — Addition of teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth after the existing denture or bridgework was installed  
  — Denture and bridgework relining and rebasting once every 36 months  
- Metal fillings.  
- Inlays, onlays, and crown restorations.  
- Re-cementing of crowns, inlays, onlays, or bridgework.  
- Nonsurgical treatment of temporomandibular joint (TMJ) disorders and bruxism.  
- One implant per tooth, including the prosthesis, every 5 years.  
- Occlusal guards.

**Type IV expenses.** Payable at 50 percent of the lifetime maximum, with no deductible. Orthodontia and any procedures necessary for treatment, as outlined below, are covered. Benefits will be limited to a lifetime maximum of $1,500 for you or your covered dependent. This coverage is not included in the dental maximum benefit for a calendar year.

Orthodontic treatment generally consists of initial placement of an appliance and a specified number of periodic follow-up visits as initially requested by the Dentist. Orthodontic treatment also includes other services required for the orthodontic treatment such as transseptal fiberotomy and extractions of certain teeth.

Upon the initial placement of the appliance, which may include other services such as the initial workup, we will pay an amount not to exceed 20% of the lifetime maximum benefit for orthodontic treatment which is $1,500.00.

After the initial placement of the orthodontic appliance, we will pay any remaining benefit during the course of the orthodontic treatment (including periodic follow-up visits) as follows:

- The amount payable during the scheduled course of the orthodontic treatment will be the lower of:
  — The amount of the covered dental expense times the covered percentage for orthodontia, and
  — The remaining amount of the aggregate maximum benefit for orthodontic treatment (for all dental expense periods)
- We will divide the benefit payable for the course of the orthodontic treatment by the number of months in the scheduled course of the orthodontic treatment (but no more than 24 months). We will use 3 times the resulting amount as the most we will pay for each 3-month period during the scheduled course of the orthodontic treatment. Benefits will only be payable during the scheduled course of the orthodontic treatment if:
  — Dental expense benefits are in effect for the person receiving the orthodontic treatment, and
  — Proof is given to us that the orthodontic treatment is continuing

For minor orthodontia services that are performed in one visit and do not require follow-up visits, we will pay the amount of the covered dental expense times the covered percentage for orthodontia.
The sum of all benefits for all covered dental expenses incurred for a covered person for orthodontic treatment will not be more than the applicable lifetime maximum benefit for orthodontic treatment of $1,500.00. This includes any services required for orthodontia received prior or related to the initial placement of an orthodontia appliance.

— The initial payment will be 20 percent of the lifetime maximum. All other payments will be paid quarterly.

DENTAL EXPENSES NOT COVERED

• Services or supplies received by you or your covered dependent before the dental expense benefits start for that person.

• Services that are not performed by a dentist, except those services of a licensed dental hygienist, supervised and billed for by a dentist, for cleaning and scaling of teeth or fluoride treatments.

• Cosmetic surgery, treatment, or supplies.

• Replacement of a lost, missing, or stolen crown, bridge, or denture.

• Repair or replacement of an orthodontic appliance.

• Services or supplies received by you or your covered dependent where no charge would have been made in the absence of dental expense benefits for that person.

• Services or supplies that you or your covered dependent is not required to pay.

• Services or supplies deemed experimental in terms of generally accepted dental standards.

• Services or supplies received as a result of dental disease, defect, or injury due to an act of war, or a warlike act in time of peace, that occurs while the dental expense benefits for you or your covered dependent are in effect.

• Adjustment of a denture or bridgework made within six months after it is installed.

• Any duplicate appliance or prosthetic device.

• Use of materials to prevent decay other than fluorides or sealants for dependent children.

• Instruction for oral care such as hygiene or diet.

• Periodontal splinting.

• Myofunctional therapy or correction of harmful habits.

• Charges for broken appointments.

• Charges by the dentist for completing dental forms.

ALTERNATIVE TREATMENT

MetLife may refer claims to consultants for review so that they can evaluate the necessity of the services and provide a professional recommendation. Upon reviewing the claim and the documentation submitted by your dentist, the MetLife professional dental consultant may recommend an alternative treatment. Any such recommendation will be based upon services that are less costly, will professionally satisfy your dental needs, and meet generally accepted professional standards. Benefits will be based on the covered expense for the proposed alternative benefit, and your out-of-pocket costs will be determined by which treatment you and your dentist ultimately decide upon. Your out-of-pocket costs will be based on whether you choose the alternative treatment plan or the more costly treatment plan, since you will be responsible for the difference if you choose the more costly treatment.

Who Pays What?

Each year you are required to give information about any other plans covering you or your dependents when you file a claim. Coordination of benefits is a cooperative claim payment between two or more insurance carriers that applies when an employee or dependent is covered under more than one plan. Reimbursement between the carriers can result in a 100 percent reimbursement of benefit. However, the member will not realize a profit above the 100 percent reimbursement.

The rules outlined below do not apply if an employee is holding two jobs and is covered under two group plans. In this event, the plan covering the person for the longest time is the primary carrier. Otherwise, the following rules are used to determine which plan is primary and which is secondary if you or your covered dependent is covered under two group plans. They are always used in the following order:

1. A plan that covers the employee is primary to a plan that covers the same person as a dependent.
2. The primary carrier is determined as follows:
   a. If the patient is a BSA or local council employee or retiree, the BSA Dental Assistance Plan is the primary carrier and pays its usual benefits first.
   b. If the patient is employed by the other employer, the other plan is the primary carrier and pays its usual benefits first.

3. If the patient is a dependent child, the plan covering the parent whose birthday comes earliest in the year (without regard to year of birth) is the primary carrier.

4. If the patient is a dependent child and both parents have the same birthday, the plan that has covered one of the parents for the longest time is the primary carrier.

5. If, in the case of divorce or separation, a court decree assigns one parent financial responsibility for the medical, dental, or other health expenses of the dependent child, and if the plan that covers the parent with financial responsibility knows the specific terms of the court decree, it is primary to any other plan that covers that dependent child.

6. If the dependent child is covered under two or more plans of divorced or separated parents, the following rules will be used to determine which plan is primary:
   a. The plan of the parent with custody is primary to the plan of the parent without custody.
   b. If the parent with custody has remarried, the order of payment is:
      i. The plan of the parent with custody pays benefits first.
      ii. The plan of the stepparent with custody pays benefits first.
      iii. The plan of the parent without custody pays benefits next.
      iv. The plan of the stepparent without custody pays benefits next.
      v. The plans of the stepparent without custody pays benefits next.
   1. If there is no court decree and the child's parents have joint custody, then the plan covering the parent whose birthday comes earliest in the year (without regard to year of birth) is the primary carrier.

7. A plan that covers a person as an employee who is not laid off or retired, or as a dependent of that employee, is primary to any plan that covers the person as laid-off or retired employee, or as a dependent of that employee. If the other plan does not have a rule for laid-off or retired employees similar to this rule, this rule will not apply.

8. If none of the above rules applies, the plan that has covered the person for the longest time is primary to all other plans.

Note: In the case of cancellation of the spouse's insurance, MetLife must be notified in writing by the spouse's employer or carrier of the cancellation date.

**Claims**

**FILING A CLAIM**

A dental claim should be filed when a course of treatment is complete. A dental claim form can be found at www.metlife.com/mybenefits or at http://bsabenefits.mercerhrs.com, under Benefits Resources. You may make copies of the form as needed. The instructions on the dental claim form should be followed carefully. This will expedite the processing of the claim.

Mail claims to:

   MetLife Dental Claims  
   P.O. Box 981282  
   El Paso, TX 79998-1282

When you or a covered dependent plans a visit to the dentist, be sure to fill out the employee portion of the claim form according to the instructions on the form. The employee/dependent portion includes authorization for the dentist to release necessary information to the insurance company so that it can process your claim. This authorization must be signed as described on the form.

**PREDETERMINATION OF BENEFITS**

If you expect to incur dental expenses over $300, such as for dentures, crowns, or root canal therapy, you should
ask your dentist to file for a predetermination of benefits. A predetermination of benefits enables you to know the services and treatment plan that is being recommended, as well as the costs associated with treatment before the work is done.

By obtaining a predetermination of benefits, you will know what your out-of-pocket costs will be and whether any alternative treatment is available for the recommended treatment. A predetermination of benefits is not required. You and your dentist will know exactly what charges are covered by the plan, and whether the treatment recommended may be just as effective utilizing an alternative treatment plan. Alternative treatment recommendations will provide effective dental care while reducing your out-of-pocket costs.

Here's how it works:

- The dentist informs MetLife of the proposed course of treatment, including the itemized list of the services and charges on the claim form you provide.
- MetLife will respond to you and your dentist with a written confirmation of what the plan will reimburse and any alternative treatment that is available for your dental care. You and your dentist should discuss the result before the work is done.

Predetermination of benefits will help you avoid surprises. Most dentists are familiar with predetermination procedures. If you do not request predetermination of benefits, MetLife will pay the claim based on information it has about your case. There are several ways to treat a particular dental problem. After reviewing your dentist’s predetermination claim, MetLife may determine a less-expensive alternative that would be just as effective as the treatment your dentist is recommending. If so, MetLife will base its payment on the less costly procedures as long as the result meets acceptable dental standards. Once you’ve been told of this decision, you can decide whether or not you want the higher cost treatment, because you will know your out-of-pocket costs. If your dentist submits a treatment plan for predetermination of benefits and then alters the course of treatment, payments will be adjusted accordingly. If the dentist makes a major change in the treatment plan, the dentist should send in a revised plan.

POST-SERVICE CLAIMS

Post-service claims are those claims that do not meet the definition of urgent care claim (see below).

Post-service claims may be both claims for services that have been received and claims for pre-statement of benefits. If your post-service claim is denied, you will receive a written notice from MetLife within 30 days of receipt of the claim, as long as all needed information was provided with the claim. MetLife will notify you within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and put your claim on “pending” status until all information is received.

If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

URGENT CARE CLAIMS

Urgent care claims are those claims where a delay in treatment could seriously jeopardize a patient’s life or health or the ability to regain maximum function or, in the opinion of a dentist with knowledge of the patient’s medical condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after MetLife receives all necessary information, taking into account the seriousness of the patient's condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.
- If you filed an urgent care claim improperly, MetLife will notify you of the improper filing and how to correct it within 24 hours after the urgent care claim was received. If additional information is needed to process the claim, MetLife will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.
You will be notified of a determination no later than 48 hours after:
- MetLife’s receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

IF A CLAIM IS DENIED OR BENEFITS ARE REDUCED

If your question or concern is about a benefit determination, you may informally contact MetLife before requesting a formal appeal. If the MetLife representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in the “Filing a Claim” section, you may appeal it as described below, without first informally contacting MetLife. If you first informally contact MetLife and later wish to request a formal appeal in writing, you should contact MetLife and request an appeal. If you request a formal appeal, a MetLife representative will provide you with the appropriate address of MetLife.

If you are appealing an urgent care claim denial, please refer to the “Urgent Care Claim Appeals” section below and contact MetLife immediately.

Appeals

APPEALING A CLAIM DETERMINATION

If you disagree with a claim determination after following the above steps, you can contact MetLife in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:
- The patient’s name and the identification number from the ID card
- The date(s) of service(s)
- Whether it is the first or second level of appeal
- The dentist’s name
- The reason you believe the claim should be paid
- Any documentation or other written information to support your request for claim payment

Your first appeal request must be submitted to MetLife within 180 days after you receive the claim denial. The request should be sent to:

MetLife
Group Claims Review
P.O. Box 14589
Lexington, KY 40512

THE APPEAL PROCESS

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a dental professional with appropriate expertise in the field who was not involved in the prior determination. MetLife may consult with, or seek the participation of, dental experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent dental claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

APPEAL DETERMINATIONS

You will be provided written or electronic notification of the decision on your appeal as follows:

For appeals of post-service claims, the first level appeal will be conducted and you will be notified by MetLife of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by MetLife of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent care claims, see the “Urgent Care Claim Appeals” section below.

If you are not satisfied with the first level appeal decision of MetLife, you have the right to request a second level appeal from MetLife as the plan administrator. Your second level appeal request must be submitted to MetLife within 60 days from receipt of first level appeal decision.
For post-service claim appeals, the Boy Scouts of America has delegated to MetLife the exclusive right to interpret and administer the provisions of the plan. MetLife’s decisions are conclusive and binding. There is not an appeal process for claims to the Boy Scouts of America.

Please note that MetLife’s decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending dental service is necessary or appropriate is between you and your dentist.

**URGENT CARE CLAIM APPEALS**

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your dentist should call MetLife as soon as possible. MetLife will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent care claim appeals, the Boy Scouts of America has delegated to MetLife the exclusive right to interpret and administer the provisions of the plan. MetLife’s decisions are conclusive and binding. There is not an appeal process for claims to the Boy Scouts of America.

**APPEALING ELIGIBILITY AND ENROLLMENT DETERMINATIONS**

In accordance with the Employee Retirement Income Security Act (ERISA), section 503, the BSA has established and maintains reasonable procedures governing filing for benefits, notification of benefit determinations, and appeal of adverse benefit determinations.

**Appeals by Plan Participants**

The BSA appeal procedures ensure:

- Participants shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and there will be a full and fair review of the appeal.

Under the appeal process:

- The participant shall have the opportunity to submit written comments, documents, records, and other information relating to the appeal request.
- The participant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant’s claim for benefits.
- The review will take into account all comments, documents, records, and other information submitted by the participant relating to the appeal.

As part of the appeal process, participants are entitled to:

- Submit written comments, documents, records, and other information relating to the appeal.
- Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the appeal.

These procedures allow a participant to appeal any determination not related to claim payment, including a denial for enrollment in the plan or a change in the benefit election for themselves or their eligible dependents.

Participants wishing to file an appeal must do so in writing, providing information on the eligibility or enrollment request that was denied, including any accompanying documentation that supports their request for appeal.

Appeal requests may be submitted by:

- U.S. Postal Service mail to:
  HR Compensation and Benefits
  SUM 288
  1325 W. Walnut Hill Lane
  Irving, TX 75038
- Fax to 972-580-2194
- Email to scouting2health@scouting.org

**Notice and Timing of Appeal Determination**

Participants will receive written notification at their home address of the determination made by the Benefits Com-
mittee within 60 days of receipt of the request for review by the Benefits Committee. Due to special circumstances, an extension of up to 60 days may occur. Written notice of the extension shall be furnished to the participant prior to the termination of the initial 60-day period.

In the case of an adverse determination on appeal, a written notice of denial will include:

- The specific reason or reasons for the adverse determination.

- Reference to the specific plan provisions on which the benefit determination is based.

- A description of the plan's internal appeal procedure and the time limits applicable, including a statement of your right to bring a civil action under ERISA after receiving an adverse benefit determination.

- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.

Limitation of Action

A participant cannot bring legal action against Boy Scouts of America until 90 days after they have properly submitted a request for appeal and all required reviews have been completed.

Your Rights

ERISA INFORMATION AND NOTICE OF RIGHTS

If you participate in the BSA Dental Assistance Plan, you are entitled to certain rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Please refer to the Legal Notices chapter for more information.

CONTINUATION OF COVERAGE (COBRA)

Boy Scouts of America is required to offer continuation of coverage in certain cases as a result of Public Law 99272, Title X, Consolidated Omnibus Budget Reconciliation Act (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Refer to the Legal Notices chapter for more information.

GOVERNMENT DENTAL PLANS

Coverage under this plan excludes any services or benefits available under any plan or program established pursuant to the laws or regulations of any government, or in which any government participates other than as an employer. Whether or not the covered person has enrolled for all government plan coverage for which he or she is eligible, service or benefits available includes all benefits to which the person would be entitled if he or she were enrolled for all such coverage. This provision is subject to any governmental requirement that insurance benefits be used before government plan benefits are available.

LEGAL INFORMATION

Right to Amend the Plan

All benefits under the BSA Dental Assistance Plan are funded by Boy Scouts of America. BSA has a contract with MetLife to process benefit claims and to provide certain other services under the plan. The BSA reserves the right to make revisions to, or terminate, the plan at any time. If you have any questions, please contact the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com. Please refer to the Legal Notices chapter for the Boy Scouts of America “Privacy of Your Information” policy and the “Notice of Privacy Policies” as required under the Health Insurance Portability and Accountability Act (HIPAA).
# 2016 Monthly Premiums

## Active Employee

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## National Council Employee on LTD

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## Local Council Employee on LTD

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## National or Local Council Retiree or Survivor

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<td>Self, spouse, &amp; 2+ children</td>
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Per child: $33.66
The BSA Vision Care Plan is insured and administered by Vision Service Plan (VSP).

For insured plans, we write a check to the insurance company for the premium each month. That ends the plan’s responsibility for costs. When the insurance company receives a claim, they pay it based on the policy we agreed to. They make money if we file fewer claims than the premiums we paid. But they also could lose money if we have more claims than we paid in premiums. We won’t be impacted by that until it is time to renew the contract with that insurance company.

VSP contracts with independent professionals of optometry and ophthalmology throughout the United States and has representation in all 50 states. VSP doctors must have the capability to dispense both glasses and contact lenses. VSP guarantees patient satisfaction. If you have any questions concerning the guarantee, contact VSP at 800-877-7195.

Eligibility

FOR EMPLOYEES

If you were hired or rehired on or before May 31, 2004, and are in a regular position scheduled to work 21 hours or more per week year-round with the BSA or a local council, you and your eligible dependents are eligible to enroll.

If you were hired or rehired on or after June 1, 2004, and are in a regular position scheduled to work 30 hours or more per week year-round with the BSA or a local council, you and your eligible dependents are eligible to enroll.

If you were hired or rehired in any position scheduled to work less than 30 hours per week year-round, you are eligible to enroll under the following circumstances:

- You were hired or rehired on or before Nov. 1, 2014, and you actually worked 30 or more hours per week on average in the 12-month period from Nov. 1, 2014, through Oct. 31, 2015. In this event, you are eligible Jan. 1, 2016. Your eligibility continues for the next 12 calendar months and will end Dec. 31, 2016, unless you have continued to work an average of 30 or more hours per week.
- You were hired or rehired after Nov. 1, 2014, and you actually worked 30 or more hours per week on average in the 12 calendar months following the month you were hired. In this event, you are eligible the first day of the calendar month following 13 full months of employment. Your eligibility continues for the next 12 calendar months and will end unless you have continued to work an average of 30 or more hours per week.

Eligible dependents include:

- Your spouse (If your spouse is a BSA or a local council employee, he or she must be enrolled as an employee, not as a dependent.)
- For the purposes of the plan, “spouse” is the person to whom you are legally married and does not include a person who is a husband or a wife by reason of a common-law marriage.
- Your children (and stepchildren) from birth to the last day of the month in which they turn age 26, including:
  — Your children related by blood or marriage
  — Children you have legally adopted (including a child for whom legal adoption proceedings have been started)
  — Children of whom you have legal custody
  — Children for whom you are required to provide coverage as part of a divorce decree, if otherwise eligible

Enrollment must be completed within 30 days from the date of your initial eligibility. Coverage will then be effective from the date of your initial eligibility. If you and/or your eligible dependents do not enroll within 30 days from the date of eligibility, your next enrollment opportunity will occur during the next annual enrollment period or if a special enrollment period applies. Refer to the Special Enrollment Periods and Annual Enrollment Period sections on pages 7 and 6, respectively.

FOR DEPENDENTS
If you are required by a Qualified Medical Child Support Order (QMCSO), as defined in the Employee Retirement Income Security Act of 1974 (ERISA), as amended, to provide health benefits coverage for your children, you may enroll them. Proof of the support order may be requested at any time.

**Note:** A person cannot be covered as a dependent of more than one employee under this plan.

*It is your responsibility to notify the BSA Benefits Center within 30 days of the date a dependent is no longer eligible. You may reach the BSA Benefits Center at 800-444-4416 or at [http://bsabenefits.mercerhrs.com](http://bsabenefits.mercerhrs.com). Benefits will be canceled effective the date the dependent was no longer eligible. Any changes in your premium will be effective at the next pay period or billing period. If notice is provided after 30 days of the date a dependent is no longer eligible, benefits will still be canceled effective the date the dependent was no longer eligible; however, no premiums will be refunded.*

### FOR CHILDREN 26 OR OLDER

At the end of the month in which they turn age 26, dependent children are no longer eligible for benefits under this plan, unless they are unmarried, unable to be self-supportive because of mental or physical handicap, and dependent mainly on you for support. If the child is covered as a dependent under the BSA Dental Assistance Plan, the BSA Group Life Insurance Plan, or the BSA Medical Plan, a request to continue coverage for such a dependent child must be submitted to MetLife or UnitedHealthcare (UHC) at least 30 days before the dependent’s coverage would otherwise end due to age.

MetLife or UHC will review the medical evidence supporting such incapacity and dependency and determine whether the continuation is approved or not. If approved, they may need to review the medical evidence and dependency each year in order for coverage to continue. They may also require proof of continuing eligibility at any time.

If the child is not covered as a dependent under the BSA Dental Assistance Plan, the BSA Group Life Insurance Plan, or the BSA Medical Plan, then the VSP provider must confirm that the dependent is disabled and once confirmed, will receive authorization from VSP.

### FOR RETIREES

If your retirement date was **on or before Dec. 1, 2004**, and you meet the definition of retiree in the glossary, vision care coverage was continued (if you elected to continue it) upon your retirement from the BSA or a local council.

If your retirement date was **on or after Jan. 1, 2005**, you meet the definition of retiree in the glossary, and you have at least 10 years of service (defined by the years of employment that were eligible for BSA benefits), you may continue your vision care coverage upon your retirement from the BSA or a local council.

### FOR SURVIVORS OF EMPLOYEES/RETIREES

Coverage under this plan will continue for those who meet the definition of survivor (in the glossary) of an employee or retiree whose date of death was on or before Dec. 31, 2004.

Coverage under this plan will continue for those who meet the definition of survivor (in the glossary) of an employee or retiree whose date of death was on or after Jan. 1, 2005, and who had at least 10 years of service (defined by the years of employment that were eligible for BSA benefits).

Survivors may continue only the coverage in effect at the time of the employee’s or retiree’s death. The survivor will not be responsible for the remainder of the month in which the employee or retiree passed away, plus one full month of premiums.

*The annual enrollment period does not apply to survivors.*

### FOR RETIREES AND SURVIVORS

You may cancel coverage at any time by contacting the BSA Benefits Center at 800-444-4416 or at [http://bsabenefits.mercerhrs.com](http://bsabenefits.mercerhrs.com). Coverage will be canceled effective the first of the next month, provided that your request is made on or before the fifth business day, unless you specifically request a later date (effective the first day of a month). A request made on or after the sixth business day will be effective the first of the month.
following the next month. **If you cancel your participation in the Vision Care Plan, you will not be able to re-enroll in the Vision Care Plan at a later date.**

If you were eligible for benefits as a retiree or survivor, you could have enrolled in the Vision Care Plan during the 2005 enrollment period, with coverage effective on Jan. 1, 2006. **If you did not enroll during the 2005 enrollment period as a retiree or survivor, you will not be allowed to re-enroll in the future.**

**Enrollment**

**HOW TO ENROLL**

To enroll, call the BSA Benefits Center at 800-444-4416 or log onto [http://bsabenefits.mercerhrs.com](http://bsabenefits.mercerhrs.com) within 30 days of the date you become eligible. Coverage will then be effective on your eligibility date. If you and/or your eligible dependents do not enroll within the first 30 days of your eligibility, your vision plan election will default to no coverage and the next opportunity to change this election will occur if a special enrollment period applies or during the annual enrollment period. Refer to the **Special Enrollment Periods** and **Annual Enrollment Period** sections.

**ANNUAL ENROLLMENT PERIOD (FOR EMPLOYEES ONLY)**

There will be an annual enrollment period each year. During this annual enrollment period, you may add or cancel coverage for yourself and/or any eligible dependents for any reason. Any changes made during the annual enrollment period will be effective on the following Jan. 1.

**CHANGING COVERAGE (FOR EMPLOYEES AND RETIREEs ONLY)**

If you are enrolled in another vision insurance plan, you may be able to enroll in the BSA Vision Care Plan if you request enrollment within 30 days of when that other coverage ends. The specific requirements for this type of enrollment are described below.

You and/or your dependents do not need to elect COBRA continuation coverage to request special enrollment.

An enrollment period is available for you and/or your dependents if the following conditions are **all** met:

- You and/or your dependents were covered under another group vision plan.
- Your and/or your dependents’ other coverage has been under a COBRA continuation provision and that other coverage has been exhausted, or your or your dependents’ other coverage has not been under a COBRA continuation provision and either that other coverage has terminated as a result of loss of eligibility (including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment); or employer contributions toward that other coverage have terminated. This is true even if you and/or your dependent continue to receive coverage under the prior plan and pay the amounts previously paid by the employer. Loss of eligibility for an individual also includes loss of group vision coverage because the individual no longer lives or works in the vision service area and has no other benefit option available; loss of coverage because the individual incurs a claim that would exceed a lifetime limit on all benefits; and loss of coverage because the plan no longer offers benefits to a class of individuals that includes you and/or your dependents.
- You may request enrollment no later than 30 days after the date of the exhaustion of coverage described above or the termination of coverage or employer contributions described above, whichever is applicable.

If these conditions are met, enrollment will be effective on the first day the other coverage ends.
If other coverage was terminated for cause, or because required contributions were not paid on a timely basis, then you are not eligible to enroll in the BSA Vision Care Plan.

If you get married while you are enrolled in the BSA Vision Care Plan, you may enroll your new spouse and stepchildren during the 30 days following your marriage. Enrollment in these circumstances will be effective on the date of marriage.

If you acquire a new dependent by birth, legal adoption, or placement for adoption while you are enrolled in the BSA Vision Care Plan, you may enroll your new dependent during the 30 days following the birth, legal adoption, or placement for adoption. Enrollment in these circumstances will be effective on the date of birth, legal adoption, or placement for adoption. You must add your new dependent even if your coverage tier is employee, spouse, and two or more children. Coverage is not automatic for newborns.

You may cancel coverage for yourself or covered dependents if you have a life event as described in the Premium Only Plan under Section 125 of the Internal Revenue Code. (See the 125 Plan chapter.) These provisions will apply even if you are not enrolled in the Premium Only Plan.

You acknowledge that the information that you have provided is accurate and complete to the best of your knowledge. This information may be investigated and verified, and is subject to the eligibility provisions of the plans. You further acknowledge that if any of this information is found to be false or misleading, you may be required to reimburse the plans for monies spent as a result of any false or misleading statements, and if coverage is through current employment, any false or misleading statements may subject you to discipline, up to and including termination of your employment.

**WHEN COVERAGE ENDS**

Your vision coverage will terminate on the earliest date on which any of the following occurs:

- When your employment ends. If it is due to retirement from the BSA or a local council, see the applicable provision.
- When you retire from the BSA or a local council as defined in the glossary but you are not eligible to continue benefits into retirement as defined under the “Eligibility” section.
- When the employee or dependent ceases to be eligible for benefits, as defined under the “Eligibility” section.
- When your death occurs. Your dependents may continue benefits as survivors, as defined in the “Eligibility” section and/or as defined in the Glossary.
- When you do not make the required contribution for the plan benefits. Coverage will end on the date through which you made your last contribution.
- When the plan ends in whole or in part.

**Vision Plan Overview**

**IN-NETWORK PROCEDURES**

- Obtain a list of VSP doctors for your area by calling VSP at 800-877-7195 or through their website at www.vsp.com.
- Select a VSP doctor from the list, make an appointment, and tell him or her that you are covered under the BSA plan with VSP.
- The VSP doctor is responsible for contacting VSP to verify your eligibility, plan coverage, and authorization for services and materials. Make sure the VSP doctor verifies the patient's eligibility under the employee’s or retiree’s Social Security number.

**IN-NETWORK EXPENSES COVERED**

You and your covered dependents are each allowed:

- One comprehensive eye exam every calendar year. You and your covered dependent(s) will pay a $10 copay at the time of service.
- One pair of lenses (glass or plastic) each calendar year and one frame every other calendar year, with the following copay:
  - Single-vision lenses or single-vision lenses and frames $35 copay
— Bifocal lenses or bifocal lenses and frames (includes no-line) $70 copay
— Progressive lenses or progressive lenses and frames $70 copay
— Trifocal lenses or trifocal lenses and frames (includes no-line) $90 copay
— Lenticular lenses or lenticular lenses and frames (includes no-line) $90 copay
— Frame without lenses $35 copay

The following patient options are included (in-network only):

- Scratch-resistant coating
- Ultraviolet protection
- Solid tint/dye
- Blended and progressive lenses
- Plastic gradient dye
- Anti-reflective coating
- Color coating of lenses
- Mirror/sky type lenses
- Rimless lenses
- Polycarbonate lenses (only for dependent children age 19 and younger)

The coverage provides a $130 allowance on a frame as well as 20 percent off any amount over the frame allowance. The allowance provides coverage for a wide selection of frames. The VSP doctor should help you choose the best frame based on your needs.

- Additional lenses and frames. A 20 percent discount is available for additional pairs of glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision exam.

**Elective Contact Lenses.** Elective contact lenses may be chosen instead of glasses. You or your covered dependent cannot have both glasses and elective contact lenses covered in the same calendar year. An allowance of up to $120 will be provided toward the contact lens exam and your contact lenses. The plan includes a 15 percent discount off the cost of your contact lens exam (fitting and evaluation) when obtained from a VSP doctor. This exam is performed in addition to your routine eye exam. You or your covered dependent is responsible for any costs exceeding the allowance.

**Medically Necessary Contact Lenses.** A copay of $35 is required if contact lenses are prescribed and approved as medically necessary by VSP.

**In-Network Low-Vision Care Benefit**

The low-vision benefit is available to you or your covered dependent who has severe visual problems that are not correctable with regular lenses, as determined by the VSP doctor and approved by VSP.

Supplemental testing and subsequent low-vision therapy are covered. Coverage includes a complete low-vision analysis and diagnosis, including a comprehensive exam of visual functions, and a prescription of corrective eye-wear or vision aids where indicated. If supplemental testing is provided, it is covered up to $125 every two years. If low-vision aids are approved, VSP will pay 75 percent of the approved amount up to a total maximum benefit of $1,000 (including supplemental testing). The patient is responsible for the remaining 25 percent of the approved amount plus any amount over the maximum.

**Out-Of-Network Procedures**

- Make an appointment with the doctor of your choice.
- You must pay the out-of-network doctor in full and submit to VSP a claim and provide an itemized receipt along with the employee’s name, address, phone number, last four digits of the Social Security number, employer name (BSA), patient's name, patient's date of birth, phone number, address, and relationship to the employee. Mail this information to VSP, Out-of-Network Provider Claims, P.O. Box 997105, Sacramento, CA 95899-7105.
- VSP will reimburse you up to the amount allowed under the plan’s out-of-network doctor’s allowance schedule.
- All claims must be filed within six months of the date services were completed. Reimbursements are made directly to the patient.
OUT-OF-NETWORK EXPENSES COVERED

There is an allowance per participant as follows:

- One comprehensive eye exam per participant each calendar year will be reimbursed up to $45.
- One pair of lenses (glass or plastic) each calendar year with the following reimbursement:
  - Single-vision lenses reimbursed up to $30 per pair
  - Progressive lenses reimbursed up to $50 per pair
  - Progressive trifocals reimbursed up to $65 per pair
  - Lenticular lenses reimbursed up to $100 per pair
- One frame every other calendar year—reimbursed up to $70

Elective Contact Lenses. Elective contact lenses may be chosen instead of glasses. You or your covered dependent cannot have both glasses and elective contact lenses covered in the same calendar year. An allowance of up to $105 will be provided toward the contact lens evaluation, exam, fitting costs, contact lenses, and any follow-up evaluations. Contact lens materials are available at the doctor's acquisition cost. Any costs exceeding the allowance are the responsibility of the patient.

Medically Necessary Contact Lenses. If approved as medically necessary by VSP, an allowance of up to $210 is available for the contact lens evaluation, fitting costs, contact lenses, and any follow-up evaluations.

The above contact lens allowances are for two contact lenses (one pair). If only one contact lens is needed, the allowance will be one-half of the pair allowance.

OUT-OF-NETWORK LOW-VISION CARE BENEFIT

The low-vision benefit is available to you or your covered dependent who has severe visual problems that are not correctable with regular lenses, as determined by the VSP doctor and approved by VSP.

Low-vision benefits secured from a doctor who is NOT a member of the VSP panel are subject to the same time limits and copay arrangements as described above for a VSP doctor. You or your covered dependent should pay the out-of-network doctor his or her full fee. You or your covered dependent will be reimbursed in accordance with an amount not to exceed what the VSP doctor would be paid in similar circumstances.

EXPENSES NOT COVERED

The following will not be covered regardless of whether the doctor is in-network or out-of-network. If you request any of these features, you will be responsible for the extra charge.

- Contact lenses (except as noted previously)
- Oversize lenses
- High-index lenses
- Low-index lenses
- Photochromic lenses
- Polycarbonate lenses (anyone 19 or older)
- A frame that costs more than the plan's allowance
- Low-vision care beyond certain limitations
- Cosmetic lenses
- Optional cosmetic processes

There is no benefit for professional services or materials connected with the following:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (non-prescription)
- Two pair of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this program that are lost or broken except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Corrective vision treatment of an experimental nature
**LASER VISION CORRECTION**

Laser vision correction is performed by a participating surgeon at a VSP Laser Vision Care Center. The vision plan participant pays the center either the discounted rate or the not-to-exceed amount, whichever is less.

The not-to-exceed amounts are:

- $1,500 per eye for conventional PRK
- $1,800 per eye for conventional LASIK
- $2,300 per eye for custom LASIK, custom PRK, or Intralase Bladeless LASIK

Your VSP doctor will work with you to make arrangements at a VSP approved laser center.

To obtain a list of VSP doctors and to learn more about laser vision correction, access their website at [www.vsp.com](http://www.vsp.com). You can also contact VSP at 888-354-4434 for a list of doctors.

**Claims**

If you have a question or problem, your first step is to call VSP's Customer Service Department. If a matter is not resolved to your satisfaction initially, you may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained from the Customer Service Department. You also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within 30 days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than 120 days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within 30 days, a letter will be sent to you to indicate VSP's expected resolution date. Upon final resolution, you will be notified of the outcome in writing.

**INITIAL DETERMINATION**

VSP will pay or deny claims within 30 calendar days of the receipt of the claim from you or your authorized representative. In the event that a claim cannot be resolved within that time, VSP may, if necessary, extend the time for decision by no more than 15 calendar days.

**REQUEST FOR APPEALS**

If your claim for benefits is denied by VSP in whole or in part, VSP will notify you in writing of the reason or reasons for the denial. Within 180 days after receipt of such notice of denial of a claim, you may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify for whom a claim for benefits was denied, including the name of the VSP enrollee, member ID of the VSP enrollee, name and date of birth, the name of the provider of services, and the claim number. You may state the reasons you believe that the claim denial was in error. You may also provide any pertinent documents for review. VSP will review the claim and give you the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. You or your authorized representative should submit all requests for appeals to:

VSP  
Member Appeals  
3333 Quality Drive  
Rancho Cordova, CA 95670  
800-877-7195

VSP’s determination, including specific reasons for the decision, shall be provided and communicated to you within 30 calendar days after receipt of a request for appeal from you or your authorized representative.

If you disagree with VSP’s determination, you may request a second-level appeal within 60 calendar days from the date of the determination. VSP shall resolve any second-level appeal within 30 calendar days.

When you have completed all appeals mandated by the Employee Retirement Income Security Act of 1974 (ERISA), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. You should contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally, under ERISA Section 502(a)(1)(B), you have the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and you disagree with the outcome.
Appealing Eligibility and Enrollment Determination

In accordance with the Employee Retirement Income Securities Act (ERISA), section 503, the BSA has established and maintains reasonable procedures governing filing for benefits, notification of benefit determinations, and appeal of adverse benefit determinations.

Appeals by Plan Participants

The BSA appeal procedures ensure:

- Participants shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and
- there will be a full and fair review of the appeal.

Under the appeal process:

- The participant shall have the opportunity to submit written comments, documents, records, and other information relating to the appeal request.
- The participant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant’s claim for benefits.
- The review will take into account all comments, documents, records, and other information submitted by the participant relating to the appeal.

As part of the appeal process, participants are entitled to:

- Submit written comments, documents, records, and other information relating to the appeal.
- Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the appeal.

These procedures allow a participant to appeal any determination not related to claim payment, including a denial for enrollment in the plan or a change in the benefit election for themselves or their eligible dependents.

Participants wishing to file an appeal must do so in writing, providing information on the eligibility or enrollment request that was denied, including any accompanying documentation that supports their request for appeal.

Appeal requests may be submitted by:

- U.S. Postal Service mail to:
  HR Compensation and Benefits
  SUM 288
  1325 W. Walnut Hill Lane
  Irving, TX 75038
- Fax to 972-580-2194
- Email to scouting2health@scouting.org

Notice and Timing of Appeal Determination

Participants will receive written notification at their home address of the determination made by the Benefits Committee within 60 days of receipt of the request for review by the Benefits Committee. Due to special circumstances, an extension of up to 60 days may occur. Written notice of the extension shall be furnished to the participant prior to the termination of the initial 60-day period.

In the case of an adverse determination on appeal, a written notice of denial will include:

- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provisions on which the benefit determination is based.
- A description of the plan’s internal appeal procedure and the time limits applicable, including a statement of your right to bring a civil action under ERISA after receiving an adverse benefit determination.
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.
Limitation of Action

A participant cannot bring legal action against Boy Scouts of America until 90 days after they have properly submitted a request for appeal and all required reviews have been completed.

Your Rights

ERISA INFORMATION AND NOTICE OF RIGHTS

If you participate in the BSA Vision Care Plan, you are entitled to certain rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Please refer to the Legal Notices chapter for more information.

CONTINUATION OF COVERAGE (COBRA)

Boy Scouts of America is required to offer continuation of coverage in certain cases as a result of Public Law 99272, Title X, Consolidated Omnibus Budget Reconciliation Act (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Refer to the Legal Notices chapter for more information.

LEGAL INFORMATION

Right to Amend the Plan

The BSA has a contract with Vision Service Plan to insure and provide services under the plan. Benefits under this plan will be paid only if the plan administrator decides in its discretion that the applicant is entitled to them. The BSA reserves the right to revise or terminate the plan at any time. Please refer to the Legal Notices chapter for the Boy Scouts of America “Privacy of Your Information” policy and the “Notice of Privacy Policies” as required under the Health Insurance Portability and Accountability Act (HIPAA).

IMPORTANT NOTICE

To obtain information or make a complaint, call Vision Service Plan at 800-877-7195.

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at 800-252-3439.

You may write the Texas Department of Insurance at:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
(Fax 512-475-1771)

PREMIUM OR CLAIM DISPUTES

If you have a dispute about your premium or a claim, you should contact the Revenue Section at Vision Service Plan Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

AVISO IMPORTANTE

Para obtener información o para someter una queja usted puede llamar gratis al número de teléfono de Vision Service Plan Insurance Company al 800-877-7195.

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al 800-252-3439.

Puede escribir al Departamento de Seguros de Texas:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
(Fax 512-475-1771)

DISPUTAS SOBRE PRIMAS O RECLAMOS

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el Revenue Section of Vision Service Plan Insurance Company primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento de Seguros de Texas.
# 2016 Monthly Premiums

## ALL GROUPS

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## COBRA

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LONG-TERM DISABILITY
The BSA Long-Term Disability (LTD) Plan provides a portion of your income while you are disabled. The plan is insured and administered by Metropolitan Life Insurance Company (MetLife).

For insured plans, we write a check to the insurance company for the premium each month. That ends the plan’s responsibility for costs. When the insurance company receives a claim, they pay it based on the policy we agreed to. They make money if we file fewer claims than the premiums we paid. But they also could lose money if we have more claims than we paid in premiums. We won’t be impacted by that until it is time to renew the contract with that insurance company.

Eligibility

FOR EMPLOYEES

You may enroll in the LTD Plan if your annual benefit base rate is less than the maximum recognizable compensation limit allowed under the plan (for 2015, the limit is $265,000) and any of the following applies:

If you were hired or rehired on or before May 31, 2004, and are in a regular position scheduled to work 21 hours or more per week year-round with the BSA or a local council, you and your eligible dependents are eligible to enroll.

If you were hired or rehired on or after June 1, 2004, and are in a regular position scheduled to work 30 hours or more per week year-round with the BSA or a local council, you and your eligible dependents are eligible to enroll.

If you were hired or rehired in any position scheduled to work less than 30 hours per week year-round, you are eligible to enroll under the following circumstances:

- You were hired or rehired on or before Nov. 1, 2014, and you actually worked 30 or more hours per week on average in the 12-month period from Nov. 1, 2014, through Oct. 31, 2015. In this event, you are eligible Jan. 1, 2016. Your eligibility continues for the next 12 calendar months and will end Dec. 31, 2016, unless you have continued to work an average of 30 or more hours per week.

- You were hired or rehired after Nov. 1, 2014, and you actually worked 30 or more hours per week on average in the 12 calendar months following the month you were hired. In this event, you are eligible the first day of the calendar month following 13 full months of employment. Your eligibility continues for the next 12 calendar months and will end unless you have continued to work an average of 30 or more hours per week.

Enrollment must be completed within 30 days of the date of initial eligibility. Coverage will then be effective on the date of your eligible employment (eligibility). You may enroll at http://bsabenefits.mercerhrs.com or by calling the BSA Benefits Center at 800-444-4416 during your initial eligibility period. If you do not enroll or waive coverage within the first 30 days of the date of eligibility, you will be automatically covered. Your next opportunity to waive coverage will be during annual enrollment. If you waive coverage, enrollment at a later date will require MetLife’s approval of your completed Statement of Health. (See “Enrollment” below.)

If you are absent from work due to injury, sickness, temporary layoff, or leave of absence, your coverage will begin on the date you return to active employment.

If you are on a temporary layoff, and if the premium is paid, you will be covered through the end of the month that immediately follows the month in which your temporary layoff begins.

If you are on a leave of absence, you will be covered for up to 120 days following the date your leave of absence begins.

HOW TO ENROLL

To enroll, call the BSA Benefits Center at 800-444-4416 or log onto http://bsabenefits.mercerhrs.com within 30 days of the date you become eligible. Coverage will then be effective on your eligibility date. If you do not enroll or waive coverage within the first 30 days of your eligibility, your long-term disability plan election will default to
covered and the next opportunity to change this election will occur if a special enrollment period applies or during the annual enrollment period. Refer to the Special Enrollment Periods and Annual Enrollment Period sections.

**ANNUAL ENROLLMENT PERIOD**

There will be an annual enrollment period each year. During this annual enrollment period, you may add or cancel coverage for yourself for any reason. Any changes made during the annual enrollment period will be effective on the following Jan. 1.

Anyone who is past the initial eligibility (30 days) and enrolls during an annual enrollment period will be required to complete and submit MetLife's Statement of Health; coverage may be denied. If it is approved, coverage will be effective on the next Jan. 1 or the first day you return to active work, if later.

MetLife considers any statements you or your employer makes in a signed application for coverage as representation and not a warranty. If any of the material statements you or your employer make are not complete and/or true at the time they are made, MetLife can do either of the following:

- Reduce or deny any claim
- Cancel your coverage from the original effective date

MetLife will use only statements made in a signed application as a basis for doing this. A copy of the statements will be provided to you or your beneficiary. These statements cannot be used to reduce or deny coverage if your coverage has been in force for at least two years.

However, if your employer gives MetLife information about you that is incorrect, MetLife will use the facts to determine if you have coverage under the plan according to the policy provisions and in what amounts, and make a fair adjustment of the premium.

**WHEN COVERAGE ENDS**

Your coverage under the plan ends on the earliest of:

- The date the plan is canceled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which required contributions are not paid (In this case, coverage will end on the date through which you made your last contribution.)
- The last day you are in active employment except as provided under the covered layoff or leave of absence provision

MetLife will provide coverage for a payable claim that occurs while you are covered under the plan.

**REINSTATEMENT OF COVERAGE**

If your coverage ends, you may become covered again as a new member. However, the following will apply:

- If your coverage ends because you cease to be a member, and if you become a member again, the eligibility waiting period will be waived.
- If your coverage ends because you fail to make a required member contribution, you must provide a satisfactory medical history to become covered again.
- If your coverage ends because you are on federal- or state-mandated family or medical leave of absence, and you become a member again immediately following the period allowed, your coverage will be reinstated pursuant to federal- or state-mandated family or medical leave act or law.
- The pre-existing conditions exclusion will be applied as if there had been no break in coverage in the following instances:
  - If you become covered again within 90 days
  - If required by federal- or state-mandated family or medical leave act or law, and you become covered again immediately following the period allowed under the family or medical leave act or law.
**LTD Plan Overview**

**DISABILITY BENEFIT**

For any disability beginning on or after Jan. 1, 2003, the monthly benefit payable is 60 percent of your pre-disability earnings up to the maximum of $22,500 per month.

The maximum benefit per month is based on the maximum recognizable compensation limit allowed under the plan that was applicable the year in which you became disabled.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under the plan.

The minimum monthly benefit is the greater of:

- $100
- 10 percent of your pre-disability earnings

MetLife may apply this amount toward an outstanding overpayment.

Once your coverage begins, any increases in your pre-disability earnings will take effect immediately if you are in active employment, or if you are on a covered layoff or leave of absence. If you are not in active employment due to injury or sickness, any increases will begin on the date you return to active employment. Any decrease in pre-disability earnings will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

For any disability beginning prior to Jan. 1, 2003, the plan and provisions in effect at the time the disability began will apply to that disability.

**Maximum Period of Payment**

The maximum benefit is the later of your normal retirement age or the period shown in the table below:

<table>
<thead>
<tr>
<th>Age At Disability</th>
<th>Maximum Period of Benefit</th>
</tr>
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<tbody>
<tr>
<td>Less than age 60</td>
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<td>18 months</td>
</tr>
<tr>
<td>68</td>
<td>15 months</td>
</tr>
<tr>
<td>69 and over</td>
<td>12 months</td>
</tr>
</tbody>
</table>

The maximum benefit period is subject to the Limited Disability Benefits and Date Benefit Payment Ends sections.

**Elimination Period**

The elimination period is 120 days. You must be continuously disabled throughout your elimination period.

If you return to active work before completing your elimination period and your return is for a period of 30 days or less, and you then become disabled again due to the same or a related sickness or accidental injury, you will not be required to complete a new elimination period. MetLife will count those days worked toward the completion of your elimination period.

If you return to active work for a period of more than 30 days and then become disabled again, you will have to complete a new elimination period.

For purposes of this provision, the term active work only includes those days you actually work.
If you return to active work after completing your elimination period and your return is for a period of 180 days or less, and you then become disabled again due to the same or a related sickness or accidental injury, you will not be required to complete a new elimination period.

For the purpose of determining your benefits, MetLife will consider such disability to be a part of the original disability and will use the same pre-disability earnings, applying the same terms, provisions, and conditions that were used for the original disability.

If you return to active work for a period of more than 180 days and then become disabled again, you will have to complete a new elimination period.

For purposes of this provision, the term active work includes all of the continuous days that follow your return to work on which you are not disabled.

### DEFINITION OF DISABILITY

You are considered to be disabled when MetLife determines that due to a sickness or as a direct result of an accidental injury you are:

- Receiving appropriate care and treatment and complying with the requirements of such treatment; and
- During the first 24 months, unable to perform each of the material duties of your own occupation; and
- After such period, unable to perform the duties of any gainful occupation for which you are reasonably qualified, taking into account your training, education, and experience.

For purposes of determining whether a disability is the direct result of an accidental injury, the disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes.

If you are disabled and have received a monthly benefit for 12 months, MetLife will adjust your pre-disability earnings only for the purposes of determining whether you continue to be disabled and for calculating the return to work incentive, if any. MetLife will make the initial adjustment as follows:

MetLife will add to your pre-disability earnings an amount equal to the product of your pre-disability earnings times the lesser of

- the annual rate of increase in the Consumer Price Index for the prior calendar year. (If the CPI-W is discontinued or replaced, MetLife reserves the right to substitute any other comparable index.)

Annually thereafter, MetLife will add an amount to your adjusted pre-disability earnings calculated by the method set forth above but substituting your adjusted pre-disability earnings from the prior year for your pre-disability earnings. This adjustment is not a cost-of-living increase.

If your occupation requires a license, the fact that you lose your license for any reason will not, in itself, constitute disability.

### PRE-EXISTING CONDITION

You have a pre-existing condition if both of the following apply:

- You received medical treatment, consultation, care, or services, including diagnostic measures, or took prescribed drugs or medicines for the condition in the three months just prior to your effective date of coverage.
- The disability began during the first 12 months after your effective date of coverage.

### LIMITED DISABILITY BENEFITS

#### Alcohol, Drug, or Substance Use Disorder or Addiction

If you are disabled due to alcohol, drug, or substance use disorder or addiction, you will be limited to one period of disability during your lifetime. During your disability, you are required to participate in an alcohol, drug, or substance use disorder or addiction recovery program recommended by a physician.

MetLife will end disability benefit payments at the earliest of the date you receive 24 months of disability benefit payments; the date you cease or refuse to participate in the recovery program referred to above; or the date you complete such recovery program.
Other Conditions With Limited Disability Benefits

If you are disabled due to one or more of the following, your disability benefits will be limited to a lifetime maximum equal to the lesser of

- 24 months; or
- the maximum benefit period.

Your disability will be limited as stated above for:

1. A mental or nervous disorder or disease except schizophrenia, dementia, or organic brain disease
2. Neuromusculoskeletal and soft tissue disorder including, but not limited to, any disease or disorder of the spine or extremities and their surrounding soft tissue; including sprains and strains of joints and adjacent muscles, unless the disability has objective evidence of:
   - Seropositive arthritis
   - Spinal tumors, malignancy, or vascular malformations
   - Radiculopathies
   - Myelopathies
   - Traumatic spinal cord necrosis
   - Myopathies
3. Chronic fatigue syndrome and related conditions

Disabilities Not Covered

The plan does not cover any disabilities caused by, contributed to by, or resulting from:

1. war, whether declared or undeclared, or act of war, or participation in an insurrection, rebellion, riot, or terrorist act;
2. intentionally self-inflicted injury;
3. attempted suicide; or
4. commission of or attempt to commit a felony.

Benefit Payment

If MetLife approves your claim, benefits will begin to accrue on the day after the day you complete your elimination period. MetLife will pay the first monthly benefit one month after the date benefits begin to accrue and subsequent monthly payments will be made to you as long as you remain disabled. Payment will be based on the number of days you are disabled during each month and will be pro-rated for any partial month of disability.

MetLife will pay monthly benefits to you. If you die, MetLife will pay the amount of any due and unpaid benefits as described in the General Provisions subsection: Who MetLife Will Pay.

If you return to active work, MetLife will consider you to have recovered from your disability.

The provisions of this subsection will not apply if your insurance has ended and you are eligible for coverage under another group long-term disability plan.

Sources of Deductible Income

MetLife will reduce your disability benefit by the amount of all other income. “Other income” includes the following:

1. Any benefits that you, your spouse or child(ren) receive or are eligible to receive because of your disability or retirement under:
   - The federal Social Security Act
   - The Railroad Retirement Act
   - Any state or public employee retirement or disability plan
   - Any pension or disability plan of any other nation or political subdivision thereof
2. Any income received for disability or retirement under the BSA Retirement Plan, to the extent that it can be attributed to BSAs contributions
3. Any income received for disability under a group insurance policy to which BSA has made a contribution, such as
— Benefits for loss of time from work due to disability
— Installment payments for permanent total disability
— A no-fault auto law for loss of income, excluding supplemental disability benefits
— A government compulsory benefit plan or program that provides payment for loss of time from your job due to your disability, whether such payment is made directly by the plan or program or through a third party
— A self-funded plan or other arrangement if BSA contributes toward it or makes payroll deductions for it
— Any sick pay, vacation pay, or other salary continuation that BSA pays to you
— Workers’ compensation or a similar law that provides periodic benefits
— Occupational disease laws
— Laws providing for maritime maintenance and cure
— Unemployment insurance law or program

4. Any income that you receive from working while disabled to the extent that such income reduces the amount of your monthly benefit as described under “Rehabilitation Incentives” (This includes but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source.)

5. Recovery amounts that you receive for loss of income as a result of claims against a third party by judgment, settlement, or otherwise, including future earnings

MetLife will reduce the amount of your disability benefit by the amount of Social Security benefits they estimate that you, your spouse or child(ren) are eligible to receive because of your disability or retirement. MetLife will start to do this after you have received 24 months of disability benefit payments unless they have received either of these:

- Approval of your claim for Social Security benefits; or
- A notice of denial of such benefits indicating that all levels of appeal have been exhausted.

However, within six months following the date you became disabled, you must:

1. Send MetLife proof that you have applied for Social Security benefits;
2. Sign a reimbursement agreement in which you agree to repay MetLife for any overpayments they may make to you under this insurance; and
3. Sign a release that authorizes the Social Security Administration to provide information directly to MetLife concerning your Social Security benefits eligibility.

If you do not satisfy the above requirements, MetLife will reduce your disability benefits by such estimated Social Security benefits starting with the first disability benefit payment coincident with the date you were eligible to receive Social Security benefits.

In either case, when you do receive approval or final denial of your claim for Social Security benefits as described above, you must notify MetLife immediately. They will adjust the amount of your disability benefit and then you must promptly repay MetLife for any overpayment you have received.

Other Income in Single-Sum Payments

If you receive other income in the form of a single-sum payment, you must, within 10 days after receipt of such payment, give written proof satisfactory to MetLife of

- the amount of the single-sum payment;
- the amount of the payment to be attributed to income replacement; and
- the time period for which the payment applies.

Your Social Security and Disability Benefits

If there is a reasonable basis for you to apply for benefits under the federal Social Security Act, you are expected to apply for them. To apply for Social Security benefits means to pursue such benefits until you either receive approval from the Social Security Administration or receive a notice of denial of benefits from an administrative law judge.
When MetLife receives that proof, they will adjust the amount of your disability benefit.

If MetLife does not receive the written proof described above, and they know the amount of the single-sum payment, MetLife may reduce your disability benefit by an amount equal to such benefit until the single sum has been exhausted.

If MetLife adjusts the amount of your disability benefit due to a single-sum payment, the amount of the adjustment will not result in a benefit amount less than the minimum amount, except in the case of an overpayment.

If you receive other income in the form of a single-sum payment and MetLife does not receive the written proof described above within 10 days after you receive the single-sum payment, MetLife will adjust the amount of your disability benefit by the amount of such payment.

**MONTHLY BENEFIT BASE RATE**

“Monthly earnings” mean your gross monthly benefit base rate in effect just prior to your date of disability. It includes income actually received from your employer. It also includes any housing allowance and commissions earned in the prior calendar year.

It does not include renewal commissions, bonuses, overtime pay, or any other extra compensation, or income received from sources other than your employer.

If you become disabled while you are on a covered layoff or leave of absence, MetLife will use your monthly earnings from your employer that were in effect just prior to the date your absence begins.

**REHABILITATION INCENTIVES**

**Rehabilitation Program Incentive**

If you participate in a rehabilitation program, MetLife will increase your monthly benefit by an amount equal to 10 percent of the monthly benefit. MetLife will do so before they reduce your monthly benefit by any other income.

**Work Incentive**

While you are disabled, MetLife encourages you to work. If you work while you are disabled and receiving monthly benefits, your monthly benefit will be adjusted as follows:

1. Your monthly benefit will be increased by your rehabilitation program incentive, if any, and
2. Your monthly benefit will be reduced by other income as defined under “Sources of Deductible Income.”

Your monthly benefit as adjusted above will not be reduced by the amount you earn from working, except to the extent that such adjusted monthly benefit plus the amount you earn from working and the income you receive from other income exceeds 100 percent of your pre-disability earnings as calculated under the “disability.”

In addition, the minimum monthly benefit will not apply.
**Limit on Work Incentive**

After the first 24 months following your elimination period, MetLife will reduce your monthly benefit by 50 percent of the amount you earn from working while disabled.

**Family Care Incentive**

If you work or participate in a rehabilitation program while you are disabled, MetLife will reimburse you for up to $400 for monthly expenses you incur for each family member as outlined below:

- Care for your or your spouse’s child, legally adopted child, or child for whom you or your spouse are legal guardian and who is living with you as part of your household, dependent on you for support, and under age 13. The child care must be provided by a licensed child care provider who is not a member of your immediate family or living in your residence.

- Care for your family member who is living with you as part of your household, chiefly dependent on you for support, and incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

The care to your family member may not be provided by a member of your immediate family.

MetLife will make reimbursement payments to you on a monthly basis starting with the first monthly benefit payment until you have received 24 monthly benefit payments. Payments will not be made beyond the maximum benefit period. MetLife will not reimburse you for any expenses for which you are eligible for payment from any other source. You must send proof that you have incurred such expenses.

**Moving Expense Incentive**

If you participate in a rehabilitation program while you are disabled, MetLife may reimburse you for expenses you incur in order to move to a new residence recommended as part of such rehabilitation program. Such expenses must be approved by MetLife in advance. You must send proof that you have incurred such expenses for moving. MetLife will not reimburse you for such expenses if they were incurred for services provided by a member of your immediate family or someone who is living in your residence.

**WHEN DISABILITY PAYMENTS END**

Your disability benefit payments will end on the earliest of:

- The end of the Maximum benefit period
- The date benefits end as specified in the Limited Disability Benefits section
- The first date on which you are no longer disabled
- The date on which you die, except for benefits paid as outlined in the section entitled “In the Event of Your Death”
- The date on which you cease or refuse to participate in a rehabilitation program that MetLife requires and that is approved by your physician
- The date on which you fail to have a medical exam requested by MetLife
- The date on which MetLife has made 12 consecutive monthly benefit payments to you while you are living outside of the United States or Canada
- The date on which you fail to provide required proof of continuing disability

While you are disabled, your disability benefits will not be affected if

- your insurance ends or if
- the BSA Policy is amended to change the plan of benefits for your class.
BENEFITS IN THE EVENT OF YOUR DEATH

Single-Sum Payment

If you die while you are disabled and you were titled to receive monthly benefits, proof of your death must be sent to MetLife. When they receive such proof, MetLife will pay the benefit described in this section.

Benefit Amount

The benefit will be equal to three times the lesser of:

- The monthly benefit you received for the calendar month immediately preceding your death
- The monthly benefit you were entitled to receive for the month in which you died, if you died during the first month that disability benefits were payable

MetLife will reduce the benefit amount by any overpayment they are entitled to recover.

Benefit Payment

- Benefit payments made after you die will be made as described in the section titled “Who MetLife Will Pay.”

BENEFITS IN THE EVENT OF YOUR TERMINAL ILLNESS

If you become terminally ill while you are disabled and entitled to receive monthly benefits, you or your legal representative must send proof of your terminal illness to MetLife. MetLife will pay the benefit(s) described in this section.

Proof of Your Terminal Illness

You or your legal representative must send MetLife a signed physician’s certification that you are terminally ill. MetLife may also request an exam by a physician of their choice, at their expense.

Increase In Your Monthly Benefit

MetLife will increase your monthly benefit amount, beginning with the next payment due after their receipt of proof of your terminal illness.

Your monthly benefit percentage, on payments made during your lifetime; will increase to 80 percent of your pre-disability earnings for a maximum period of 12 consecutive months.

Monthly Payment

You may elect to receive the additional benefit described in this subsection. MetLife will pay such benefit in addition to any other benefit they pay.

MetLife will pay this additional benefit monthly for a period of 12 months. Payments will begin one month after the month they receive proof of your terminal illness.

In the event of your death prior to the payment of all such monthly benefits, MetLife will pay the remaining monthly benefits as stated in the “Who MetLife Will Pay” section.

The additional monthly benefit will be equal to 100 percent of the monthly benefit you receive for the calendar month immediately preceding the month in which you are diagnosed as terminally ill.

MetLife will reduce the benefit amount by any overpayment they are entitled to recover.

Single-Sum Payment

You may elect to receive an additional single-sum payment equal to three times the monthly benefit you received for the calendar month immediately preceding the month in which you were diagnosed as terminally ill. MetLife will pay such benefit in addition to any other benefits they pay under this coverage. Benefit payments will be made as described in the section entitled “Who MetLife Will Pay.” MetLife will reduce the benefit amount by any overpayment they are entitled to recover. If you elect to receive the additional benefit described here, no benefit will be paid as described under “Benefits in the Event of Your Death.”

GENERAL PROVISIONS

Assignment

The rights and benefits under the group policy are not assignable prior to a claim for benefits, except as required by law. MetLife is not responsible for the validity of an assignment.
Who MetLife Will Pay

MetLife will make any benefit payments during your lifetime to you or your legal representative. Any payment made in good faith will discharge MetLife from liability to the extent of such payment.

Upon your death, MetLife will pay any amount that is or becomes due to your designated beneficiary. If there is no beneficiary designated or no surviving beneficiary at your death, MetLife will pay any benefit that is or becomes due, according to the following:

1. Your spouse, if alive
2. Your child(ren), if there is no surviving spouse
3. Your parent(s), if there is no surviving child(ren)
4. Your sibling(s), if there is no surviving parent(s)
5. Your estate, if there is no surviving sibling.

If more than one person is eligible to receive payment, MetLife will divide the benefit amount in equal shares.

Payment to a minor or incompetent person will be made to such person’s guardian. The term “children” or “child” includes natural and adopted children.

Any periodic payments owed to your estate may be paid in a single sum. Any payment made in good faith will discharge MetLife from liability to the extent of such payment.

Incontestability: Statements Made by You

Any statement made by you will be considered a representation and not a warranty. MetLife will not use such a statement to contest life insurance, reduce benefits, or defend a claim, unless all of the following requirements are met:

1. The statement is in a written application or enrollment form.
2. You have signed the application or enrollment form.
3. A copy of the application or enrollment form has been given to you or your beneficiary.

MetLife will not use your statements that relate to insurability to contest disability insurance after it has been in force for two years during your life. In addition, MetLife will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for two years during your life, unless the statement is fraudulent.

Misstatement of Age

If your age is misstated, the correct age will be used to determine whether insurance is in effect and, as appropriate, MetLife will adjust the benefits and/or premiums accordingly.

Overpayment of Benefits

Recovery of Overpayments

MetLife has the right to recover any amount that they determine to be an overpayment. An overpayment occurs if MetLife determines that:

- the total amount paid by MetLife on your claim is more than the total of the benefits due to you or
- the payment MetLife made should have been made by another group plan.

If such overpayment occurs, you have an obligation to reimburse MetLife. MetLife’s rights and your obligations in this regard are described in the reimbursement agreement that you are required to sign when you submit a claim for benefits. This agreement

- confirms that you will reimburse MetLife for all overpayments and
- authorizes MetLife to obtain any information relating to sources of other income.

Overpayment Recovery

MetLife may recover the overpayment from you by any of these means:

- Stopping or reducing any future disability benefits, including the minimum benefit, payable to you or any other payee under the disability sections
- Demanding an immediate refund of the overpayment from you
- Taking legal action
If the overpayment results from MetLife having made a payment to you that should have been made under another group plan, MetLife may recover such overpayment from one or more of the following:

- Any other insurance company
- Any other organization
- Any person to or for whom payment was made

SPECIAL SERVICES

Social Security Assistance Program

If you become disabled, MetLife provides you with assistance in applying for Social Security disability benefits. Before outlining the details of this assistance, you should understand why applying for Social Security disability benefits is important.

Why You Should Apply

Both you and your employer contribute payroll taxes to Social Security. A portion of those tax dollars is used to finance Social Security’s program of disability protection. Since your tax dollars help fund this program, it is in your best interest to apply for any benefits to which you may be entitled. Your spouse and children may also be eligible to receive Social Security disability benefits due to your disability.

There are several reasons why it may be to your financial advantage to receive Social Security disability benefits. Some of them are:

1. Avoids Reduced Retirement Benefits

   Should you become disabled and approved for Social Security disability benefits, Social Security will freeze your earnings record as of the date Social Security determines that your disability has begun. This means that the months/years that you are unable to work because of your disability will not be counted against you in figuring your average earnings for retirement and survivor’s benefit.

2. Provides Eligibility for Medicare Protection

   Once you have received 24 months of Social Security disability benefits, you will have Medicare protection for hospital expenses. You will also be eligible to apply for the medical insurance portion of Medicare.

3. Enables Trial Work Period Benefits

   Social Security provides a trial work period for the rehabilitation efforts of disabled workers who return to work while still disabled. Full benefit checks can continue for up to nine months during the trial work period.

4. Social Security Freeze

   MetLife employs a “Social Security freeze,” meaning that they will not decrease your disability benefit by the periodic cost-of-living increases awarded by Social Security. This is also true for any cost-of-living increases awarded by Social Security to your spouse and children. Only the basic Social Security benefit awarded to you and your dependents will be used by MetLife to reduce your disability benefit, with the following exceptions:

   a. If an error was made by Social Security in computing the initial amount
   b. If there is a change in dependent status
   c. If your employer submits updated earnings records to Social Security for earnings received prior to the onset of your disability.

   Over a period of years, the net effect of these cost-of-living increases can be substantial.

How MetLife Assists You

As soon as you apply for disability benefits, MetLife begins assisting you with the Social Security approval process. Their assistance is offered at no cost to either you or your employer.

1. Assistance Throughout the Application Process

   MetLife has a dedicated team of Social Security specialists in our Claim Department. These specialists, many of whom have worked for the Social Security Administration, provide expert assistance from the beginning, offer support while you are completing the Social Security forms, and help guide you through the application process.
2. **Guidance Through the Appeal Process**

Social Security disability benefits may be initially denied, but often they are approved following an appeal. If your benefits are denied, MetLife Social Security specialists provide expert assistance on an appeal if your situation warrants continuing the appeal process. They guide you through each stage of the appeal process, which may include:

a. Reconsideration by the Social Security Administration
b. A hearing before an administrative law judge
c. Review by an appeals council established within the Social Security Administration in Washington, D.C.
d. A civil suit in federal court

3. **Social Security Attorneys**

Depending on your individual needs, MetLife may provide a referral to an attorney who specializes in Social Security law. The Social Security–approved attorney's fee is credited to the long-term disability overpayment, which results upon your receipt of the retroactive Social Security benefits. The attorney's fee, which is capped by Social Security law, will be deducted from the lump sum Social Security disability benefits award and will not be used to further reduce your long-term disability benefit.

**Early Intervention Program**

The MetLife Early Intervention Program is offered to all covered employees, and your participation is voluntary. The program helps identify early those employees who might benefit from vocational analyses and rehabilitation services before they are eligible for long-term disability benefits. Early rehabilitation efforts are more likely to reduce the length of your long-term disability and help you return to work sooner than expected.

If you cannot work, or can only work part-time due to a disability, your employer will notify MetLife. Our clinical specialists may be able to assist you by:

1. With your consent, reviewing and evaluating your disabling condition, even before a claim for long-term disability benefits is submitted
2. Designing individualized return-to-work plans that focus on your abilities, with the goal of your being able to return to work
3. Identifying local community resources for you
4. Coordinating services with other benefit providers, including medical carrier, short-term disability carrier, workers’ compensation carrier, and state disability plans
5. With your consent, monitoring return-to-work plans in progress and modifying them as recommended by the attending physician

**Return-to-Work Program**

MetLife focuses on employees’ abilities, rather than disabilities. This “abilities” philosophy is the foundation of our return-to-work program. By focusing on what employees can do versus what they can’t, we can assist you in returning to work sooner than expected.

**Incentives for Returning to Work**

Your disability plan is designed to provide clear advantages and financial incentives for returning to work either full-time or part-time while still receiving a disability benefit. In addition to financial incentives, there may be personal benefits resulting from returning to work. Many employees experience higher self-esteem and the personal satisfaction of being self-sufficient and productive once again. If it is determined that you are capable, but you do not participate in the return-to-work program, your disability benefits may cease.

**Return-to-Work Services**

As a covered employee you are automatically eligible to participate in our return-to-work program. The program aims to identify the necessary training and therapy that can help you return to work. In many cases, this means helping you return to your former occupation, although rehabilitation can also lead to a new occupation that is better suited to your condition and makes the most of your current abilities.

There is no additional cost to you for the services we provide, and they are tailored to meet your individual needs. These services include, but are not limited to, the following:

1. **Vocational Analysis.** Vocational analysis includes assessment and counseling to help determine how your skills and abilities can be applied to a new or a modified job with your employer.
2. **Labor Market Surveys.** MetLife uses studies to find jobs available in your locale that could use your abili-
ties and skills and to identify the earning potential for a specific occupation.

3. **Retraining Programs.** MetLife has programs to facilitate return to your previous job or to train you for a new job.

4. **Job Modifications/Accommodations.** MetLife will analyze job demands and functions to determine what modifications may be made to maximize your employment opportunities.

This also includes changes in your job or accommodations to help you perform the previous job or a similar vocation, as required of your employer under the Americans With Disabilities Act (ADA).

5. **Job Seeking Skills and Job Placement Assistance.** MetLife can help with special training to identify abilities, set goals, develop résumés, polish interviewing techniques, and provide other career search assistance.

**Return-to-Work Program Staff**

The case manager handling your claim will coordinate return-to-work services. You may be referred to a clinical specialist, such as a nurse consultant, psychiatric clinical specialist, or vocational rehabilitation consultant, who has advanced training and education to help people with disabilities return to work. One of our clinical specialists will work with you directly, as well as with local support services and resources. They have returned hundreds of individuals to meaningful, gainful employment.

**Rehabilitation Vendors**

In many situations, the services of independent vocational rehabilitation specialists may be used at no additional cost to you; MetLife pays for all vendor services. Selecting a rehabilitation vendor is based on:

1. The attending physician’s evaluation and recommendations
2. Your individual vocational needs
3. The vendor’s credentials, specialty, reputation, and experience

When working with vendors, we continue to collaborate with you and your doctor to develop an appropriate return-to-work plan.

**Claims**

**WHEN TO NOTIFY METLIFE**

You are encouraged to notify MetLife of your claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 45 days after the date your disability begins. However, you must send MetLife written proof of your claim no later than 90 days after your elimination period. If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

The claim form is available by calling MetLife at 866-

729-9201. If you do not receive the form from MetLife within 15 days of your request, send MetLife written proof of claim without waiting for the form.

You and your employer must fill out your own sections of the claim form and give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to MetLife.

You must notify MetLife immediately when you return to work in any capacity.

**FILING A CLAIM**

When MetLife receives the claim form and proof, they will review the claim and, if it is approved, MetLife will pay benefits subject to the terms and provisions of the group policy.

**Items to Submit**

When submitting proof on an initial or continuing claim for disability income insurance, the following items may be required:

- Documentation of the facts about your disability that must include, but is not limited to, the following information:
  - The date your disability started
  - The cause of your disability
  - The prognosis of your disability
  - The continuity of your disability
• Documentation of your application for:
  — Other income
  — Social Security disability benefits
  — Workers’ compensation benefits or benefits under a similar law

• Written authorization for MetLife to obtain and release medical, employment, and financial information and any other items they may reasonably require to document your disability or to determine your receipt of or eligibility for other income

• Any and all medical information, including but not limited to:
  — X-ray films
  — Photocopies of medical records, including:
    • Histories
    • Physical, mental, or diagnostic examination notes
    • Treatment notes

• Names and addresses of:
  — All physicians and medical practitioners who have provided you with diagnosis, treatment or consultation
  — All hospitals or other medical facilities that have provided you with diagnosis, treatment, or consultation
  — All pharmacies that have filled your prescriptions within the past three years

### Appeals

#### Appealing a Claim Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide to you free of charge copies of documents, records, and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife’s decision. Appeals must be in writing and must include at least the following information:

• Name of the employee
• Name of the plan
• Reference to the initial decision
• An explanation of why you are appealing the initial determination (your basis for appeal)

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife’s review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination.

The person who reviews your appeal will not be the same person who made the initial decision to deny your claim, and will not be a subordinate of the person who made the initial decision to deny your claim.

If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.
MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife’s receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife’s notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references to any specific plan provision(s) on which the denial is based. If an internal rule, protocol, guideline, or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline, or other criterion or indicate that such rule, protocol, guideline, or other criterion was relied upon and that you may request a copy of it free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records, and other information relevant to your claim.

**TIME LIMIT ON LEGAL ACTIONS**

A legal action on a claim may only be brought against MetLife during the period beginning 60 days after the date proof is filed and ending three years after the date such proof is required.

**IF METLIFE OVERPAYS YOUR CLAIM**

MetLife has the right to recover any overpayments due to:

- Fraud
- Any error MetLife makes in processing a claim
- Your receipt of deductible income

You must reimburse MetLife in full. MetLife will determine the method by which the repayment is to be made. MetLife will not recover more money than the amount MetLife paid you.

**INSURANCE FRAUD**

It is a crime if you knowingly and with intent injure, defraud, or deceive MetLife, or provide any information, including filing a claim that contains any false, incomplete, or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. MetLife will pursue all appropriate legal remedies in the event of insurance fraud.

**Appealing Eligibility and Enrollment Determination**

In accordance with the Employee Retirement Income Securities Act (ERISA), section 503, the BSA has established and maintains reasonable procedures governing filing for benefits, notification of benefit determinations, and appeal of adverse benefit determinations.

**Appeals by Plan Participants**

The BSA appeal procedures ensure:

- Participants shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and
- there will be a full and fair review of the appeal.
Under the appeal process:

- The participant shall have the opportunity to submit written comments, documents, records, and other information relating to the appeal request.
- The participant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant’s claim for benefits.
- The review will take into account all comments, documents, records, and other information submitted by the participant relating to the appeal.

As part of the appeal process, participants are entitled to:

- Submit written comments, documents, records, and other information relating to the appeal.
- Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the appeal.

These procedures allow a participant to appeal any determination not related to claim payment, including a denial for enrollment in the plan or a change in the benefit election for themselves or their eligible dependents.

Participants wishing to file an appeal must do so in writing, providing information on the eligibility or enrollment request that was denied, including any accompanying documentation that supports their request for appeal.

Appeal requests may be submitted by:

- U.S. Postal Service mail to:
  HR Compensation and Benefits
  SUM 288
  1325 W. Walnut Hill Lane
  Irving, TX 75038
- Fax to 972-580-2194
- Email to scouting2health@scouting.org

**Notice and Timing of Appeal Determination**

Participants will receive written notification at their home address of the determination made by the Benefits Committee within 60 days of receipt of the request for review by the Benefits Committee. Due to special circumstances, an extension of up to 60 days may occur. Written notice of the extension shall be furnished to the participant prior to the termination of the initial 60-day period.

In the case of an adverse determination on appeal, a written notice of denial will include:

- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provisions on which the benefit determination is based.
- A description of the plan’s internal appeal procedure and the time limits applicable, including a statement of your right to bring a civil action under ERISA after receiving an adverse benefit determination.
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.

**Limitation of Action**

A participant cannot bring legal action against Boy Scouts of America until 90 days after they have properly submitted a request for appeal and all required reviews have been completed.

**Your Rights**

**ERISA INFORMATION AND NOTICE OF RIGHTS**

**Name of Plan:**
Boy Scouts of America Employee Welfare Benefits Plan

**Name and Address of Employer:**
Boy Scouts of America
1325 West Walnut Hill Lane
Irving, TX 75038

**Plan Identification Number:**
- Employer IRS identification number: 22-1576300
- Plan number: 503
**Type of Welfare Plan:**

Disability

**Type of Administration:**

The plan is administered by the plan administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the plan.

This summary plan description is expressly made part of the plan and is legally enforceable as part of the plan with respect to its term and conditions. In the event there is no other plan document, this document shall serve as a summary plan description and shall constitute the plan.

**ERISA Plan Year Ends:**

December 31

**Plan Administrator, Name, Address, and Telephone Number:**

Boy Scouts of America  
1325 West Walnut Hill Lane  
Irving, TX 75038  
972-580-2000

Boy Scouts of America is the plan administrator, with authority to delegate its duties. MetLife is the fiduciary of the plan. The plan administrator may designate trustees of the plan, in which case the administrator will advise you separately of the name, title, and address of each trustee.

**Agent for Service of Legal Process on the Plan:**

Boy Scouts of America  
1325 West Walnut Hill Lane  
Irving, TX 75038

Service of the legal process may also be made upon the plan administrator, or any trustee of the plan.

**Funding and Contributions**

The plan is funded as an insured plan under policy number 136003, issued by Metropolitan Life Insurance Company, 200 Park Ave., New York, NY 10166. Contributions to the plan are made by your employer.

**Your Rights Under ERISA**

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- **Receive information about your plan and benefits.** Examine, without charge, at the plan administrator’s office and at other specified locations, 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 Employee Benefits Security Administration.

Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- **Prudent actions by plan fiduciaries.** In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of 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 benefit or exercising your rights under ERISA.

**Assistance With Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory.
directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Ave. N. W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**LEGAL INFORMATION**

**Right to Amend the Plan**

BSA has contracted with MetLife to insure and provide benefits through a group policy issued to Boy Scouts of America. The certificate of insurance attached to the policy specifically describes the benefits and provisions available to you and is the governing document for determining your benefit under the BSA Long-Term Disability Plan. Benefits under this plan will be paid only if the plan administrator decides in its discretion that the applicant is entitled to them. BSA reserves the right to make revisions to or to terminate the plan at any time.

**Important Notice**

To obtain information or make a complaint, you may call MetLife at 866-729-9201. You may also write MetLife at:

MetLife Disability Unit
Metropolitan Life Insurance Company
200 Park Ave.
New York, NY 10166

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at 800-252-3439.

You may also write the Texas Department of Insurance at:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
(Fax: 512-475-1771)

**Premium or Claim Disputes**

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

This notice is for information only and does not become a part or condition of the attached document.

**Aviso Importante**

Para obtener información o para someter una queja usted puede llamar gratis al numero de teléfono de Metropolitan Life al 866-729-9201.

Usted tambien puede escribir a Metropolitan Life:

MetLife Disability Unit
Metropolitan Life Insurance Company
200 Park Ave.
New York, NY 10166

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al 800-252-3439.

Puede escribir al Departamento de Seguros de Texas:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
(Fax: 512-475-1771)

**Disputas Sobre Primas o Reclamos**

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento de Seguros de Texas.

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento de Seguros de Texas.

**EFFECT ON STATE INSURANCES**

The plan does not replace or affect the requirements for coverage by any workers’ compensation or state disability insurance.
METLIFE’S COMMITMENT TO PRIVACY

MetLife understands your privacy is important. MetLife values their relationship with you and is committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why MetLife collects NPI, what MetLife does with NPI, and how MetLife protects your privacy.

Collecting Information

MetLife collects NPI about their customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income, and health history. MetLife may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations, and service providers.

Sharing Information

MetLife shares the types of NPI described above primarily with people who perform insurance, business, and professional services for them, such as helping them pay claims and detect fraud. MetLife may share NPI with medical providers for insurance and treatment purposes. MetLife may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, MetLife may share NPI with group policyholders for reporting and auditing purposes. MetLife may share NPI with parties to a proposed or final sale of insurance business or for study purposes. MetLife may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, MetLife asks your permission before sharing NPI about you. MetLife’s practices apply to their former, current, and future customers.

Access to Information

You may request access to certain NPI MetLife collects to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number, and policy number if MetLife has issued a policy. If you request, MetLife will send copies of the NPI to you. If the NPI includes health information, MetLife may provide the health information to you through a health-care provider you designate. MetLife will also send you information related to disclosures. MetLife may charge a reasonable fee to cover their copying costs.

This section applies to NPI MetLife collects to provide you with coverage. It does not apply to NPI MetLife collects in anticipation of a claim or civil or criminal proceeding.
Correction of Information

If you believe NPI MetLife has information about you that is incorrect, please write to them. Your letter should include your full name, address, telephone number, and policy number if MetLife has issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If MetLife agrees with you, they will correct the NPI and notify you of the correction. MetLife will also notify any person who may have received the incorrect NPI from them in the past two years if you ask MetLife to contact that person.

If MetLife disagrees with you, they will tell you that they are not going to make the correction. MetLife will give you the reason(s) for their refusal. MetLife will also tell you that you may submit a statement to them. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with MetLife’s decision not to correct the NPI in their files. MetLife will file your statement with the disputed NPI. MetLife will also give the statement to any person designated by you if MetLife disclosed the disputed NPI to that person in the past two years.

Coverage Decisions

If MetLife decides not to issue coverage to you, they will provide you with the specific reason(s) for their decision. MetLife will also tell you how to access and correct certain NPI.

Contacting MetLife

For additional information about MetLife’s commitment to privacy, please write to: MetLife Disability Unit, Metropolitan Life Insurance Company, 200 Park Ave., New York, NY 10166. MetLife reserves the right to modify this notice. MetLife will provide you with a new notice if they make material changes to their privacy practices.

Discretionary Acts

In exercising its discretionary powers under the plan, the plan administrator, and any designee (which shall include MetLife as a claims fiduciary) will have the broadest discretion permissible under ERISA and any other applicable laws, and its decisions will constitute final review of your claim by the plan. Benefits under this plan will be paid only if the plan administrator or its designee (including MetLife) decides in its discretion that the applicant is entitled to them.
LTD Plan Glossary

**active employment or active work.** You are performing all of the usual and customary duties of your job on a full-time basis. This must be done at

- BSA’s place of business,
- an alternate place approved by BSA, or
- a place to which BSA’s business requires you to travel.

You will be deemed to be actively at work during weekends or BSA-approved vacations, holidays, or business closures if you were actively at work on the last scheduled work day preceding such time off.

**annual benefit base rate.** The employee’s base annual salary and housing allowance, excluding overtime pay, bonuses, commissions, and any other type of incentives.

**appropriate care and treatment.** Medical care and treatment that are

- given by a physician whose medical training and clinical specialty are appropriate for treating your disability;
- consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations, and governmental agencies;
- consistent with a physician’s diagnosis of your disability; and
- intended to maximize your medical and functional improvement.

**beneficiary.** The recipient of insurance benefits as named by the employee.

**Consumer Price Index.** The CPI-W, the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor.

**elimination period.** The period of your disability during which MetLife does not pay benefits. The elimination period begins on the day you become disabled and continues for the period shown in the schedule of benefits.

**full-time** means active work on BSA’s regular work schedule for the eligible class of employees to which you belong.

**mental or nervous disorder or disease.** A medical condition that meets the diagnostic criteria set forth in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* as of the date of your disability. A condition may be classified as a mental or nervous disorder or disease regardless of its cause.

**myelopathies.** Diseases of the spinal cord supported by objective clinical findings of spinal cord pathology.

**myopathies.** Diseases of skeletal muscle supported by clinical, hystological, biochemical, and/or electrodiagnostic findings.

**own occupation** means the essential functions you regularly perform that provide your primary source of earned income.

**pre-disability earnings.** Gross salary or wages you were earning from BSA as of your last day of active work before your disability began. MetLife will calculate this amount on a monthly basis.

The term “pre-disability earnings” includes:

- Commissions you earned averaged over the 12-month period before disability began, or over the period of your employment, if less
- Bonuses you earned averaged over the 12-month period before disability began, or over the period of your employment, if less
- Your annual benefit base rate averaged over the 12-month period before disability began or over the period of your employment, if less
- Housing allowances averaged over the 12-month period before disability began or over the period of your employment, if less
- Contributions you were making through a salary reduction agreement with BSA to any of the following:
  - An IRC Section 401(k), 403(b), or 457 deferred compensation arrangement
  - An executive non-qualified deferred compensation arrangement
  - your fringe benefits under an IRC Section 125 plan

**consumer price index.** The CPI-W, the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor.
The term “pre-disability earnings” does not include:

- Awards
- Overtime pay
- The grant, award, sale, conversion and/or exercise of shares of stock or stock options
- BSA's contributions on your behalf to any deferred compensation arrangement or pension plan
- Any other compensation from BSA

**proof.** Written evidence provided at the claimant's expense that explains to MetLife's satisfaction that a person has satisfied the conditions and requirements for any benefit described in the plan. When a claim is made for any benefit, proof must establish

- the nature and extent of the loss or condition,
- MetLife's obligation to pay the claim, and
- the claimant's right to receive payment.

**radiculopathies.** Diseases of the peripheral nerve roots supported by objective clinical findings of nerve pathology.

**rehabilitation program.** A program that has been approved by MetLife for the purpose of helping you return to work. It may include, but is not limited to, your participation in one or more of the following activities:

- Return to work on a modified basis with a goal of resuming employment for which you are reasonably qualified by training, education, experience and past earnings
- On-site job analysis
- Job modification/accommodation
- Training to improve job-seeking skills
- Vocational assessment
- Short-term skills enhancement
- Vocational training
- Restorative therapies to improve functional capacity to return to work

**seropositive arthritis.** An inflammatory disease of the joints supported by clinical findings of arthritis plus positive serological tests for connective tissue disease.

**sickness.** Illness, disease, or pregnancy, including complications of pregnancy.

**signed.** (noun) Any symbol or method executed or adopted by a person with the present intention to authenticate a record that is on or transmitted by paper or by an electronic medium that is acceptable to MetLife and consistent with applicable law. (verb) To execute or adopt such a symbol or method.

**spinal.** Involving components of the bony spine or spinal cord.

**spouse.** Your lawful spouse.

**terminally ill or terminal illness.** You have an illness due to which you are expected to die within 12 months.

**traumatic spinal cord necrosis.** Injury or disease of the spinal cord resulting from traumatic injury with resultant paralysis.

**tumor(s).** Abnormal growth(s), which may be either malignant or benign.

**vascular malformations.** Abnormal developments of blood vessels.

**written or writing.** A record that is on or transmitted by paper or by an electronic medium that is acceptable to MetLife and consistent with applicable law.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
Enrollment must be completed within 30 days of the date of initial eligibility. Coverage will then be effective on the date of your eligible employment (eligibility). If you do not enroll or waive coverage for yourself or your eligible dependents within the first 30 days of the date of eligibility, your coverage will default to the employee–only level of basic accidental death and dismemberment coverage. Your next opportunity to add dependents or change coverage will be during annual enrollment or if a special enrollment period applies.

Eligibility

FOR EMPLOYEES

If you were hired or rehired on or before May 31, 2004, and are in a regular position scheduled to work 21 hours or more per week year-round with the BSA or a local council, you and your eligible dependents are eligible to enroll.

If you were hired or rehired on or after June 1, 2004, and are in a regular position scheduled to work 30 hours or more per week year-round with the BSA or a local council, you and your eligible dependents are eligible to enroll.

If you were hired or rehired in any position scheduled to work less than 30 hours per week year-round, you are eligible to enroll under the following circumstances:

- You were hired or rehired on or before Nov. 1, 2014, and you actually worked 30 or more hours per week on average in the 12-month period from Nov. 1, 2014, through Oct. 31, 2015. In this event, you are eligible Jan. 1, 2016. Your eligibility continues for the next 12 calendar months and will end Dec. 31, 2016, unless you have continued to work an average of 30 or more hours per week.

- You were hired or rehired after Nov. 1, 2014, and you actually worked 30 or more hours per week on average in the 12 calendar months following the month you were hired. In this event, you are eligible the first day of the calendar month following 13 full months of employment. Your eligibility continues for the next 12 calendar months and will end unless you have continued to work an average of 30 or more hours per week.

FOR DEPENDENTS

Eligible dependents include:

- Your spouse (If your spouse is a BSA or local council employee, he or she must be enrolled as an employee, not as a dependent.)

- For the purposes of the plan, “spouse” is the person to whom you are legally married and does not include a person who is a husband or a wife by reason of a common-law marriage.

- Your children (and stepchildren) from birth up to the last day of the month in which they turn age 26, including:
  - Unmarried children related by blood or marriage
  - Children you have legally adopted (including a child for whom legal adoption proceedings have been started)
  - Children of whom you have legal custody
  - Children for whom you are required to provide coverage as part of a divorce decree, if otherwise eligible

Note: A person cannot be covered as a dependent of more than one employee under this plan.
It is your responsibility to notify the BSA Benefits Center within 30 days of the date a dependent is no longer eligible. You may reach the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com. Benefits will be canceled effective the date the dependent was no longer eligible. Any changes in your premium will be effective on the next pay period or billing period. If notice is provided after 30 days of the date a dependent is no longer eligible, benefits will still be canceled effective the date the dependent was no longer eligible; however, no premiums will be refunded.

FOR CHILDREN 26 OR OLDER
At age 26, dependent children are no longer eligible for benefits under this plan, unless they are unmarried, unable to be self-supportive because of mental or physical handicap, and dependent mainly on you for support. To continue coverage, the Children with Disabilities Form, found at http://bsabenefits.mercerhrs.com, must be completed by the employee and the attending physician and submitted to MetLife within 31 days of the child’s reaching age 26.

FOR RETIREES
If your retirement date was on or before Dec. 1, 2004, and you meet the definition of retiree in the glossary, your additional accidental death and dismemberment coverage will be continued upon your retirement from BSA or a local council.

If your retirement date was on or after Jan. 1, 2005, you meet the definition of retiree in the glossary, and you have at least 10 years of service (defined by the years of employment that were eligible for BSA benefits), you may continue your additional accidental death and dismemberment coverage upon your retirement from BSA or a local council.

Retirees cannot enroll during the annual enrollment period.

Enrollment

HOW TO ENROLL
To enroll, call the BSA Benefits Center at 800-444-4416 or log onto http://bsabenefits.mercerhrs.com within 30 days of the date you become eligible. Coverage will then be effective on your eligibility date. If you and/or your eligible dependents do not enroll within the first 30 days of your eligibility, your basic accidental death and dismemberment plan election will default to covered and the next opportunity to change this election will occur if a special enrollment period applies or during the annual enrollment period. Refer to the Special Enrollment Periods and Annual Enrollment Period sections.

ANNUAL ENROLLMENT PERIOD (FOR EMPLOYEES ONLY)
There will be an annual enrollment period each year. During this annual enrollment period, you may add or cancel coverage for yourself and/or any eligible dependents for any reason. Any decreases or cancellations of coverage will be effective on Jan. 1 following the annual enrollment period.

Anyone who is past the initial eligibility (30 days) and is enrolled during the annual enrollment period will be subject to MetLife’s “statement of health.” Coverage may be denied. If approved, coverage will be effective on Jan. 1 or the first day of the month following the approval, if later.

CHANGING COVERAGE (FOR EMPLOYEES ONLY)
The provisions in the Premium Only Plan under Section 125 of the Internal Revenue Code (see the 125 Plan chapter) will be used to determine whether you can add or increase coverage, regardless of whether you are or are not enrolled in the Premium Only Plan.

You acknowledge that the information that you have provided is accurate and complete to the best of your knowledge. This information may be investigated and
verified, and is subject to the eligibility provisions of the plans. You further acknowledge that if any of this information is found to be false or misleading, you may be required to reimburse the plans for monies spent as a result of any false or misleading statements, and if coverage is through current employment, any false or misleading statements may subject you to discipline, up to and including termination of your employment.

You may add a new eligible dependent within 30 days of marriage. Coverage will be effective as of the date of marriage.

You may add a new eligible dependent within 30 days of the birth of your child or legal adoption or placement for legal adoption or gaining legal custody of a child. Coverage will be effective as of the date of birth, legal adoption, or granting of legal custody.

**CHANGING COVERAGE (FOR RETIREES ONLY)**

You may cancel coverage at any time by contacting the BSA Benefits Center at 800-444-4416 or at [http://bsa-benefits.mercerhrs.com](http://bsa-benefits.mercerhrs.com). Coverage will be canceled effective the first of the next month, provided that your request is made on or before the fifth business day, unless you specifically request a later date (effective the first day of a month). A request made on or after the sixth business day will be effective the first of the month following the next month.

**WHEN COVERAGE ENDS**

Your coverage under the plan ends on the earliest date on which any of the following occurs:

- The date cancellation is requested
- The date the policy is terminated
- The date through which you made your last contribution
- The date a dependent ceases to be eligible for coverage
- The date you terminate employment or cease to be an eligible person

**PORTABILITY**

If your voluntary AD&D coverage ends because you are no longer eligible, you may be eligible to apply for portability. You may apply for coverage for yourself and any eligible dependents who were covered under this plan, unless their coverage continued under this same plan. You may apply to continue coverage only if the policy has not been terminated and your coverage was not terminated because you failed to pay any required premium.

You must give MetLife a written request for portability and pay the initial premium all within 31 days after your coverage terminates under this plan. The maximum amount of coverage you can apply to continue is the lesser of:

1. For you, the voluntary AD&D insurance in effect on the date you applied or $2,000,000.
2. For your spouse, the voluntary AD&D insurance in effect on the date you applied or $250,000.
3. For a child, the voluntary AD&D insurance in effect on the date you applied or $25,000.

**Accidental Death and Dismemberment Insurance Plan Overview**

**BENEFITS**

**Employee Benefits**

| Basic coverage— paid by employer Principal Sum |
|-----------------------------------------------|------------------|
| BSA or local council commissioned professional, certified executive, or professional-technical employee | $50,000 |
| Other BSA or local council employee | $10,000 |

| Additional coverage— paid by employee Principal Sum |
|-----------------------------------------------------|------------------|
| Minimum | $25,000 |
| Maximum | The lesser of 10 X pay or $500,000 |
| Increments of $25,000 |
The principal sum for additional coverage cannot exceed the maximum shown above. For purposes of determining this amount, the basic coverage is not considered.

“Annual Benefit Base Rate” means the employee's base annual salary and housing allowance, excluding overtime pay, bonuses, commissions, and any other type of incentives.

**Retiree Benefits**

Basic coverage—terminates upon retirement from BSA or a local council as defined in the glossary. Additional coverage—paid by retiree.

If you retired prior to Jan. 1, 2015, your additional coverage was reduced 50 percent (rounded to the nearest $25,000), within the minimum and maximum limits stated below:

<table>
<thead>
<tr>
<th>Principal Sum</th>
<th>Minimum</th>
<th>$25,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum</td>
<td>The lesser of 10 X pay or $250,000</td>
<td></td>
</tr>
</tbody>
</table>

Increments of $25,000

For employees who are eligible to continue coverage upon retirement as defined in the glossary and who retire Jan. 1, 2015, or later, coverage in place on the date of retirement can be continued, to a maximum of $250,000.

The principal sum for retiree coverage cannot exceed the lesser of 10 times the retiree's benefit base rate in effect on the day before retirement from BSA or a local council, or the maximum shown above.

You may elect to increase or decrease coverage as long as the principal sum is within the guidelines. Contact the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com.

Any change will be effective the first day of the month following receipt of your request, unless you specifically requested a later date (effective the first day of a month).

**Additional Family Coverage**

The principal sum for a spouse and/or dependent child or children will be determined as follows:

<table>
<thead>
<tr>
<th>PERCENT APPLICABLE TO:</th>
<th>Spouse</th>
<th>Each Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse, with no eligible children</td>
<td>60%</td>
<td>—</td>
</tr>
<tr>
<td>Spouse and children</td>
<td>50%</td>
<td>15%</td>
</tr>
<tr>
<td>Children, but no eligible spouse</td>
<td>—</td>
<td>20%</td>
</tr>
</tbody>
</table>

*The percent applicable will be determined at the time of the claim for the spouse and/or child or children.

For example, if at the time of a claim for a spouse, the employee/retiree does not have any children eligible for coverage, then 60 percent of the principal sum the employee elected would be the principal sum for the spouse. If at the time of a claim for a spouse, children are eligible for coverage, then the principal sum for the spouse would be 50 percent of the principal sum.
REDUCTION AT OR AFTER AGE 70

A reduction due to age will apply to anyone covered under the optional AD&D Plan. On the first day of the month following the covered person’s attainment of ages 70, 75, 80, and 85, the amount of the principal sum will reduce. The reduced amount will be determined by multiplying the amount of the principal sum shown in the schedule and applicable to the covered person shown below for his or her attained age:

<table>
<thead>
<tr>
<th>Covered Person</th>
<th>Percentage of Principal Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 70–74</td>
<td>80%</td>
</tr>
<tr>
<td>Age 75–79</td>
<td>55%</td>
</tr>
<tr>
<td>Age 80–84</td>
<td>35%</td>
</tr>
<tr>
<td>Age 85 or Over</td>
<td>20%</td>
</tr>
</tbody>
</table>

Although the principal sum will be reduced, the premium will continue to be based on 100 percent of the principal sum in effect in the month the covered person becomes 70 years of age.

LOSS BENEFITS

If any of the following losses result from an injury sustained in an accident, and the loss occurs within 365 days after that accident, this plan will pay as follows:

<table>
<thead>
<tr>
<th>Loss Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>the principal sum</td>
</tr>
<tr>
<td>Either hand or foot and sight of one eye</td>
<td>the principal sum</td>
</tr>
<tr>
<td>Coma</td>
<td>1% of the principal sum, paid monthly</td>
</tr>
<tr>
<td>Speech and hearing</td>
<td>the principal sum</td>
</tr>
<tr>
<td>Movement of both upper and lower limbs (quadriplegia)</td>
<td>the principal sum</td>
</tr>
<tr>
<td>Movement of both lower limbs (paraplegia)</td>
<td>the principal sum</td>
</tr>
<tr>
<td>Movement of both upper and lower limbs of one side of the body (hemiplegia)</td>
<td>one half of the principal sum</td>
</tr>
<tr>
<td>Either hand or foot</td>
<td>one half of the principal sum</td>
</tr>
<tr>
<td>Sight of one eye</td>
<td>one half of the principal sum</td>
</tr>
<tr>
<td>Speech or hearing</td>
<td>one half of the principal sum</td>
</tr>
<tr>
<td>Thumb and index finger on either hand</td>
<td>one quarter of the principal sum</td>
</tr>
<tr>
<td>Brain damage</td>
<td>the principal sum</td>
</tr>
<tr>
<td>Paralysis of one arm or leg</td>
<td>one quarter of the principal sum</td>
</tr>
<tr>
<td>Loss of a leg</td>
<td>three quarters of the principal sum</td>
</tr>
<tr>
<td>Loss of an arm</td>
<td>three quarters of the principal sum</td>
</tr>
</tbody>
</table>

The total limit of liability for any one person for all losses due to the same accident will not be more than the principal sum.

Loss of an arm or leg means one that has been permanently severed at or above the elbow or knee.
“Loss” means, with regard to hands and feet, actual severance through or above wrist or ankle joints; with regard to sight, speech, or hearing, entire and irrecoverable loss thereof; with regard to thumb and index finger, actual severance through or above the metacarpophalangeal joints.

“Injury” means a bodily injury resulting directly from an accident and independent of all other causes. Loss resulting from sickness or disease, or from medical or surgical treatment of a sickness or disease, is not covered. The accident must occur while you are covered under the policy.

“Brain damage” means permanent and irreversible physical damage to the brain causing inability to perform all substantial and material functions of everyday life.

**TRAVEL ASSISTANCE**

Effective January 1, 2015, an employee who purchases voluntary AD&D coverage is eligible for Travel Assistance Services at no cost to them.

Travel Services include:

- 24-hour toll-free access worldwide
- Website access to AXA Assistance USA
- Referrals to primary care physicians and hospitals.
- Referrals to medical specialists
- Dental referrals
- Vaccination recommendations/insect precautions
- Hospital admission guarantee
- Medical monitoring
- Medical transportation services
- Emergency medical evacuation
- Emergency medical repatriation
- Return of mortal remains
- Transport of a family member
- Escort of dependent children
- Emergency prescription transfer
- Shipment of medication
- Urgent message relay
- Emergency cash/bail assistance
- Legal referrals
- Telephone interpretation
- Lost document and luggage assistance
- Claims processing assistance
- General travel assistance/information services
- City profiles
- Vehicle repatriation services
- Political evacuation arrangement services
- Pet concierge services
- Travel concierge services
- Identity theft services

Travel services will be provided to employees with voluntary AD&D who are traveling 100 miles or more from their permanent residence or in another country which is not their country of residence. Services are limited to travel of 120 days or less. Services arranged and provided by AXA Assistance USA are subject to a limit of $200,000 per person per event.

**ADDITIONAL BENEFITS**

**Seat Belt Use**—If the employee or a dependent dies as a result of an accidental injury, MetLife will pay an additional Seat Belt Use benefit of no less than $1,000 and no more than $25,000, if applicable.

**Air Bag Use**—If the employee or a dependent dies as a result of an accidental injury, MetLife will pay an additional Air Bag Use benefit of no less than $1,000 and no more than $25,000, if applicable.
**Spouse Education**—If the employee dies as a result of an accidental injury, MetLife will pay an additional Spouse Education benefit of tuition charges incurred for a period of up to one academic year, not to exceed $10,000 per year and an overall maximum of 20 percent of the principal sum, if applicable.

**Hospital Confinement**—MetLife will pay an additional benefit if the employee or a dependent is confined in a hospital as a result of an accidental injury, and will pay the lesser amount of 1 percent of the principal sum or $2,500 for each full month of hospital confinement, if applicable.

**Rehabilitative Physical Therapy**—MetLife will pay an additional benefit of Rehabilitative Physical Therapy for a loss resulting from an accidental injury to the employee in an amount equal to the lesser of actual charges incurred; 5 percent of the principal sum; or $5,000, if applicable.

**Common Carrier**—If the employee or dependent dies as a result of an accidental injury, MetLife will pay an additional benefit if the injury resulting in the deceased's death occurred while traveling in a Common Carrier, if applicable.

**Common Disaster**—If the employee and spouse are injured in the same accident and die within 365 days as a result of injuries in such accident, the amount paid due to the spouse's loss of life will be increased to the full amount of the principal sum paid for the employee's loss of life.

## EXCLUSIONS

We will not pay benefits under this section for any loss caused or contributed to by:

1. Physical or mental illness or the diagnosis or treatment of such illness;
2. Infection, other than infection occurring in an external accidental wound or from food poisoning;
3. Committing or attempting to commit a felony;
4. War, whether declared or undeclared; or act of war, participation in an insurrection, rebellion, or active participation in a riot.
5. MetLife will not pay benefits under this section for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

6. The voluntary intake (by any means) of any drug, medication, or sedative unless it is prescribed by a physician; an over-the-counter drug taken as directed; alcohol in combination with any drug, medication, or sedative or poison; and gas or fumes;

7. Suicide or attempted suicide;

8. Intentionally self-inflicted injury;

9. Service in the armed forces of any country or international authority. (This does not include reserve forces on weekend or summer training.);

10. Any incident related to:
   - Travel in an aircraft as a pilot, crew member, or flight student, or while acting in any capacity other than as a passenger;
   - Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
   - Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
   - Travel in an aircraft or device used for testing/experimental purposes by or for any military authority or for travel beyond the earth's atmosphere.

## COMA BENEFIT

If you or your covered dependent becomes comatose within 30 days of a covered injury and remains comatose continuously for at least 7 days, the plan will pay 1 percent of the principal sum each month after the waiting period that you or your covered dependent remains in a coma, to a maximum of 60 months.

The comatose maximum benefit amount equals the principal sum less all other payments under the policy for the injury.

“Coma” means deep and total unconsciousness and inability to respond to external or internal stimuli.
BENEFICIARY

You may name or change a beneficiary anytime by contacting the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com. Your request takes effect on the date you execute it, regardless of whether you are living or when your local council or BSA receives it. The plan will be relieved of further responsibility to the extent of any payment made in good faith before your local council or BSA received your request.

Claims and Appeals

REPORTING A CLAIM

Notice of a claim should be reported to the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com, within 90 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible.

Claim forms will be sent within 15 days after notice is received. If the forms are not received, you will satisfy the proof of loss requirement if a written notice of the occurrence, character, and nature of the loss is sent to MetLife.

Proof of loss must be sent in writing within 90 days after either:

- The end of a period of the plan liability for periodic payment claims
- The date of the loss for all other claims

If you are not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless you are legally incapacitated.

The plan will pay any daily, weekly, or monthly benefit due on a monthly basis after proof of loss is received, while the loss and plan liability continue, or immediately after MetLife received the proof of loss following the end of plan liability.

PAYMENT OF CLAIMS

All benefits due will be paid to you, if living. For loss of your life, the plan will pay any benefit due either:

- According to the beneficiary designation in effect at the time of your death;
- If no beneficiary is designated, according to the beneficiary designation under the BSA Basic Life Insurance Plan in effect at the time of death
- To the survivors, in equal shares, in the first of the following classes to have a survivor at your death:
  - Spouse
  - Children
  - Parents
  - Brothers and sisters

If there is no survivor in these classes, payment will be made to your estate. If a benefit is payable to your estate or to you or any person who is either a minor or is not competent, the plan may pay up to $1,000 of the amount to some other person, to give a valid release for the payment. The other person will be someone related to the minor or incompetent person by blood or marriage who MetLife believes is entitled to the payment.

The plan will be relieved of further responsibility to the extent of any payment made in good faith.

PHYSICAL EXAMINATIONS AND AUTOPSY

While a claim is pending, MetLife has the right at their expense to have the person who has a loss examined by a physician when and as often as they feel is necessary, and in case of death to have an autopsy conducted where it is not forbidden by law.

DISCLAIMER

This plan description explains the general purposes of the insurance described but in no way changes or affects the insurance afforded under the group insurance policy actually issued. All coverage is subject to actual policy conditions and exclusions.
Your Rights

ERISA INFORMATION AND NOTICE OF RIGHTS

If you participate in the BSA Accidental Death and Dismemberment Plan, you are entitled to certain rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Please refer to the Legal Notices chapter for more information.

LEGAL INFORMATION

RIGHT TO AMEND THE PLAN

BSA has a contract with MetLife to insure and administer benefits under the plan. Benefits under this plan will be paid only if the plan administrator decides in its discretion that the applicant is entitled to them. BSA reserves the right to make revisions to or terminate the plan at any time.

IMPORTANT NOTICE

To obtain information or make a complaint:
• You may call MetLife's toll-free telephone number for information or to make a complaint at 800-638-6420.
• You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at 800-252-3439.
• You may write the Texas Department of Insurance at:
  Texas Department of Insurance
  P.O. Box 149104
  Austin, TX 78714-9104
  (Fax: 512-475-1771)
  Web: http://www.tdi.state.tx.us
  Email: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES

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

Attach this notice to your certificate: “This notice is for information only and does not become a part or condition of the attached document.”

AVISO IMPORTANTE

Para obtener información o para someter una queja:
• Usted puede llamar al número de teléfono gratis de MetLife para información o para someter una queja al 800-638-6420.
• Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al 800-252-3439.
• Puede escribir al Departamento de Seguros de Texas:

  Texas Department of Insurance
  P.O. Box 149104
  Austin, TX 78714-9104
  (Fax: 512-475-1771)
  Web: http://www.tdi.state.tx.us
  Email: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS

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

Una este aviso a su certificado: Este aviso es solo para propósito de información y no se convierte en parte o condición del documento adjunto.
2016 Monthly Premiums

EMPLOYER-PAID COVERAGE

National and local council staff employees—$0.17 per $10,000 of coverage

National and local council commissioned professionals, certified executives, and professional-technical employees—$0.85 per $50,000 of coverage

EMPLOYEE-PAID COVERAGE

$0.023 per $1,000 for employee only

$0.036 per $1,000 for family

<table>
<thead>
<tr>
<th>ADDITIONAL COVERAGE AMOUNT</th>
<th>PREMIUM FOR EMPLOYEE ONLY</th>
<th>PREMIUM FOR FAMILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000</td>
<td>$0.58</td>
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<td>$125,000</td>
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<tr>
<td>$475,000</td>
<td>$10.93</td>
<td>$17.10</td>
</tr>
<tr>
<td>$500,000</td>
<td>$11.50</td>
<td>$18.00</td>
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Retiree coverage maximum is $250,000.
GROUP LIFE INSURANCE
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Eligibility

FOR EMPLOYEES

If you were hired or rehired on or before May 31, 2004, and are in a regular position scheduled to work 21 hours or more per week year-round with the BSA or a local council, you and your eligible dependents are eligible to enroll.

If you were hired or rehired on or after June 1, 2004, and are in a regular position scheduled to work 30 hours or more per week year-round with the BSA or a local council, you and your eligible dependents are eligible to enroll.

If you were hired or rehired in any position scheduled to work less than 30 hours per week year-round, you are eligible to enroll under the following circumstances:

- You were hired or rehired on or before Nov. 1, 2014, and you actually worked 30 or more hours per week on average in the 12-month period from Nov. 1, 2014, through Oct. 31, 2015. In this event, you are eligible Jan. 1, 2016. Your eligibility continues for the next 12 calendar months and will end Dec. 31, 2016, unless you have continued to work an average of 30 or more hours per week.

- You were hired or rehired after Nov. 1, 2014, and you actually worked 30 or more hours per week on average in the 12 calendar months following the month you were hired. In this event, you are eligible the first day of the calendar month following 13 full months of employment. Your eligibility continues for the next 12 calendar months and will end unless you have continued to work an average of 30 or more hours per week.

Enrollment must be completed within 30 days of the date of initial eligibility. Coverage will then be effective on the date of your eligible employment (eligibility), provided you are actively at work on that date. Otherwise, coverage becomes effective on the day you return to work. Dependent life coverage for eligible dependents is effective on the date of enrollment. If you do not enroll or waive coverage for yourself or your eligible dependents within the first 30 days of the date of eligibility, your coverage will default to the employee–only level of basic life insurance coverage. Your next opportunity to add dependents or change coverage will be during annual enrollment or if a special enrollment period applies.

FOR DEPENDENTS

Eligible dependents include:

- Your spouse (If your spouse is a BSA or local council employee, he or she must be enrolled as an employee, not as a dependent.)
- For the purposes of the plan, “spouse” is the person to whom you are legally married and does not include a person who is a husband or a wife by reason of a common-law marriage.
- Your children (and stepchildren) from birth to the last day of the month in which they turn 26, including
  - Your children related by blood or marriage
  - Children you have legally adopted (including a child for whom legal adoption proceedings have been started)
  - Children of whom you have legal custody
  - Children for whom you are required to provide coverage as part of a divorce decree, if otherwise eligible

The BSA Group Life Insurance Plan is insured and administered by MetLife. Each policy is a term life policy with no cash value.

For insured plans, we write a check to the insurance company for the premium each month. That ends the plan’s responsibility for costs. When the insurance company receives a claim, they pay it based on the policy we agreed to. They make money if we file fewer claims than the premiums we paid. But they also could lose money if we have more claims than we paid in premiums. We won’t be impacted by that until it is time to renew the contract with that insurance company.
Note: A person cannot be covered as a dependent of more than one employee under this plan. In addition, a person cannot be covered as a dependent if

- that person is already insured under this policy as an employee, or
- that person is in active duty in the military.

It is your responsibility to notify the BSA Benefits Center within 30 days of the date a dependent is no longer eligible. You may reach the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com. Benefits will be canceled effective the date the dependent was no longer eligible. Any changes in your premium will be effective at the next pay period or billing period. If notice is provided after 30 days of the date a dependent is no longer eligible, benefits will still be canceled effective the date the dependent was no longer eligible; however, no premiums will be refunded.

FOR CHILDREN 26 AND OLDER

At age 26, dependent children are no longer eligible for benefits under this plan, unless they are unmarried, unable to be self-supportive because of mental or physical handicap, and depend mainly on you for support. A request to continue coverage for such a dependent child must be submitted to MetLife 30 days prior to when the dependent’s coverage would otherwise end due to age.

MetLife will review the medical evidence supporting such incapacity and dependency and determine whether the continuation is approved or not. If approved, MetLife may need to review the medical evidence and dependency each year in order for coverage to continue. They may also require proof of continuing eligibility at any time.

FOR RETIREES

If your retirement date was on or before Dec. 1, 2004, and you meet the definition of retiree in the Glossary, life insurance coverage will be continued upon your retirement from BSA or a local council.

If your retirement date was on or after Jan. 1, 2005, you meet the definition of retiree in the glossary, and you have at least 10 years of service (defined by the years of employment that were eligible for BSA benefits), you may continue your life insurance coverage upon your retirement from BSA or a local council.

You may cancel coverage at any time by contacting the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com. Coverage will be canceled effective the first of the next month, provided that your request is made on or before the fifth business day, unless you specifically request a later date (effective the first day of a month). A request made on or after the sixth business day will be effective the first of the month following the next month.

Retirees cannot enroll during the annual enrollment period.

Enrollment

HOW TO ENROLL

To enroll, call the BSA Benefits Center at 800-444-4416 or log onto http://bsabenefits.mercerhrs.com within 30 days of the date you become eligible. Coverage will then be effective on your eligibility date. If you and/or your eligible dependents do not enroll within the first 30 days of your eligibility, your next opportunity to enroll will occur if a special enrollment period applies or during the annual enrollment period. Refer to the Special Enrollment Periods and Annual Enrollment Period sections.

ANNUAL ENROLLMENT PERIOD (FOR EMPLOYEES ONLY)

There will be an annual enrollment period each year. During this annual enrollment period, you may add or cancel coverage for yourself and/or any eligible dependents for any reason. Any decreases or cancellations of coverage will be effective on Jan. 1 following the annual enrollment period.

Anyone who is past the initial eligibility (30 days) and is enrolled during the annual enrollment period will be subject to MetLife’s “statement of health.” Coverage may be denied. If approved, coverage will be effective on Jan. 1 or the first day of the month following the approval, if later.
CHANGING COVERAGE (FOR RETIREES ONLY)

You may cancel or reduce coverage to a minimum of $10,000 at any time by contacting the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com. Coverage will be canceled or reduced effective the first of the next month, provided that your request is made on or before the fifth business day, unless you specifically request a later date (effective the first day of a month). A request made on or after the sixth business day will be effective the first of the month following the next month.

A retiree cannot add or increase coverage.

WHEN COVERAGE ENDS

Your life insurance coverage will terminate on the earliest date on which any of the following occurs:

- When your employment ends, unless your employment ends due to retirement from BSA or a local council. For those cases, see the applicable provisions.
- When you retire from BSA or a local council as defined in the glossary, but you are not eligible to continue benefits into retirement as defined under the “Eligibility” section.
- When the employee or dependent ceases to be eligible for benefits, as defined under the “Eligibility” section.
- When you do not make the required contributions for plan benefits. Coverage will end on the date through which you made your last contribution.
- When the plan ends in whole or in part.
- Coverage for all of your dependents ends when your coverage ends or when you stop making contributions for the dependents’ coverage, whichever happens first.

Coverage for an individual dependent will also end on one of the following:

- The day the dependent becomes covered as an employee under this plan
- The day the dependent ceases to be eligible for benefits

“ACTIVE AT WORK” REQUIREMENT

If you make a request to change your life insurance benefits during the annual enrollment period, a statement of health will be required for any enrollment or increase in coverage. The change will become effective the later of Jan. 1 following the annual enrollment period or upon MetLife’s approval of your statement of health. Note that changes in life insurance are subject to the “active at work” requirement. “Active at work” means that you are performing all of the material duties of your job with BSA or a local council where these duties are normally carried out. If you were actively at work on your last scheduled working day, you will be deemed to have been actively at work on a scheduled non-working day, provided you are not disabled at that time.

CHANGING COVERAGE (FOR EMPLOYEES ONLY)

The provisions in the Premium Only Plan under Section 125 of the Internal Revenue Code (see the 125 Plan chapter) will be used to determine whether you can add or increase coverage, regardless of whether you are or are not enrolled in the Premium Only Plan.

You acknowledge that the information that you have provided is accurate and complete to the best of your knowledge. This information may be investigated and verified, and is subject to the eligibility provisions of the plans. You further acknowledge that if any of this information is found to be false or misleading, you may be required to reimburse the plans for monies spent as a result of any false or misleading statements, and if coverage is through current employment, any false or misleading statements may subject you to discipline, up to and including termination of your employment.

You may add a new eligible dependent within 30 days of marriage. Coverage will be effective as of the date of marriage.

You may add a new eligible dependent within 30 days of the birth of your child or legal adoption or placement for legal adoption or gaining legal custody of a child. Coverage will be effective as of the date of birth, legal adoption, or granting of legal custody.
CONVERSION PRIVILEGE

If your group life insurance is reduced or stops, you may convert to an individual life insurance policy from MetLife.

Upon application, MetLife will issue for the employee only, without statement of health, an individual life insurance policy (only) if the employee should leave the employment of BSA or a local council.

The amount of the policy will be no more than the amount of coverage on the individual under the group plan; however, at the option of the individual, the policy may be issued for a lesser amount. The premium will be based on the attained age of the individual and will be payable to the insurance company. The individual will be told the cost. The first premium must be paid before the policy can be put in force.

If the life insurance stops because Boy Scouts of America has ended the group plan with MetLife or changed the plan so that you are no longer eligible, you must have been covered under this policy for at least five years and the new policy cannot be for more than $2,000.

If you die within the 31-day conversion period, MetLife will pay your beneficiary the amount of life insurance that could have been bought under the individual policy, whether you have applied or not. The individual policy will not go into effect.

Your dependent life insurance can be converted to an individual life insurance policy if the Dependent Life insurance ends for any of the following reasons:
- Your employment ends
- You are no longer an eligible employee
- You die
- A dependent is no longer eligible under the group plan

You may convert to an individual policy (not term insurance) without a medical examination if you apply within 31 days of the date benefits were terminated or 15 days of the date of the notice, if notice is given more than 15 days from the date benefits were terminated. In no event will this period extend more than 91 days from the date benefits were terminated. You may request a conversion form from the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com.

Group Life Insurance Plan Overview

EMPLOYEE BENEFITS

Under the Group Life Insurance Plan, “salary” is equal to base salary plus any housing allowance.

BASIC LIFE

The amount of this insurance is equal to your annual salary and it automatically changes with any change in your salary, subject to a maximum of $2,000,000 (combined with optional coverage).

The minimum amount of coverage is $10,000.

OPTIONAL LIFE

If you enroll in the Basic Life Plan, you may enroll in the Optional Life Plan. You may elect coverage in increments of your annual salary, up to six times. The amount of this coverage automatically changes with any change in your salary.

Coverage under the Basic and Optional Life plans of $1,500,000 or more is subject to an approved statement of health. Coverage cannot exceed $2,000,000.

If You Are 65 or Older

The amounts of your basic and optional life benefits on and after age 65 will be determined by applying the appropriate percentage from the following table to the amount of such benefits in effect on the day preceding your birth date. Coverage will reduce to a minimum of $10,000.

<table>
<thead>
<tr>
<th>Age of Employee</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>65–69</td>
<td>65%</td>
</tr>
<tr>
<td>70–74</td>
<td>45%</td>
</tr>
<tr>
<td>75–79</td>
<td>30%</td>
</tr>
<tr>
<td>80 and older</td>
<td>20%</td>
</tr>
</tbody>
</table>

These provisions also apply to you if you are pending initial approval for, or receiving benefits from, the BSA Long-Term Disability Plan.
RETIREE BENEFITS

Basic Life
- You must be enrolled in the Basic Life Plan as an active employee of BSA or a local council in order to continue basic life coverage as a retiree.
- If you retired before Jan. 1, 1999, and had coverage in effect over $10,000 as of Dec. 31, 1998, your coverage may be continued.
- If you retired before Jan. 1, 1999, and had coverage in effect less than $10,000 as of Dec. 31, 1998, your coverage was increased to $10,000.
- If you retired on or after Jan. 1, 1999, basic life coverage will be reduced to $10,000 if you were enrolled as an active employee.
- The minimum amount of coverage is $10,000.

Optional Life
- You must be enrolled in the Basic Life Plan in order to continue coverage in the Optional Life Plan.
- If you retired before Jan. 1, 1999, and had additional life coverage in effect as of Dec. 31, 1998, your coverage will continue under the Optional Life Plan. You may reduce the coverage to 25 percent of your final salary by contacting the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com.
- If you retired on or after Jan. 1, 1999, optional life coverage will be reduced to 25 percent of your final salary if you were enrolled as an active employee.
- The minimum amount of coverage is $10,000.

Dependent Life (Employee)
If you are enrolled in the Basic Life Plan, you may enroll your eligible dependents in one of the following options:

<table>
<thead>
<tr>
<th>Coverage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>$5,000 per enrolled dependent</td>
</tr>
<tr>
<td>Option 2</td>
<td>$10,000 per enrolled dependent</td>
</tr>
</tbody>
</table>

Your eligible dependents enrolled during each one’s initial eligibility are covered as a family unit. This means that the monthly premium is the same regardless of the number of covered dependents. However, if you add a dependent after his or her initial eligibility period, a “statement of health” must be approved by MetLife. Only those dependents who are approved will be enrolled.

Dependent life coverage cannot exceed 100 percent of the employee’s basic, optional, and Scout Executives’ Alliance coverages combined, or $10,000, whichever is less.

Dependent life coverage will continue at retirement, and cannot exceed 100 percent of the retiree’s basic, optional life, and Scout Executives’ Alliance coverages combined, or $10,000, whichever is less.

Imputed Income
All employer-paid basic and optional group term life insurance coverage over $50,000 generates taxable income subject to income tax and FICA tax withholding. This does not include dependent life.

For employees enrolled in the 125 Plan, all life insurance premiums deducted from pay on a pre-tax basis are considered employer-paid.

For employees not enrolled in the 125 Plan, the value of life insurance over $50,000 less the employee-paid premiums determines the taxable amount.

The taxable amount of imputed income may be added during the year in each paycheck. It also may be calculated at the end of the year and included as taxable income on your W-2 form.

Your payroll department can tell you whether the imputed income is added during the year or at year-end.

Beneficiary
Upon your death from any cause, benefits will be paid to the beneficiary you name. If less than $5,000, benefits are payable in a lump sum. For benefits in excess of $5,000, a total control account will automatically be established with your life insurance proceeds, unless your beneficiary elects to receive the proceeds in a
lump sum. The total control account provided through MetLife is a money market account earning current money market rates and is designed to provide your beneficiary immediate access to and control of the life insurance proceeds.

Beneficiary designations may be changed at any time by contacting the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com.

ACCELERATED BENEFIT PROVISION

This provision enables you to receive a portion of your life insurance benefit when you are no longer able to provide for yourself and are dependent on others for care. You are eligible for this provision if you are enrolled in the Group Life Insurance Plan and have at least $10,000 coverage under this plan. Dependents are not eligible to receive this benefit. You can receive up to 80 percent of the amount of your group life insurance benefit in effect at the time of the qualifying event.

“Meet the requirements” below means if your life span is drastically limited, you are not expected to recover, and you are expected to die within 24 months. A physician’s certification is required and is subject to MetLife’s review and approval.

COVERAGE

MetLife will pay accelerated benefits to you if:

1. you apply for accelerated benefits while your life benefits are in effect; and
2. you meet the requirements while you are covered for life benefits.

Accelerated benefits are payable only once.

Payment of accelerated benefits will reduce your life benefits and the amount available for you to convert to a personal policy of life insurance as described under “Conversion Privilege.” For assistance on accelerated benefits, please contact the BSA Benefits Center at 800-444-4416.

PROOF

Accelerated benefits will be payable when MetLife receives proof that you meet the requirements. Proof must be given to MetLife; MetLife has no duty to ask for any proof. Any delay in submitting proof will not cause a claim to be denied as long as the proof is given as soon as is reasonably possible. At the time that such proof is given, MetLife may have you examined by doctors of their choice, at their expense. If there is a conflicting opinion between your doctor and MetLife’s doctor, MetLife reserves the right to have a third doctor of their choice make the determination.

AMOUNT

The amount payable is up to 80 percent of your life benefits, up to a maximum of $500,000.

If your life benefits will be reduced within six months of meeting the requirements, the accelerated benefits payable will be up to 80 percent of such reduced amount.

Accelerated benefits will be payable only if you are living on the date of payment.

This benefit payment against your group life insurance can be made only once in your lifetime. The subsequent death benefit will be reduced by the amount of the accelerated benefit payment.

Receipt of payment for the accelerated benefit may affect your eligibility for Medicaid or other governmental benefits or entitlements. You should seek assistance from a tax adviser. The accelerated benefit provision may not be available to you if life benefits are to be paid to a former spouse as part of a divorce decree.

For Texas residents: Upon receipt of your claim form, MetLife will send you a preadjudication letter containing specific information on the payment you requested. Such information will include the amount of payment that will be made to you and the amount of death benefit remaining after payment of the accelerated benefit.
CONTINUED PROTECTION (WAIVER OF PREMIUM)

This provision applies only to those employees whose disability occurred between Jan. 1, 1999, and Dec. 31, 2004.

COVERAGE

If you cease to be actively at work as an employee due to total disability, your life benefits may be continued for up to 12 months.

“Total disability” or “totally disabled” means that because of sickness or an injury, both of these apply:
- You cannot do your job.
- You cannot do another job for which you are fit by your education, training, or experience.

Your life benefits will end once you have ceased to be actively at work as an employee due to total disability for 12 months. Death benefits may be payable after your life benefits end in certain cases of total disability. Death benefits will be paid to your beneficiary if all of these apply:
- You became totally disabled before your life benefits ended.
- Your total disability starts for basic life benefits while you are covered for such benefits and for optional life benefits after you have been covered for such benefits for one year.
- You were less than 60 years old when you became totally disabled.
- You continue to be totally disabled after your life benefits end and until the date of your death.
- You die before you are 65 years old.
- The required proof is submitted to MetLife.

However, no death benefits are payable if a death benefit is payable under the conversion privilege. Once an employee is approved for continued protection, the employee no longer has life insurance. They have a death benefit. Since life insurance has ceased, no further premiums are payable by the employer. If they no longer have a death benefit, they may be eligible to enroll for life insurance again, and if coverage becomes effective, premium payments will start again.

Proof of Claim

The death benefits will be payable when MetLife receives proof of your death if all of these conditions are met:
- MetLife has received proof of your total disability no later than 12 months after the date you ceased to be actively at work because of total disability. This proof must establish that your total disability had continued for at least nine months from the date you were last actively at work.
- You submit further proof, when MetLife asks for it, that you continue to be totally disabled. MetLife will not ask for such proof more than once a year.
- Upon your death, MetLife is given proof that total disability continued to the date of your death.

If you die within a year after your life benefits ended and before any proof has been given, then proof that your total disability continued to the date of your death must be given to MetLife. This proof must be given within one year of your death.

All proofs must be given to MetLife. The proofs must be in a form that is satisfactory to MetLife. MetLife has no duty to ask for any proof. If any proof is not given on time, the delay will not cause a claim to be denied as long as the proof is given as soon as reasonably possible.

At any time that proof of your total disability is given, MetLife may have you examined by doctors of their choice, at their expense.

Amount

The amount of your death benefits will be determined by the table below. The percentage for your age on the date of your death is to be applied to the amount of your life benefits on the date your life benefits ended.

If You Die | Percentage
---|---
Before age 65 | 100%
On or after age 65 | None

Your death benefits will be reduced if accelerated benefits are paid.
Termination

Your death benefits will end on any of these:
• The date you are no longer totally disabled
• The date you do not give MetLife proof of total disability when required
• The day before the date you became 65 years old

At age 65, you can continue your life benefits provided you remit the required premium payments.

Claims

Filing a Claim

The death of a covered employee or dependent should be reported to the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com. A claim form and additional information will be sent directly to the designated beneficiary.

Suicide Exclusion

Optional life or dependent life benefits will not be paid if the covered person commits suicide, while sane or insane, within two years from the effective date of coverage. Instead, MetLife will pay the beneficiary an amount equal to any contributions paid, without interest. If the covered person commits suicide, while sane or insane, more than two years after the effective date of coverage but within two years from the effective date of any increase in coverage, such increased amount will not be paid to the beneficiary. Instead, MetLife will pay the beneficiary both of the following:
• An amount equal to all contributions paid for the increased amount, without interest
• An amount equal to the amount of optional life benefits that were in effect on the day before the effective date of such increased amount

Initial Determination

After MetLife receives a claim for benefits, they will review the claim and notify the claimant of their decision to approve or deny the claim. Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date MetLife receives the claim, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies a claim in whole or in part, the notification of the claims decision will state the reason why the claim was denied and reference the specific plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient infor-
mation, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the plan review procedures and time limits, including a statement of the claimant’s right to bring a civil action if the claim is denied after the appeal.

**Appeals**

**Appealing the Initial Determination**

In the event a claim has been denied in whole or in part, the claimant can request a review of the claim by MetLife. This request for review should be sent in writing within 60 days after the claimant receives notice of denial of the claim to Group Insurance Claims Review at the address of the MetLife office that processed the claim.

When requesting a review, the claimant should state the reason he or she believes the claim was improperly denied and submit in writing any written comments, documents, and records of other relevant information. Upon written request, MetLife will provide the claimant copies of documents, records, and other information relevant to the claim, free of charge.

MetLife will re-evaluate all the information and conduct a full and fair review of the claim, and the claimant will be notified of the decision. Such notification will be provided within a reasonable period, not to exceed 60 days from the date MetLife receives the request for review, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, they will send the claimant a final written decision that includes a statement of the reason(s) why the appealed claim is being denied, references to any specific plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the plan, and a statement of the claimant’s right to bring a civil action if the claim is denied after the appeal. Upon written request, MetLife will provide the claimant copies of documents, records, and other information relevant to the claim, free of charge.

**Appealing Eligibility and Enrollment Determinations**

In accordance with the Employee Retirement Income Security Act (ERISA), section 503, the BSA has established and maintains reasonable procedures governing filing for benefits, notification of benefit determinations, and appeal of adverse benefit determinations.

**Appeals by Plan Participants**

The BSA appeal procedures ensure:

- Participants shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and
- there will be a full and fair review of the appeal.

Under the appeal process:

- The participant shall have the opportunity to submit written comments, documents, records, and other information relating to the appeal request.
- The participant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant’s claim for benefits.
- The review will take into account all comments, documents, records, and other information submitted by the participant relating to the appeal.

As part of the appeal process, participants are entitled to:

- Submit written comments, documents, records, and other information relating to the appeal.
- Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the appeal.

These procedures allow a participant to appeal any determination not related to claim payment, including a denial for enrollment in the plan or a change in the benefit election for themselves or their eligible dependents.

Participants wishing to file an appeal must do so in writing, providing information on the eligibility or enrollment request that was denied, including any accompanying documentation that supports their request for appeal.
Appeal requests may be submitted by:

- U.S. Postal Service mail to:
  HR Compensation and Benefits
  SUM 288
  1325 W. Walnut Hill Lane
  Irving, TX 75038
- Fax to 972-580-2194
- Email to scouting2health@scouting.org

**Notice and Timing of Appeal Determination**

Participants will receive written notification at their home address of the determination made by the Benefits Committee within 60 days of receipt of the request for review by the Benefits Committee. Due to special circumstances, an extension of up to 60 days may occur. Written notice of the extension shall be furnished to the participant prior to the termination of the initial 60-day period.

In the case of an adverse determination on appeal, a written notice of denial will include:

- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provisions on which the benefit determination is based.
- A description of the plan's internal appeal procedure and the time limits applicable, including a statement of your right to bring a civil action under ERISA after receiving an adverse benefit determination.
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.

**Limitation of Action**

A participant cannot bring legal action against Boy Scouts of America until 90 days after they have properly submitted a request for appeal and all required reviews have been completed.

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**Your Rights**

**ERISA INFORMATION AND NOTICE OF RIGHTS**

If you participate in the BSA Group Life Insurance Plan, you are entitled to certain rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Please refer to the [Legal Notices](#) chapter for more information.

**LEGAL INFORMATION**

**Right to Amend the Plan**

BSA has contracted with MetLife to insure and provide benefits through a group policy issued to Boy Scouts of America. The certificate of insurance attached to the policy specifically describes the benefits and provisions available to you and is the governing document for determining your benefit under the BSA Group Life Insurance Plan. Benefits under this plan will be paid only if the plan administrator decides in its discretion that the applicant is entitled to them. BSA reserves the right to make revisions to or terminate the plan at any time.

**Important Notice**

To obtain information or make a complaint, you may call MetLife at 800-638-5433.

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at 800-252-3439.

You may write the Texas Department of Insurance at:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
(Fax: 512-475-1771)
**Premium or Claim Disputes**

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

**AVISO IMPORTANTE**

Para obtener información o para someter una queja usted puede llamar gratis al numero de teléfono de MetLife al 800-638-5433.

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos or quejas al 800-252-3439.

Puede escribir al Departamento de Seguros de Texas al:

Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104  
(Fax: 512-475-1771)

**Disputas Sobre Primas o Reclamos**

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento de Seguros de Texas.
2016 Monthly Premiums

BASIC LIFE (1X SALARY)

$.550/$1,000 of coverage

OPTIONAL LIFE —ACTIVE/LTD AND RETIREE (1X – 6X SALARY)

Premium per thousand dollars is age based, as follows:

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<thead>
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<th>AGE</th>
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<th>ACTIVE/LTD TOBACCO</th>
<th>RETIREE</th>
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<td>$0.060</td>
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<tr>
<td>75+</td>
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</table>

DEPENDENT LIFE

Option 1—$2.30 Option 2—$4.60
SCOUT EXECUTIVES’ ALLIANCE
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The Scout Executives’ Alliance (SEA) is a fellowship fund conceived and administered by Scouters. **It is not a BSA benefit or insurance plan.** The fund is fully insured through a term life policy with no cash value.

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**Eligibility**

**ELIGIBILITY FOR EMPLOYEES**

Eligibility for membership in the Scout Executives’ Alliance begins immediately upon employment in a commissioned professional, certified executive, or professional-technical position with BSA or a local council. Membership guidelines and procedures are according to the provisions set forth in Article 2 of the Constitution of the SEA.

Enrollment must be completed within 30 days of the date of initial eligibility. Coverage will then be effective on the date of your eligible employment (eligibility). If you do not enroll or waive coverage within the first 30 days of the date of eligibility, your coverage will default to enrolled. Your next opportunity to change coverage will be during annual enrollment.

Application after five years of eligibility will not be accepted. Once membership is canceled, coverage will not be reinstated.

**ELIGIBILITY FOR RETIREES**

If your retirement date was **on or before Dec. 1, 2004,** and you meet the definition of retiree in the glossary, membership will be continued upon your retirement from BSA or a local council.

If your retirement date was **on or after Jan. 1, 2005,** you meet the definition of retiree in the glossary, and you have at least 10 years of service (defined by the years of employment that were eligible for BSA benefits), membership will be continued upon your retirement from BSA or a local council.

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**ELIGIBILITY UPON RE-EMPLOYMENT**

If a former member is rehired within the first five years of employment, membership may be reinstated automatically upon rehire without providing a statement of health. Application for membership submitted during an annual enrollment period after rehire but still within the first five years of employment constitutes late enrollment and will require an approved statement of health. Membership may be denied.

**TERMINATION OF MEMBERSHIP AND REINSTatement**

See under the “**Constitution of the Scout Executives’ Alliance**” section, page 204, Article 5.

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**Enrollment**

**HOW TO ENROLL**

To enroll, call the BSA Benefits Center at 800-444-4416 or log onto [http://bsabenefits.mercerhrs.com](http://bsabenefits.mercerhrs.com) within 30 days of the date you become eligible. Coverage will then be effective on your eligibility date. If you do not enroll or waive membership within the first 30 days of your eligibility, your Scout Executives’ Alliance election will default to covered and the next opportunity to change this election will occur if a special enrollment period applies or during the annual enrollment period. Refer to the **Special Enrollment Periods** and **Annual Enrollment Period** sections.
ANNUAL ENROLLMENT PERIOD (FOR EMPLOYEES ONLY)

There will be an annual enrollment period each year. During this annual enrollment period, you may enroll (if within five years of initial eligibility) or cancel membership for yourself. Any changes made during the annual enrollment period will be effective on Jan. 1 following the annual enrollment period.

Anyone who is past the initial eligibility (30 days) and is enrolled during the annual enrollment period will be subject to MetLife’s “statement of health.” Membership may be denied. If approved, it will be effective on Jan. 1 or the first day of the month following the approval, if later.

If approved, payment of contributions will be applied subsequent to the enrollment date.

“ACTIVE AT WORK” REQUIREMENT

If you make a request to change your Scout Executives’ Alliance membership during the annual enrollment period, the change will become effective on Jan. 1 following the annual enrollment period, subject to the active at work requirements.

“Active at work” means that you are performing all of the material duties of your job with BSA or a local council where these duties are normally carried out. If you were actively at work on your last scheduled working day, you will be deemed actively at work on a scheduled non-working day, provided you are not disabled at that time.

Application after five years of eligibility will not be approved.

WHEN COVERAGE ENDS

Your SEA coverage will terminate on the earliest date on which any of the following occurs:

- When you retire from BSA or a local council as defined in the glossary but you are not eligible to continue benefits into retirement as defined under the “Eligibility” section.
- When you cease to be eligible for membership, as defined under the “Eligibility” section.
- When your death occurs.
- When you do not make the required contribution for the plan benefits. Coverage will end on the date through which you made your last contribution.
- When the plan ends in whole or in part.

CONVERSION PRIVILEGE

If your Scout Executives’ Alliance is reduced or stops, you may convert to an individual life insurance policy from MetLife.

Upon application, MetLife will issue for you only, without statement of health, an individual life insurance policy.

The amount of the policy will be no more than the amount of coverage on the individual under the group plan; however, at the option of the individual, the policy may be issued for a lesser amount. The premium will be based on the attained age of the individual and will be payable to the insurance company. You will be told the cost. The first premium must be paid before the policy can be put in force.

You must have been covered under this policy for at least five years in order to convert, and the new policy cannot be for more than $2,000, if the Scout Executives’ Alliance benefit ends because the Board of Trustees has

- Ended this group policy with MetLife
- Changed the Alliance so that you are no longer an eligible employee

If you die within the 31-day conversion period, MetLife will pay your beneficiary the amount of life insurance that could have been bought under the individual policy, whether you have applied or not. The individual policy will not go into effect.
You may convert to an individual policy (not term insurance) without a medical examination if you apply within 31 days of the cancellation date or 15 days of the date of the notice, if notice is given more than 15 days from the date benefits were terminated. In no event will this period extend more than 91 days from the date benefits were terminated. You may request a conversion form from the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com.

**Contributions**

Contributions to the Scout Executives’ Alliance are waived the first year of first-time employment.

Monthly contributions, deducted from payroll, are based on salary levels. They will be determined by the trustees of the SEA fund and are subject to change.

**Scout Executives’ Alliance Overview**

**BENEFITS**

A total of $20,000 is payable to the named beneficiary at the death of the member actively employed by BSA or a local council.

A total of $10,000 is payable to the named beneficiary upon the death of a retiree from BSA or a local council who is a member of the SEA.

Benefit amounts shall be determined by the trustees of the SEA and are subject to change.

**IMPUTED INCOME**

All employer-paid group term life insurance coverage over $50,000, which includes the Scout Executives’ Alliance, generates taxable income subject to income tax and FICA tax withholding. This does not include dependent life.

For employees not enrolled in the 125 Plan, the value of life insurance over $50,000 less the employee-paid premiums determines the taxable amount.

The taxable amount of imputed income may be added during the year in each paycheck. It also may be calculated at the end of the year and included as taxable income on your W-2 form.

Your payroll department can tell you whether the imputed income is added during the year or at year-end.

**BENEFICIARY**

If you are enrolled in the Scout Executives’ Alliance, you must name a primary beneficiary or beneficiaries. In keeping with the purpose of the SEA, the primary beneficiary should be the person who would assume responsibility for family affairs upon your death. A contingent beneficiary may also be named.

Beneficiary designations may changed at any time by contacting the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com.

**ACCELERATED BENEFIT PROVISION**

This provision enables you to receive a portion of your life insurance benefit when you are no longer able to provide for yourself and are dependent on others for care. You may use this benefit to pay catastrophic healthcare bills or provide funds for necessary living expenses that are lost if wages are cut back upon disability. If you are not facing financial hardship, you may opt for these benefits simply to enhance the last months of your life.

You are eligible for this provision if you are enrolled in the Scout Executives’ Alliance. You can receive up to 80 percent, to a maximum of $16,000, of the amount of your Scout Executives’ Alliance benefit in effect at the time of the qualifying event.

The qualifying event is terminal illness. If you are diagnosed as being terminally ill with a life expectancy of fewer than 24 months, you may qualify. A physician’s certification is required and is subject to MetLife’s review and approval.
Payment will be made in a lump sum with a maximum payout of $10,000. This benefit payment against your Scout Executives’ Alliance can be made only once in your lifetime. The subsequent death benefit will be reduced by the amount of the accelerated benefit payment.

Receipt of payment for the accelerated benefit may affect your eligibility for Medicaid or other governmental benefits or entitlements. You should seek assistance from a tax adviser. The accelerated benefit provision may not be available to you if life benefits are to be paid to a former spouse as part of a divorce decree.

CONTINUED PROTECTION
(WAIVER OF PREMIUM)

This provision applies only to those employees whose disability occurred between Jan. 1, 1999, and Dec. 31, 2004.

COVERAGE

If you cease to be actively at work as an employee due to total disability, your Scout Executives’ Alliance may be continued for up to 12 months.

“Total disability” or “totally disabled” means that because of sickness or an injury, both of these apply:

- You cannot do your job.
- You cannot do another job for which you are fit by your education, training, or experience.

Your life benefits will end once you have ceased to be actively at work as an employee due to total disability for 12 months. Death benefits may be payable after your SEA benefits end in certain cases of total disability. Death benefits will be paid to your beneficiary if all of these apply:

- You became totally disabled before your SEA benefits ended.
- Your total disability starts for SEA benefits while you are covered for such benefits for one year.
- You are less than 60 years old when you became totally disabled.
- You continue to be totally disabled after your SEA benefits end and until the date of your death.
- You die before you are 65 years old.
- The required proof is submitted to MetLife.

However, no death benefits are payable if a death benefit is payable under the conversion privilege. Once an employee is approved for continued protection, the employee no longer has a Scout Executives’ Alliance life benefit. They have a death benefit. Since the Scout Executives’ Alliance has ceased, no further premiums are payable by the employer. If the employee recovers, they may be eligible to enroll for SEA again, and if coverage becomes effective, premium payments will start again.

PROOF OF CLAIM

The death benefits will be payable when MetLife receives proof of your death if all of these conditions are met:

- MetLife has received proof of your total disability no later than 12 months after the date you ceased to be actively at work because of total disability. This proof must establish that your total disability had continued for at least nine months from the date you were last actively at work.
- You submit further proof, when MetLife asks for it, that you continue to be totally disabled. MetLife will not ask for such proof more than once a year.
- Upon your death, MetLife is given proof that total disability continued to the date of your death.

If you die within a year after your Scout Executives’ Alliance benefits ended and before any proof has been given, then proof that your total disability continued to the date of your death must be given to MetLife. This proof must be given within one year of your death.

All proofs must be given to MetLife. The proofs must be in a form that is satisfactory to MetLife. MetLife has no duty to ask for any proof. If any proof is not given on time, the delay will not cause a claim to be denied as long as the proof is given as soon as reasonably possible.

At any time that proof of your total disability is given, MetLife may have you examined by doctors of their choice, at their expense.
**AMOUNT**

<table>
<thead>
<tr>
<th>If you Die</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before age 65</td>
<td>100%</td>
</tr>
<tr>
<td>On or after age 65</td>
<td>None</td>
</tr>
</tbody>
</table>

Your death benefits will be reduced if accelerated benefits are paid.

**TERMINATION**

Your death benefits will end on:
- The date you are no longer totally disabled
- The date you do not give MetLife proof of total disability when required
- The day before the date you became 65 years old

At age 65 you can continue your life benefits provided you remit the required premium payments.

**ONE PAYMENT ONLY**

If MetLife has issued a personal policy under the conversion privilege, MetLife will pay death benefits only if that policy is returned to them, without any claim. In such cases an amount equal to the premiums paid on the personal policy will be given to the beneficiary. Your death benefits will be reduced if accelerated benefits are paid.

If you were totally disabled before Jan. 1, 1999, Boy Scouts of America will continue to pay your Scout Executives’ Alliance contribution provided you were disabled for at least nine months and were receiving benefits from the BSA Long-Term Disability Plan. Boy Scouts of America will continue to pay these contributions as long as you are receiving benefits from the BSA Long-Term Disability Plan.

Provided you remit the required contribution and your coverage is not subject to termination per the “When Coverage Ends” section, your life benefits will continue if:
- You are not approved by MetLife for continued protection.
- You do not meet the requirements to submit for continued protection approval.
- You did not apply during the 12-month filing limitation.

**Claims**

**FILING A CLAIM**

The death of a member should be reported to the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com. In nearly every instance, the check is mailed within two working days after the death is reported. The check is mailed either directly to the beneficiary or to a fellow Alliance member for personal delivery to the beneficiary.

**REVIEW OF CLAIMS DENIED IN WHOLE OR IN PART**

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

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

**LEGAL INFORMATION**

The SEA is insured by MetLife Insurance Company. The group policy number is 1136003, experience number 100427. Legal process for disputes arising under the insurance contract may be served on MetLife at one of its local offices or upon the supervisory official of the insurance department in the state in which you reside.
Appealing Eligibility and Enrollment Determinations

In accordance with the Employee Retirement Income Security Act (ERISA), section 503, the BSA has established and maintains reasonable procedures governing filing for benefits, notification of benefit determinations, and appeal of adverse benefit determinations.

Appeals by Plan Participants

The BSA appeal procedures ensure:

- Participants shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and
- there will be a full and fair review of the appeal.

Under the appeal process:

- The participant shall have the opportunity to submit written comments, documents, records, and other information relating to the appeal request.
- The participant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant’s claim for benefits.
- The review will take into account all comments, documents, records, and other information submitted by the participant relating to the appeal.

As part of the appeal process, participants are entitled to:

- Submit written comments, documents, records, and other information relating to the appeal.
- Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the appeal.

These procedures allow a participant to appeal any determination not related to claim payment, including a denial for enrollment in the plan or a change in the benefit election for themselves or their eligible dependents.

Participants wishing to file an appeal must do so in writing, providing information on the eligibility or enrollment request that was denied, including any accompanying documentation that supports their request for appeal.

Appeal requests may be submitted by:

- U.S. Postal Service mail to:
  HR Compensation and Benefits
  SUM 288
  1325 W. Walnut Hill Lane
  Irving, TX 75038
- Fax to 972-580-2194
- Email to scouting2health@scouting.org

Notice and Timing of Appeal Determination

Participants will receive written notification at their home address of the determination made by the Benefits Committee within 60 days of receipt of the request for review by the Benefits Committee. Due to special circumstances, an extension of up to 60 days may occur. Written notice of the extension shall be furnished to the participant prior to the termination of the initial 60-day period.

In the case of an adverse determination on appeal, a written notice of denial will include:

- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provisions on which the benefit determination is based.
- A description of the plan’s internal appeal procedure and the time limits applicable, including a statement of your right to bring a civil action under ERISA after receiving an adverse benefit determination.
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.

Limitation of Action

A participant cannot bring legal action against Boy Scouts of America until 90 days after they have properly submitted a request for appeal and all required reviews have been completed.
2016 Monthly Contributions

MEMBERSHIP RATES

All employees who join the Scout Executives’ Alliance when first eligible will have the first 12 months of membership contribution waived.

After the first 12 months of membership, the contribution is based on the member’s annual salary or annual pension per the following:

**Active Members**

$.28 per $1,000 of annual salary (maximum premium per month of $32.00)

**Retired Members**

$.28 per $1,000 of annual pension (maximum premium per month of $17.50)

**Constitution of the Scout Executives’ Alliance**

The Constitution may be amended at any regular meeting. Refer to Article 8 of the Constitution.
ARTICLE 1

NAME AND PURPOSE

The name of this organization shall be the Scout Executives’ Alliance. Its objective is mutual helpfulness in accord with the true spirit of Scouting. Its purpose is to provide a medium through which the membership may, by a united effort, help effectively in lightening the burden of the family of a deceased member.

ARTICLE 2

MEMBERSHIP

a. Membership shall be open to commissioned professionals, certified executives, and professional-technical employees of BSA or a local council on the date of their employment and to members after retirement, under the terms of the Boy Scouts of America Retirement Plan, according to provisions as set forth in Articles 3, 4, and 5 of this Constitution.

b. Membership may be applied for at any time during the first five years of commissioned professional, certified executive, or professional-technical employment. If, however, an eligible person applies after more than 30 days from date of employment, satisfactory evidence of good health will be required before membership shall be approved. At the time an eligible person joins, he or she shall be expected to pay for contributions subsequent to the enrollment date.

c. Membership is automatically and immediately terminated at the date a member leaves the employ of BSA or a local council, including entering military service, except if a member retires or as provided in Article 5. For members who retire under the Boy Scouts of America Retirement Plan, membership will be continued according to the provisions set forth in Articles 3, 4, and 5 of this Constitution.
ARTICLE 3

MONTHLY CONTRIBUTIONS, CUSTODY OF FUNDS, REPORTS, AUDITS, INSURANCE

a. Monthly contributions shall be determined by the trustees from time to time, and the membership shall be advised of any changes.

b. Remittances by check shall be accepted subject to collection. In the event a member’s bank does not honor the check on first presentation, the member’s status shall be the same as though no transmittal had been made.

c. The spirit of the Alliance is such as to require that contributions represent a personal investment on the part of each member. Payment of contributions by the employer is not in keeping with this spirit.

d. Remittances of contributions shall be made to the Scout Executives’ Alliance. When received by the secretary-treasurer, all funds not needed to cover current operating costs shall be invested in accord with the policies established by the trustees as provided in Article 3(e). The secretary-treasurer shall maintain such records as are necessary for a full accounting and for such reports as the trustees may require.

e. The trustees shall prepare, review, and revise, as circumstances make advisable or necessary, a statement of policy regarding custody of the funds of the trust. This policy shall specifically instruct the secretary-treasurer in matters pertaining to the custody of funds, depositories, deposit limits in one banking institution, investment of reserve funds, and on all related matters. If deemed advisable by the trustees, the chairperson may appoint, from the membership of the trustees, a subcommittee on investments and custody of funds to serve for such period of time as may be determined at the time of appointment. It is specifically provided; however, that all funds shall be retained in such fashion as will keep them currently available for the purposes for which contributed and that no investments shall be undertaken except as necessary for safekeeping of funds and consistent with this general policy.

f. There shall be an annual audit of the accounts by a certified public accountant, and the report shall be reviewed by the trustees.

g. Expenses for reports, audits, record books, forms, stationery, postage, insurance, etc., shall be paid from the funds of the Alliance.

h. The Alliance shall be insured as a part of the group insurance contract of Boy Scouts of America, insuring the payment of benefits.

i. A member may be eligible for a waiver of the monthly contribution to the Alliance if approved for continued protection (waiver of premium) by the insuring company.

ARTICLE 4

BENEFICIARIES, AMOUNT OF DEATH BENEFIT, COLLECTION OF CONTRIBUTIONS, INSURANCE PREMIUMS, RESERVES

a. At the time of enrollment or re-enrollment each member shall name one or more persons as primary beneficiary to whom the benefits shall be paid in the event of the member’s death.
Contingent beneficiaries may be named. Members shall have the right to change these at any time. If the purpose of the Alliance is to be fulfilled, beneficiaries should be dependents of the Alliance member’s family, but the member shall have the privilege of establishing the beneficiary designation that best meets his or her needs. If there is no surviving named beneficiary, the benefit will be paid as specified in the certificate of insurance.

b. The single benefit shall be $20,000 for the death of an employed member and $10,000 for the death of a retired member.

c. Upon notification of the death of an employed member, the secretary-treasurer shall immediately pay $20,000 to the beneficiary.

d. Upon notification of the death of a retired member, the secretary-treasurer shall immediately pay $10,000 to the beneficiary.

e. The secretary-treasurer shall send all members notices of death with such facts as can be secured.

f. The first of each month the secretary-treasurer shall call for a contribution from each member, with the member having 30 days to pay the appropriate contribution.

g. The contributions collected from the membership shall be used to pay the monthly insurance premiums, with any excess retained as part of the Alliance reserves.

ARTICLE 5

Termi nation of Membership and Reinstatement

a. A member who terminates employment with Boy Scouts of America or a local council automatically terminates membership as provided in Article 2(c).

b. Any member who retires from Boy Scouts of America or a local council on or after Jan. 1, 2005, and has less than 10 years of service (defined by the years of employment that were eligible for BSA benefits).

c. Any member who fails to remit a contribution within the allotted 30 days shall be automatically dropped. A member so dropped may renew membership within 60 days of the date of termination of membership by paying such contributions as may have been called during active employment and since last contribution.

d. A former member who is rehired within the first five years of employment may enroll during an annual enrollment period that is still within the first five years of employment by submitting a statement of health. Membership may be denied.

ARTICLE 6

Meetings

a. Regular meetings of the membership shall be held in connection with any national meeting of all commissioned professionals, certified executives, and professional-technical employees and at such other times as may be determined by referendum vote of members, with two-thirds of the members voting affirmatively.

b. There shall be a meeting of the membership in each region, incident to regional meetings of commissioned professionals, certified executives, and professional-technical employees, for the purposes of electing representative trustees and alternates, transacting business prescribed by the trustees, and receiving reports. The
trustee from the region shall serve as chairperson of such meetings. If there has been no called meeting of all the members in a region for five years, there shall be an election of representative trustees by mail vote. Mail vote may include e-mail or other current technology for active employees and retirees and regular mail for those for whom we don't have e-mail addresses.

c. The trustees shall meet annually and at such other times and places and in such manner as the chairperson shall determine. Special meetings shall be called by the chairperson upon the request of three or more of the trustees. Business may be transacted by mail.

ARTICLE 7

ORGANIZATION

a. Voting power shall be vested only in the membership. Voting by mail shall be permitted when deemed necessary by the trustees.

b. There shall be the following trustees:

1. One local council Scout executive elected from the membership of each region. Each region shall elect another local council Scout executive as an alternate who can represent the region in the absence of the regional representative trustee.

2. The Chief Scout Executive of Boy Scouts of America, representing the Alliance members of the national commissioned professionals, certified executives, and professional-technical employees. In the event the Chief Scout Executive cannot attend a meeting, the Chief Scout Executive may designate any Alliance member of the national staff to serve as an alternate.

3. The director of Human Resources Administration shall be a trustee ex officio.

4. Such other trustees ex officio as may be provided for in this article. Trustees ex officio shall exercise full privileges as voting members. All trustees must be members of the Alliance.

The trustees shall determine policy between meetings of the membership.

c. At a meeting of the membership in each region or at least once every five years by a mail and/or e-mail vote, the local council Scout executive from each region and alternate shall be elected to serve as trustees by the membership in the region and shall assume office upon certification to the chairperson and secretary-treasurer of election by a two-thirds vote. They shall serve until relieved by election and qualification of successors.

d. The director of Human Resources Administration of Boy Scouts of America shall be a trustee ex officio and shall serve as the secretary-treasurer of the Alliance. With the approval of the chairperson, the director may appoint one or more assistant secretary-treasurers, who shall assume office upon certification of appointment to the chairperson by the secretary-treasurer and who shall serve for such period and perform such duties as shall be designated by the secretary-treasurer.

e. The chairperson of the trustees, in consultation with the secretary-treasurer and other trustees, may appoint additional trustees ex officio to serve for a specified period of time or until replaced. There shall be no more than three such additional trustees ex officio at any one time.

f. At a meeting of the trustees or by mail and/or e-mail vote, at least once every five years, upon nomination of two trustees, one of the trustees representing a region shall be elected to serve as chairperson and one to serve
as vice-chairperson. They shall assume office immediately upon certification by the secretary-treasurer of election by a two-thirds vote, and shall serve until relieved by duly elected successors. The chairperson shall preside at all meetings of the Alliance and of the trustees, shall appoint such special committees as may be necessary, shall report to the membership periodically on the status of the Alliance, and shall perform such other duties as may be required for the efficient administration of the Alliance affairs. The vice-chairperson shall serve in the absence of the chairperson.

g. Interim appointments of trustees made necessary by death, removal, or resignation of any of its members shall be made by the chairperson and the secretary-treasurer after consultation with the regional director of the region affected. A person so appointed shall serve until relieved by a duly elected successor.

h. The secretary-treasurer, assistant secretary-treasurer, and all other persons authorized to deal with Alliance funds shall serve without compensation and shall be bonded in an amount satisfactory to the trustees.

i. No officer or member, except as provided in this Constitution, shall have authority to commit the Scout Executives’ Alliance in any way. All authority for the Alliance is vested in its total membership and trustees.

ARTICLE 8

Amendments

a. This Constitution may be amended at any regular meeting of the total membership by a two-thirds vote of the members present, provided such amendment shall have been considered by the trustees at least 30 days prior to the meeting.

b. Between meetings of the total membership, temporary amendments may be made to the Constitution by a two-thirds vote of the members of the trustees, subject to confirmation by the membership at its next regular meeting.

c. The trustees may submit proposed constitutional changes to the members by mail, in the interim between regular meetings, when in the judgment of the trustees a decision by the membership may be required. A two-thirds vote of the entire membership shall be required for approval of such amendments. Ballots, both paper and electronic, may be destroyed 60 days after the constitutional change is communicated in the next issue of the Boy Scouts of America Benefits Handbook.

ARTICLE 9

Dissolution of Trust

In the event this trust is dissolved, all assets will be distributed to active members as soon as possible after the date of dissolution. These assets will be allocated based upon the number of years an active member has been in the Alliance. Therefore, each member’s allocation will be the total assets available for allocation multiplied by the ratio of that member’s years of membership in the Alliance to the total years of membership for all active members.
BSA RETIREMENT

Plan
The BSA Retirement Plan is a defined benefit plan and is designed to provide you with a regular monthly income when you retire.

BSA Retirement Plan at a Glance

Eligibility. Generally requires a one-year waiting period after employment to participate.

Employee Contributions. The employee contributes 2 percent of his or her compensation to the plan.

Service. Employees are fully vested in the plan when they have five years of vesting service; the first year of employment is counted for vesting service. Credited benefit service is the number of years the employee has been a member of the plan and is used in the retirement formula, with a 35-year maximum.

Retirement Income. When you reach age 55 and have completed five years of vesting service or you reach age 65 with one year of credited service, you are eligible to retire and may begin receiving a monthly benefit. If you retire between the ages of 55 and 65 and have not satisfied the Rule of 85 (when the sum of your age and your vesting service is 85 or more) your retirement benefit amount will be reduced by 4 percent for each year you are under age 65. If you retire between the ages of 55 and 65 and have satisfied the Rule of 85, your retirement benefit will be reduced by 5 percent for each year you are under age 60. If you retire at age 60 or older and you have satisfied the Rule of 85, your retirement benefit amount will not be reduced. If you retire at age 62 or older with 10 or more years of vesting service, your retirement benefit will not be reduced.

Retirement Benefit Options.

• Leveling Option: If you retire before age 62, you may elect to receive a higher monthly benefit from the plan until you are eligible for Social Security benefits (at age 62) and a lower monthly benefit from the plan after age 62.

Termination Before Retirement. If you should leave BSA or a local council with five or more years of vesting service and younger than age 55, you will be eligible for deferred vested benefits. You may leave your personal contributions and interest in the plan and begin monthly annuity benefits as early as age 55 (with early commencement reductions) or your full accrual at age 65; or you may request a refund of your personal contributions plus interest in the form of a lump sum payment or a monthly annuity, and you will have a lesser benefit from the retirement plan than you would have if you left them in the plan. If your employment terminates and you have less than five years of vesting service, you are not eligible to receive any retirement benefits under the plan other than a refund of your employee contributions in the form of an annuity at age 65. However, you may elect to receive an immediate annuity or lump sum payment of your employee contributions (plus interest) to the plan.

For further details, please refer to the specific sections in this chapter.

Rehire of a retired member. If a former member who is receiving a retirement annuity from the plan is rehired, his or her retirement annuity shall stop. Upon subsequent retirement, the retirement allowance will be based on prior and current service.

Eligibility

FOR EMPLOYEES

If you were hired or rehired on or before May 31, 2004, and are in a regular position scheduled to work 21 hours or
more per week year-round with BSA or a local council, you are eligible to participate on the first day of the month following the completion of 12 full months of employment.

If you were hired or rehired on or after June 1, 2004, and are in a regular position scheduled to work 32 hours or more per week year-round with BSA or a local council, you are eligible to participate on the first day of the month following the completion of 12 full months of employment.

If you do not qualify under the above provisions, you are eligible to enroll after you have completed one year of employment and worked 1,000 hours in your first year of employment. If you do not work 1,000 hours in your first 12 months of employment, you are eligible to join Jan. 1 following the year in which you worked 1,000 hours in a calendar year.

Employees do not have to join the plan when first eligible and can join on the first of any month, but you will not receive service credit under the plan between the date you originally were eligible and the date you actually began participating in the plan. You are not eligible to participate if you are a leased employee, a union employee, or an individual treated as an independent contractor for income tax purposes.

**UPON RE-EMPLOYMENT**

If your BSA or local council employment ends after you have satisfied the one-year eligibility period but before you complete the vesting requirement and you are re-employed within five years of your termination date, you may enroll in the plan immediately. If you are re-employed after five years from your termination date, you must complete the one-year wait before being eligible to enroll in the plan.

If your BSA or local council employment ends after completing the vesting requirement and you are re-employed, you may join the plan immediately.

**Credit for Prior Service**

If you leave employment with a deferred vested benefit, prior vesting service credit is automatically restored to you upon re-employment if you did not withdraw your personal contributions, plus earned interest, after your employment ended. If you withdrew your personal contributions, plus interest, your credited benefit service is restored upon re-employment only if you return, within five years, all of the withdrawn contributions and interest, plus additional interest from the date you received your contributions to the date you return them to the plan. Payment must be made in a lump sum.

If you leave employment with less than five years of vesting service, and are re-employed within 12 months of the date your employment ended, your prior vesting service credits will be restored and you will receive vested credit for your period of absence. This is provided you return within five years all of the withdrawn contributions and interest, plus additional interest from the date you received your contributions to the date you return them to the plan. Payment must be made in a lump sum.

If you leave employment with less than five years of vesting service, and are re-employed after five years from your termination date, you must complete the one-year wait before being eligible to enroll in the plan.

If you leave employment because of service in the armed forces, you will receive vesting and credited service for the period of your service. This is provided you are re-employed within 90 days of the completion of your service and you did not withdraw your contributions and interest or you returned your contributions and interest within five years of your re-employment and remain a BSA or local council employee for a minimum of five additional years.

**Enrollment**

To participate, you must enroll and agree to contribute a percentage of your annual compensation through payroll deductions. To enroll, go to http://bsabenefits.mercerhrs.com or call the BSA Benefits Center at
800-444-4416. As your salary increases, your contribution increases. Your compensation is one of the elements used to calculate your retirement income. You do not make contributions after you complete 35 years of credited benefit service.

The following chart reflects the effect authorized absences have on employee contributions, vesting service, and credited benefit service.

<table>
<thead>
<tr>
<th>Authorized Absences (After Feb. 1, 1976)</th>
<th>Your Contributions</th>
<th>Vesting Service (Determines whether you are eligible to receive a benefit under the plan if your employment ends before age 65)</th>
<th>Credited Benefit Service (Determines how much your income will be when you retire)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Leave—Eligible to receive benefits under the BSA Long-Term Disability (LTD) Plan.</td>
<td>Your contributions may not be withdrawn unless you are no longer employed by BSA or a local council. You are not permitted to contribute once your BSA or local council salary stops.</td>
<td>You are credited with vesting service as long as you are receiving benefits from the BSA LTD Plan.</td>
<td>You are credited with credited benefit service as long as you are receiving benefits from the BSA LTD Plan. Credited benefit service cannot exceed the 35-year maximum.</td>
</tr>
<tr>
<td>Other Leaves</td>
<td>Your contributions may not be withdrawn unless your employment ends.</td>
<td>Prior vesting service credit retained; also credited for the period of absence if you return to service within one year.</td>
<td>Prior benefit service credit retained. None credited after BSA or local council salary stops. Benefit service is granted for period of leave of absence if missed contributions are remitted.</td>
</tr>
<tr>
<td>Military Leave—Other than annual reserve or National Guard obligation.</td>
<td>Your contributions will stop when your employment ends, and you may withdraw your contributions.</td>
<td>You will be credited with vesting service for the period of your military service, provided you return to work within the time prescribed by law, immediately rejoin the plan, do not withdraw your contributions (or return withdrawn contributions plus interest within five years), and remain a member for a minimum of five additional years.</td>
<td>You will be credited with credited benefit service for the period of your military service, provided you return to work within the time prescribed by law, immediately rejoin the plan, do not withdraw your contributions (or return withdrawn contributions plus interest within five years), and remain a member for a minimum of five additional years.</td>
</tr>
</tbody>
</table>
Contributions

It is the intention of BSA and local councils to make regular contributions each year to the trustee of the trust that funds the plan in amounts necessary to maintain the plan on a sound actuarial basis. These contributions are not part of an individual’s retirement account but are provided to support the plan.

Your personal contributions cannot be returned to you while you are considered to be a BSA or local council employee, but your contributions and interest are always vested.

Your contributions and interest may be returned to you:
- in a lump sum or as a monthly income if your employment ends before you are eligible for normal or early retirement; or
- as monthly income when you retire; or
- in a lump sum or as monthly income to your beneficiary if you should die.

Once you begin participation in the plan, you must continue as a member and make contributions until your employment ends or you retire or you go into long-term disability leave.

Vesting Service

In determining what benefits you are eligible to receive under the plan, your employment and participation are considered in two different ways: vesting service and credited benefit service.

Vesting service determines whether you are eligible to receive a monthly retirement income when you terminate your employment. If you are a full-time employee and join the plan as soon as you are eligible, you earn vesting service credit from your date of hire.

Example
- You are hired on April 1, 2004, and enroll.
- You become eligible, and participation begins April 1, 2005.
- Your employment ends on April 1, 2009.
- Total credited benefit service is four years (April 1, 2005, to April 1, 2009).
- Total vesting service is five years (April 1, 2004, to April 1, 2009).

If you do not join the plan when you become eligible, vesting service does not begin to accumulate until you actually join; however, you are credited with the one-year eligibility period.

Example:
- You are hired on April 1, 2004.
- You become eligible on April 1, 2005.
- You do not join until April 1, 2007.
- You terminate on April 1, 2009.
- Total vesting service is three years, even though you were employed for five years (April 1, 2004, to April 1, 2005) and (April 1, 2007, to April 1, 2009).

The importance of joining as soon as you are eligible is to accumulate vesting and credited benefit service which is apparent in the “Retirement Income,” “The Rule of 85,” and “Retirement Plan Formula” sections.

Credited Benefit Service

Credited benefit service is used to determine how much monthly income you will receive from the plan when you retire.

For most employees, credited benefit service simply equals the period during which you made contributions to the plan.

Retirement Plan Formula

FINAL AVERAGE COMPENSATION

At retirement, your final average compensation is determined by selecting the 36-consecutive-month period of highest compensation during your last 10 years of employment. Compensation means the regular salary and the hourly wages for regularly scheduled hours, including housing, living allowance, and commissions, but excluding any bonuses, overtime pay, and special pay. For most employees, this will be the average annual compensation for the final 36 months of employment.
BREAKPOINT
This figure is meant to reflect the increasing wage base covered by Social Security and recognizes the increasing **monthly benefits** received from Social Security. The same breakpoint is used to calculate all retirement benefits in the respective year.

<table>
<thead>
<tr>
<th>Year</th>
<th>Breakpoint</th>
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<tbody>
<tr>
<td>2009</td>
<td>$17,400</td>
</tr>
<tr>
<td>2010</td>
<td>$17,900</td>
</tr>
<tr>
<td>2011</td>
<td>$18,400</td>
</tr>
<tr>
<td>2012</td>
<td>$19,000</td>
</tr>
<tr>
<td>2013</td>
<td>$19,600</td>
</tr>
<tr>
<td>2014</td>
<td>$20,200</td>
</tr>
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<td>2015</td>
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<td>2017</td>
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<tr>
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<td>2019</td>
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<tr>
<td>2023</td>
<td>$26,300</td>
</tr>
<tr>
<td>2024</td>
<td>$27,100</td>
</tr>
</tbody>
</table>

**FORMULA**

1.2 percent of final average compensation up to the breakpoint, times credited benefit service, up to a maximum of 35 years, or your accumulated years of credited benefit service as of March 1, 1987, if greater

Plus

1.7 percent of final average compensation over the breakpoint, times credited benefit service, up to a maximum of 35 years, or your accumulated years of credited benefit service as of March 1, 1987, if greater.

**Example:**
- Retire Aug. 1, 2009
- 10 years credited benefit service
- 65 years of age
- Average salary for 36 highest consecutive months = $35,000

\[
[(0.012 \times 17,400) + (0.017 \times (35,000 - 17,400))] \times 10 \text{ years} \div 12 \text{ months} = 423.34 \text{ per month}
\]

**Retirement Income**

Benefits are calculated on the basis of your credited benefit service and final average compensation. Your credited benefit service is limited to an allowable maximum of 35 years of credited service or your accumulated years of credited service as of March 1, 1987, if greater.

**RETIREMENT BETWEEN 55 AND 65**

When you reach age 55 and have completed five years of vesting service or you reach age 65 with one year of credited service, you are eligible to retire and may begin receiving monthly retirement income. After reaching this retirement eligibility, you may not withdraw your personal contributions if your employment ends with BSA or a local council. If you prefer, you may defer receiving your monthly retirement income until age 65, or any age between 55 and 65.

If you begin receiving your monthly retirement income before age 65, your payments will be reduced because of early retirement unless you are age 60 or older and satisfy the “rule of 85”, or you are age 62 or older and have 10 or more years of vesting service. Otherwise, retirement income commencing before age 65 will be reduced as follows:

- Those age 55 or older whose age plus years of vesting service total less than 85 will receive a reduction of 4 percent per year from age 65 on both the 1.2 and the 1.7 portion of the retirement formula.
- Those ages 55 to 59 whose age plus years of vesting service total at least 85, will receive a reduction of 5 percent per year from age 60. This reduction applies to the 1.7 portion of the retirement formula only.

**Example:** Suppose you are vested and retire early (between 55 and 65), your age plus vesting service does not equal 85 and you are not age 62 or older with at least 10 years of vesting service, the monthly retirement income you would receive at age 65 is $1,000. If you defer your monthly payments until age 65, you would receive the full $1,000 per month. If you begin payments before age 65, your monthly income would be reduced by reduction factors related to your age.
Age and vesting service less than 85 and you are not age 62 or older with 10 years of vesting service

<table>
<thead>
<tr>
<th>AGE</th>
<th>PERCENTAGE</th>
<th>INCOME PER MONTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>100%</td>
<td>$1,000</td>
</tr>
<tr>
<td>64</td>
<td>96%</td>
<td>$960</td>
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<td>64%</td>
<td>$640</td>
</tr>
<tr>
<td>55</td>
<td>60%</td>
<td>$600</td>
</tr>
</tbody>
</table>

Age and vesting service equals 85 or more

<table>
<thead>
<tr>
<th>AGE</th>
<th>PERCENTAGE</th>
<th>INCOME PER MONTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>100%</td>
<td>$1,000</td>
</tr>
<tr>
<td>59</td>
<td>95%</td>
<td>$970 (est.)*</td>
</tr>
<tr>
<td>58</td>
<td>90%</td>
<td>$940 (est.)*</td>
</tr>
<tr>
<td>57</td>
<td>85%</td>
<td>$912 (est.)*</td>
</tr>
<tr>
<td>56</td>
<td>80%</td>
<td>$882 (est.)*</td>
</tr>
<tr>
<td>55</td>
<td>75%</td>
<td>$852 (est.)*</td>
</tr>
</tbody>
</table>

Any early retirement reduction is permanent and does not change once your monthly retirement income payments have started. *Early reduction factors are only applicable to .017 portion of annuity formula.

THE RULE OF 85

If you retire at or after age 60 and the sum of your age and the number of years of vesting service is equal to at least 85, or if you retire at age 62 with at least 10 years of vesting service, you will receive an unreduced early retirement benefit.

Examples:
- Age 60 with 25 or more years of vesting service
- Age 61 with 24 or more years of vesting service
- Age 62 with 10 or more years of vesting service
- Age 63 with 10 or more years of vesting service
- Age 64 with 10 or more years of vesting service

Retirement Benefit Options

When you retire, a number of options are available for payment of your retirement income benefits. You will be asked to select the option that will best suit your needs.

LIFE ONLY OPTION

This is the normal form of retirement benefit payment if you are unmarried. If you are married, your spouse's written consent is required for this option.

If you elect this option, no benefits are payable to any survivor unless the total of the monthly payments you receive before your death is less than your contributions to the plan, plus interest accumulated at your retirement date. In that event, the remainder of your contributions, plus interest, is payable to your named beneficiary or your estate in a lump sum.

JOINT AND SURVIVOR OPTIONS

The joint and 50 percent survivor option is the normal form of retirement benefit payment if you are married. Under this option, your monthly benefit is payable for your lifetime, with one-half of that amount payable to your spouse each month for his or her lifetime if you should die first. The reduction factors for the joint and survivor options will depend on the relationship of your
spouse’s age to your age. If both you and your spouse should die before your personal contributions have been paid to you and/or your spouse, the remainder, plus interest accumulated as of your retirement date, will be paid to your named beneficiary or to your estate in a lump sum.

“Spouse” refers to the spouse at the time of retirement. Effective beginning on June 26, 2013, for the purposes of the BSA Retirement Plan, the term “spouse” means an individual to whom you are legally married under the laws of the state in which you are married, regardless of the laws of the state in which you live. If you are married, your spouse’s written consent is required unless you elect a joint and survivor option of 50 percent or greater for you and your spouse.

You may also select a joint and 100 percent survivor option or any percentage of survivor option that you wish for you and a designated co-pensioner. The percentage elected determines the amount payable to your co-pensioner, if you should die first.

If you name a beneficiary other than your spouse as a co-pensioner, your spouse’s written consent is required for this option.

Example:
100 percent option: Your monthly benefit for your lifetime would be reduced from the life only benefit, and upon your death, your co-pensioner would receive that same monthly amount for his or her lifetime.

LEVELING OPTION

If you retire before you are eligible to receive Social Security benefits at age 62, you may elect to receive a higher monthly income from the plan until Social Security benefits may begin (at age 62) and a lower monthly income from the plan after they begin. The result of such an election is that your monthly income is relatively level. This method of payment may be elected in conjunction with any other option you elect.

120-MONTH CERTAIN OPTION

This option provides you with an income for the rest of your life, but the monthly benefit payment is slightly less than the life only benefit because it guarantees that 120 months of benefits will be paid. If you begin to receive your monthly payments and should die before 120 monthly payments have been made, your named beneficiary will receive the same monthly amount until the balance of the 120 monthly payments have been made. If your named beneficiary should die before the 120 monthly benefits payments have been made, the value of the remaining monthly payments will be paid to your named beneficiary or to your estate in a lump sum. If at least 120 payments have been made to you or to your named beneficiary after you die, no further payments are due. If you are married, your spouse’s written consent is required for this option.

OTHER OPTIONS

Lump sum payments are not available except for the refund of contributions plus interest for terminated employees or if the lifetime value of all benefits payable at the time that your employment ends is less than $1,000.

Retirement Plan Overview

APPLYING FOR BENEFITS

To apply for any plan benefit, you should request the necessary forms from the BSA Benefits Center at 800-444-4416 at least 60 days before you want your benefits to begin.

ELECTING AN OPTION

Forms for the election of the benefit option you choose should be returned to the BSA Benefits Center 30 days prior to the annuity commencement date.
You are only permitted to revoke your annuity payment option election until the later of your annuity starting date or seven days following the date on which you received the option election notice.

**Note:** If you or your co-pensioner should die after electing an option and before payments begin, the option will be canceled.

Once payments begin, the amount you receive will not be increased if your beneficiary or co-pensioner should die before you.

**APPEALING DENIED CLAIMS**

If your claim for a benefit is denied, the plan administrator will provide a written statement explaining why the request was denied, the plan section on which the denial is based, a description of any additional information needed to process your claim, and an explanation of the appeals procedures.

You may appeal the denial of your claim by sending a written request for appeal to the plan administrator within 60 days of the date your claim is denied. Your request must include your name, Social Security number, and work location, and must state the reasons you believe you are entitled to payment. You may include any documents or records that will support your appeal. You may inspect any plan documents which affect your claim. If you do not send your appeal within the 60-day period, no further action will be taken, and you cannot request an appeal later. Send your request to:

Boy Scouts of America  
HR Compensation and Benefits Department  
1325 West Walnut Hill Lane  
P.O. Box 152079  
Irving, TX 75015-2079

The plan administrator will review your claim and make a decision within 60 days. If additional time is needed, you will be notified during the initial 60-day period, and the plan administrator may take up to an additional 60 days to make a decision. If the plan administrator denies the claim, you will be notified of the specific reasons and the plan provisions upon which the decision is based. The decision of the plan administrator is final.

**SURVIVOR’S BENEFITS**

**Spouse’s benefit.** If you should die while actively employed by BSA or a local council or while eligible to receive benefits from the BSA Long-Term Disability Plan and before you begin receiving monthly retirement benefits under the plan, and you are married with five years of vesting service, your spouse will be paid a **monthly benefit** for the remainder of his or her life, beginning with the first day of the month following your death, as follows:

- If you are 50 or older and had at least five years of vesting service on the date of your death, your spouse’s **monthly benefit** will be equal to 50 percent of the monthly retirement income you had earned at your date of death. However, if your spouse is more than five years younger than you are, the monthly payment is reduced 2 percent for each additional year over five years.

- If you are younger than age 50 and had five years of vesting service on the date of your death, your spouse’s **monthly benefit** will be equal to 50 percent of the monthly retirement income you had earned at your date of death, reduced by the 50 percent joint and survivor factor, and reduced to reflect your age at the time of death.

In either case, your spouse has the option to withdraw the total amount of your personal contributions plus earned interest and still be eligible for a monthly income of $100 for the rest of his or her life.

**Death after normal or early retirement.** If you should die after you begin receiving your monthly retirement income, payments will be paid (or cease to be paid) according to the terms of the option you elected.

If you retired early but deferred receiving your monthly retirement income until a later date and should die before benefits begin, any option you may have elected will be canceled. If you are married, your spouse will have the same spouse’s benefit choices previously outlined.

If you are unmarried at the time of your death, your personal contributions, plus interest, will be paid to your named beneficiary or to your estate in a lump sum.

**Note:** If you should die and are not vested in the plan, your named beneficiary will be entitled to your personal contributions, plus interest, in a lump sum.
FUTURE OF THE PLAN

BSA expects to continue the plan indefinitely. Since future conditions cannot be foreseen, BSA reserves the right to amend or discontinue the plan at any time. If the plan were ever terminated, you would become fully vested in all benefits credited to you up to that date, to the extent then funded. The assets of the plan would be distributed in the order of priority set forth in the plan or as otherwise required.

WHEN YOUR EMPLOYMENT ENDS BEFORE RETIREMENT

WITH VESTING SERVICE

If you should leave BSA or a local council with five or more years of vesting service and younger than age 55, you will be eligible for deferred vested benefits. If you qualify, you must make one of the following choices:

- You may leave your personal contributions in the plan and begin receiving a monthly retirement income at age 65 based on formulas discussed previously.
- You may request a refund of your personal contributions plus interest in the form of a monthly annuity or a lump sum payment. If you elect a lump sum, for federal income tax purposes, you will not be taxed on the portion of your refund equal to your personal contributions. You will be taxed on the interest portion of your refund, unless you roll this portion into an IRA or other tax-qualified plan. If you withdraw your personal contributions and interest, your monthly retirement annuity will be less than if you had left your contributions in the plan. In a few cases, you may not be entitled to any deferred vested benefits because your personal contributions, plus interest, are as valuable as your total benefit. This could result from factors such as your age at termination, length of service, and compensation while a plan member.

If you are eligible for a deferred vested benefit, you may elect to begin receiving your retirement benefit any time after you reach age 55. However, the monthly income you otherwise would have received at age 65 will be reduced permanently by $6/2$ percent for each of the first five years before age 65 (age 60 to 65) and $3/2$ percent for each of the next five years (age 55 to 60).

Example

If your deferred vested benefit when you terminated would yield an income of $1,000 per month at age 65, and you decide to begin payments at age 55 (10 years early), your monthly income would be reduced 50 percent to $500 per month ($6/2$ percent reduction per year times five years for ages 60 through 65, plus $3/2$ percent reduction per year times five years for ages 55 to 60).

If you decide to wait until age 62 to begin payments, your monthly income would be reduced 20 percent to $800 per month ($6/2$ percent reduction per year times three years for ages 62 to 65).

Deferred Vested Factors

(Based on a deferred vested benefit of $1,000 at age 65)

<table>
<thead>
<tr>
<th>INCOME AGE</th>
<th>PERCENT-AGE</th>
<th>AMOUNT PER MONTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>100.0%</td>
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<td>50.0%</td>
<td>$500</td>
</tr>
</tbody>
</table>

At termination, you must decide whether to request a refund of your personal contributions or to leave them in the plan; but you do not need to decide when you wish to begin receiving the monthly income (after age 55), nor must you indicate under what option it will be paid.

If you die between the time your employment ends and before your retirement payments start, and both you and your spouse have not elected to waive the spousal benefit protection coverage, your spouse may immediately be eligible to begin monthly annuity payments. The spousal benefit protection coverage is equal to 50 percent of the member’s normal retirement allowance at the time of his or her death, reduced by early retirement factors.
**Without Vesting Service**

If you should leave BSA or a local council before age 65 with less than five years of vesting service, your personal contributions, plus interest, will be returned to you, but you will not be entitled to any other retirement benefit. For federal income tax purposes, the portion of your refund equal to your personal contributions will not be taxable, and the portion related to interest earned will be taxable. The interest rate on personal contributions is established annually according to federal regulations.

If your personal contributions, plus interest, total at least $1,000, you may elect to receive your contributions plus interest in the form of an annuity or a lump sum, or you may leave them in the plan to provide a retirement income, payable at age 65. However, you will not be entitled to any retirement benefit from employer contributions.

**Your Rights**

**ERISA INFORMATION AND NOTICE OF RIGHTS**

If you participate in the BSA Retirement Plan, you are entitled to certain rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Please refer to the Legal Notices chapter for more information.

**BENEFIT RESTRICTIONS**

There are various ERISA and Internal Revenue Code (IRC) restrictions on plan benefits. These include:

1. There is a life only maximum annual benefit that can be paid to any retiring member and an amount of compensation maximum that can be used in the plan formula. These restrictions will apply to only a very few plan members.

2. If the plan is terminated within 10 years after any benefit increase, certain highly compensated employees are subject to additional restrictions unless earned benefits for all members have been fully funded. At the time of this writing, all earned benefits were fully funded.

**LEGAL INFORMATION**

**Plan Identification Numbers and Sponsor**

The employer identification number assigned to Boy Scouts of America by the Internal Revenue Service is EIN 22-1576300. The number assigned to the plan by Boy Scouts of America is 001.

The plan is sponsored by:

- Boy Scouts of America
  1325 West Walnut Hill Lane
  P.O. Box 152079
  Irving, TX 75015-2079

BSA and its chartered local councils participate in the plan. You may request a complete list of employers participating in the plan by writing to the plan administrator. You also have the right to examine this list or to request the address of these separate employers.

**Plan Administrator**

The administrator of the plan is the Chief Scout Executive. The address and telephone number are:

- Boy Scouts of America
  1325 West Walnut Hill Lane
  P.O. Box 152079
  Irving, TX 75015-2079
  972-580-2000

The Chief Scout Executive is responsible for the overall administration of the plan.

In addition, the following administrative duties are assigned for plan purposes:

- Each local council Scout executive has the responsibility for maintaining proper records related to salaries, salary changes, and hours worked for all local council employees.
- The director of the Human Resources Administration Department has responsibility for handling contacts with employees, interpreting the provisions of the plan, computing benefits payable under the plan, and making judgments with respect to benefits.
The BSA Benefits Committee is responsible for reviewing and rendering a decision on benefit claims that are in dispute.

Legal process may be served on the Chief Scout Executive of Boy Scouts of America at the address on the preceding page, or on the plan's trustee. (See "Investment of Funds" below.)

A benefit under this plan will be paid only if the plan administrator determines that the member is entitled to such benefit.

The last day of the plan year is Jan. 31. However, some plan records are maintained on a calendar-year basis.

**Investment of Funds**

Contributions are held by a master trust entered into between Boy Scouts of America and the trustee, State Street Bank & Trust Company. The address of the trustee is:

State Street Financial Center  
One Lincoln Street  
Boston, MA 02111

Funds held in trust by the trustee are invested by investment managers appointed by the National Executive Board, upon the recommendation of the Pension Plan Investment Support Committee. The committee retains LCG Associates, Inc., a third-party investment consultant firm, as an investment consultant, to monitor the performance and to evaluate investment managers.

In addition, certain benefits are also paid by:

Metropolitan Life Insurance Company  
P.O. Box 14710  
Lexington, KY 40512-4710

No further contributions are being made to the Metropolitan Life Insurance Company, but some benefits earned before Nov. 1, 1959, are payable under a contract with Metropolitan Life Insurance Company.

**Plan Contributions**

The plan is a “defined benefit plan.” The costs of a defined benefit plan cannot be definitely determined because of uncertainties as to future happenings.

However, each year an independent firm of actuaries “values” the plan to determine the actuarially needed levels of contribution. At present, BSA and local councils contribute regularly to the plan's trust to maintain the plan on a sound actuarial basis and to pay for the expenses of administering the plan.

If the valuations by the independent actuaries should so determine, the present rate of contributions could be increased or decreased. Your contributions are also added to the trust fund.

**Pension Benefit Guaranty Corporation**

Your plan benefits are insured by the Pension Benefit Guaranty Corporation (PBCG), a federal insurance agency. If the plan terminates without enough money to pay all benefits, the PBCG will step in to pay pension benefits. Most people receive all of the pension benefits they would be entitled to receive under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of the benefit increases and new benefits based on plan provisions that have been in place for fewer than five years at the time the plan terminates; (3) benefits that are not vested because you have not completed the vesting service requirement; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for social security) that result in an early retirement monthly income greater than your monthly retirement income at normal retirement age; and (6) certain non-pension benefits.
Even if certain of your benefits are not guaranteed, you may still receive some of those benefits from the PBGC depending on how much money the plan has and how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division, 1200 K St. N.W., Suite 930, Washington, D.C. 20005-4026, or call 202-236-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 800-877-8339 and ask to be connected to 202-236-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website at www.pbgc.gov.
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Although not a BSA-sponsored benefit, BSA employees may elect to make payroll-deducted pre-tax contributions to a tax-deferred annuity (TDA) described in Internal Revenue Code section 403(b).

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**Eligibility**

You may begin to contribute to a TDA program immediately upon employment with BSA.

**TDA Programs**

Two TDA programs are available to employees of BSA. Local council employees should contact their employer to find out if they offer any similar program. These programs offer the opportunity for you, through salary reduction, to supplement the BSA Retirement Plan and to realize a tax savings while employed. These TDA programs are provided through Mutual of America Life Insurance Company and Fidelity Investments.

Both programs allow you to place pre-tax dollars in an annuity program in which you are immediately vested. The minimum salary reduction is $10 per pay period. The maximum reduction amount is governed by the Internal Revenue Code. The maximum limit for 2015 is $18,000 for the combined contributions to all 403(b) plans.

Under the present provisions of the Internal Revenue Code, the contributions and earnings credited to your TDA account are not currently includable in your income for federal income tax purposes. Amounts withdrawn or distributed to you from your TDA will normally be includable in your gross income for federal income tax purposes when and as received.

The amount you put into the program or programs you choose reduces your salary for federal income tax reporting but does not reduce the salary on which group life insurance, the basic retirement plan, Social Security, and long-term disability benefits are based.

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**Tax-deferred Annuity Program Overview**

**FUNDS**

**FIDELITY INVESTMENTS**

Fidelity Investments offers a wide selection of funds. For a complete listing of the funds available, informational material, or account information, call Fidelity’s Retirement Services at 800-343-0860.

A prospectus for any of Fidelity’s investment funds may be requested from a Fidelity representative and should be read carefully. Due to market fluctuations, historical performance is not an indication of future returns.

**MUTUAL OF AMERICA LIFE INSURANCE COMPANY**

Mutual of America offers a wide selection of funds. A prospectus for any of its offerings may be requested and should be read carefully. For a complete listing of the funds available, material information, or account information, call 800-468-3785.

**HOW YOUR TDA GROWS**

Assume that you are investing $100 per month into your TDA. This example illustrates three different interest growth rates.
**Tax-deferred Annuity**

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<td>135,268</td>
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</table>

**Withdrawals**

Contributions, interest, and investment earnings credited to your account after Dec. 31, 1988, may not be withdrawn before you reach age 59½ unless you have separated from service or because of death, disability, or financial hardship. In the case of financial hardship, only contributions are available, not earnings.

A “financial hardship” is generally defined as a heavy and immediate financial need for funds that cannot be obtained from other sources. Some examples of hardship situations include the purchase of a primary residence, certain tuition expenses, and un-reimbursed medical expenses.

Before you can qualify for a hardship withdrawal, you may be required to provide proof that other resources, such as loans and asset liquidations, are not available to meet the need.

Generally a federal tax penalty applies to withdrawals made before age 59½. Some exceptions may apply, such as disability withdrawals, a separation from service after attainment of age 55, and the distribution of a life annuity benefit.

Distribution forms may be obtained by calling Mutual of America at 800-468-3785, or Fidelity Investments at 800-343-0860.

**Transfers**

TDA plan participants may transfer all or part of their TDA account in accordance with the procedures established by the TDA company. Information with respect to transferring to other funds may be obtained by calling Mutual of America at 800-468-3785, or Fidelity Investments at 800-343-0860.

**Catch-up Provision**

Employees who are age 50 or older are allowed to make pre-tax catch-up contributions to tax-deferred annuity plans in accordance with federal regulations. The maximum catch-up contribution limit is $6,000 for 2015.

**Beneficiary and Retirement Options**

Various options for the payment of your accumulated account are available, if payment is made to you at retirement or to your beneficiary, should you die before retirement.

Your right to withdraw amounts from your account balance may be restricted by federal law.

**Administrative Fees**

An administrative fee is determined annually by the TDA company. For more information on administrative charges, call Mutual of America at 800-468-3785, or Fidelity Investments at 800-343-0860.
BSA 403(B) THRIFT Plan
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The BSA 403(b) Thrift Plan can help you prepare for a financially secure retirement. This plan is available to employees of BSA. Check to see if your local council offers this plan.

**Eligibility**

If you are employed with BSA or a participating local council, you become eligible to participate in the BSA Thrift Plan when you are at least 21 years old and have completed at least one year of service. You will be credited with one year of service at the end of your first year of employment (or at the end of any calendar year that begins after your initial employment date) if you have been credited with at least 1,000 hours of service during the prior 12-month period.

If you do not work at least 1,000 hours in your first year of employment, you will become eligible at the end of any calendar year in which you work 1,000 hours. Participation may begin the first day of any month once you have satisfied these eligibility requirements. Once you are eligible, you may continue to participate while employed, even though you may work less than 1,000 hours in the years following.

If you do not join the plan when you first become eligible, you may join at a later date.

This plan does not cover leased employees or independent contractors.

**Enrollment**

To enroll, go to [http://bsabenefits.mercerhrs.com](http://bsabenefits.mercerhrs.com) or call the BSA Benefits Center at 800-444-4416.

If you are first hired on or after July 1, 2008, and do not make an election to either enroll or decline participation in the plan, you will be deemed to have entered into a compensation reduction agreement authorizing your council to make pre-tax contributions of 3 percent of your compensation to the plan. You may choose to change or discontinue your contributions at any time.

**Contributions**

Contributions to your Thrift Plan account come from two sources: you and your employer (BSA or your local council).

**Your Contributions**

You authorize pre-tax payroll deductions to make your contributions. You can save a set dollar amount (not less than $10) from each paycheck. Or, you can save from 1 percent to 50 percent of your compensation, up to the federal income tax limit, which is $18,000 for 2015. If you are 50 years of age or older, you can also contribute an additional $6,000 in 2015 to all 403(b) plans combined.

“Compensation” means your total salary and wages. This includes base salary, overtime, and bonuses before any payroll deductions.

You may stop, start, increase, or decrease your payroll deduction at any time. This can be done at [http://bsabenefits.mercerhrs.com](http://bsabenefits.mercerhrs.com) or by calling the BSA Benefits Center.
Matching Contributions

Your employer adds a 50-cent matching contribution to every dollar up to 6 percent of your pay you contribute each pay period. This means as much as 3 percent of your pay can be added to your retirement savings every year through matching contributions.

Ownership of Money in the Plan

You are 100 percent vested upon enrollment in the plan. This means all contributions and earnings thereon are yours, regardless of their source.

Limits on Pre-Tax Contributions

The Internal Revenue Code (IRC) limits your annual pre-tax savings. This limit, which is subject to certain annual adjustments, limits the total amount of money that can be contributed annually for an individual to any combination of plans like this one.

The IRC also limits the amount of matching contributions highly compensated employees may receive under the plan. You will be notified if any of these limits affect you.

Thrift Plan Overview

Investing Your Savings

Your retirement savings grow as you add money and as BSA or your local council contributes matching funds. Your savings can grow even more because all plan money is invested. How much your money grows depends on your choice of investment options.

Investment Options

The Thrift Plan offers many investment funds in which you can invest your savings. The funds represent investment strategies from the most conservative to the most aggressive. Each has a different degree of potential risk and return on your money. You can place all your money in one of the funds or spread it among some or all of the funds.

The plan is designed to be a plan described in section 404(c) of the Employee Retirement Income Security Act of 1974, as amended. Under the plan, you are responsible for directing the investment of the amounts credited to your account, and the plan fiduciaries and administrators are not responsible or liable for any losses which result from your investment directions.

Although the specific mutual funds offered might change from time to time, there will always be a broad range of investment strategies represented. Specific information about each fund that is currently offered is in your Fidelity Investments enrollment package. You will also receive information about investing that could be useful in making your investment choices.

Managing Your Investment

The value of your Thrift Plan account, including all contributions, earnings, and losses (if any), is determined at the end of each business day based on the fair market value of the investment funds you select.

Because of daily valuation, you can make changes in your investments as often as you wish. Simply call Fidelity Investments or visit their website at www.fidelity.com to:

- Move your savings from one fund to another
- Change the percentage allocation among funds

To help you keep track of your investments and how they are performing, you will receive a statement that will provide information on all activity in your account during the quarter, your gains or losses in each investment option, and the total value of your account. You can get similar information between reports by calling Fidelity or visiting Fidelity online.

Beneficiary

After you enroll, you will be asked to name a beneficiary—someone who will receive plan benefits if you die. If you want to name someone other than your spouse as your beneficiary, your spouse must sign a special consent form. You may change your beneficiary at any time by submitting a new form, but if you are married, your spouse must approve any changes.
LOANS AND WITHDRAWALS

The purpose of the Thrift Plan is to help you save for retirement. However, in some situations you may need part of your money before you retire. While you are working for a participating employer, you may be eligible to obtain a loan from your account or request a withdrawal.

**Loans** are temporary withdrawals from your account that you must repay. When you take a plan loan, you are really borrowing money from yourself at a reasonable rate of interest, and then paying both principal and interest to yourself instead of to some other lender. You do not pay taxes on the amount of your loan if you repay it according to the terms of the loan agreement.

**Withdrawals** are permanent distributions from your account. They are carefully regulated under the IRC, and it is difficult to qualify for one. Withdrawals are subject to income taxes and possible additional penalty taxes.

**Loans**

The minimum loan amount is $1,000. There is a $35 loan fee. You can only have one loan outstanding at any time.

You can take two types of loans from the plan.

1. **A home purchase loan** must be used to buy your principal residence. You may take up to 10 years to repay a home purchase loan.

2. **A general purpose loan** can be used for anything you choose. You may take up to five years to repay this type of loan.

The IRC limits the maximum amount available for a loan from the Thrift Plan. You may borrow the lesser of:
- 50 percent of your account balance
- $50,000 minus the highest outstanding loan balance you had during the previous 12 months from the plan and all other such plans

You may request a loan application by contacting Fidelity Investments at 800-343-0860. After receiving, reviewing, and signing the form, you must forward it to the HR Compensation and Benefits Department for approval.

Your loan interest rate is determined at the time you apply for the loan. The interest rate in effect at the time of your loan application will be fixed for the duration of your loan.

You repay your loan, including principal plus interest, in equal installments. Payments are made over the length of time approved for the loan. The money sent to repay your loan will be deposited into your plan account. These payments are invested in the same portions and funds that you have chosen for your employee pre-tax contributions.

**Withdrawals**

To ensure that your savings are used for retirement income, the IRC limits how and when you can permanently withdraw money from your account.

You may make two types of withdrawals prior to your retirement:

**In-service withdrawals after age 59½.** You may withdraw from your account in any amount and for any purpose once you reach age 59½. Your withdrawals will be ordinary income subject to federal income tax.

**Hardship withdrawals.** Before you reach age 59½, you may withdraw your own contributions from your account balance only when a financial hardship arises. The IRC regulations define “financial hardship” as an immediate and heavy financial need due **only** to the following conditions:
- Payment of medical expenses for you, your spouse, or your dependents
- Costs directly related to the purchase of your principal residence (excluding mortgage payments)
- Payment of tuition and related educational fees for the next 12 months of post high-school education for you, your spouse, or your dependents
- Payment to prevent eviction from your principal residence or foreclosure on the mortgage of your principal residence

You must have used up all other sources of income before you can take a withdrawal to meet these hardship needs. If you are eligible for a loan from this plan or any other plan, you must borrow the maximum allowable from all of your accounts before you will be considered for a hardship withdrawal.
The withdrawal cannot be more than the amount needed to meet the expense—plus amounts necessary to pay any applicable taxes or penalties on the withdrawal—after all other sources have been tapped.

If you make a hardship withdrawal from your account, you will not be allowed to make pre-tax payroll contributions to this plan or any other plan for six months. Contributions during the calendar year immediately following the calendar year of the withdrawal may also be limited.

If you take a withdrawal, the Internal Revenue Service will consider your money taxable income. Depending on the situation, federal law may require automatic tax withholding of a portion of your withdrawal, and you may be required to complete a form that would authorize tax withholding of up to 20 percent. You may also owe an early payout penalty tax of 10 percent if you are under age 59½.

Tax laws are complicated and change frequently. Be sure you receive accurate, current information. Consult a qualified tax expert before receiving a withdrawal from this plan.

**PAYMENT OF PLAN BENEFITS**

Your total account balance may be paid to you in a single lump sum after your employment ends for any reason, including retirement. Money can be distributed to you only after you have completed and returned all required forms.

If the value of your account is more than $1,000 when your employment ends, you may choose to:

- Receive payment right away after your termination date, or
- Authorize direct rollover of your account’s value into another qualifying plan, or
- Leave your savings invested in the plan until you request payment. In this case, you continue to choose how the money in your account is invested.

If you continue working for a participating employer beyond age 65, you may continue participating in the plan and defer taking a distribution for as long as you remain an active employee.

The full value of your account balance will be paid to you in a lump sum if it is less than $1,000 when your employment ends. Contact Fidelity Investments at 800-343-0860 to request a distribution from your account. Complete the form in accordance with instructions from Fidelity Investments and mail it to the Retirement Department at the national office for approval.

Payments are made as soon as administratively possible after you request distribution of your account or after the date the plan is required to pay out a distribution automatically.

**TAXES ON YOUR BENEFIT**

If you receive a lump-sum payment from the plan, you will owe income taxes on the full amount. By law, 20 percent must be withheld from the distribution check, and you may also have to pay a 10 percent penalty tax if you are taking an early payout (prior to your retirement). The penalty tax does not apply in the event of your death, disability, termination of employment after age 55, or if you make a withdrawal or receive a distribution from the plan after you reach age 59½.

You can avoid immediate withholding and the penalty tax if you roll over your account directly into an Individual Retirement Account (IRA) or another qualified plan. Check with the receiving IRA provider or savings plan sponsor for “direct rollover” instructions.

If you have not fully repaid a loan that you took from the plan, the amount you owe will be considered in default and reported as taxable income. To avoid this situation, you have up to 60 days after your termination date to repay your loan.

Before you may take a distribution or withdrawal from the plan, federal law requires that a special tax notice explaining the taxability of your payment must be provided to you. You must receive this notice no more than 90 days before your request for a distribution or withdrawal is processed.
ADDITIONAL INFORMATION

Some circumstances could affect your Thrift Plan benefits.

- To avoid delay of payment to you or your beneficiary, you should keep updated addresses on file with the plan administrator.
- If you reach the IRC limit for annual pre-tax contributions to your account, your payroll deductions will stop.
- The plan administrator makes every effort to ensure that all records are correct, but reserves the right to correct any error that might occur.
- If you divorce or separate, certain court orders could require that part of your benefit be paid to someone else. This is called a qualified domestic relations order (QDRO). As soon as you are aware of any court proceedings that may affect your plan benefits, call the Retirement Department.
- Your benefit under the plan belongs to you (or your beneficiary) and generally may not be sold, assigned, transferred, pledged, or garnished, except under a QDRO or an enforceable tax levy by the Internal Revenue Service.
- Nothing in this explanation or in the official plan document promises or implies a guarantee of continued employment with a participating employer.
- The BSA and local councils that are participating in the BSA 403(b) Thrift Plan intend to continue offering the Thrift Plan. However, the plan can be changed, suspended, or amended by the BSA at any time. Benefits may be discontinued at any time for any group of participants. As required by law, you will be notified if any material changes are made to the plan.
- BSA and your local council intend to comply with all applicable laws and regulations. If any provision described in this section becomes contrary to such laws or regulations, the provision should be considered changed to the extent necessary to comply with the law.
- Each plan provision is independent and does not affect the validity of any other plan provision. If any provision is found to be invalid or unenforceable, the remaining plan provisions remain fully effective.

- The plan is a defined contribution plan. Your benefits under the plan depend solely upon the value of your account as invested in accordance with your directions, and plan benefits are not insured by the Pension Benefit Guaranty Corporation under the provisions of Title IV of the Employee Retirement Income Security Act of 1974, as amended.

Claims

APPEALING A CLAIM DECISION

If your claim for a distribution is denied, the plan administrator will provide a written statement explaining why the request was denied, the plan section on which the denial is based, a description of any additional information needed to process your claim, and an explanation of the appeals procedures.

You may appeal the denial of your claim by sending a written request for appeal to the plan administrator within 60 days of the date your claim is denied. Your request must include your name, Social Security number, and work location, and must state the reasons you believe you are entitled to payment. You may include any documents or records that will support your appeal. You may inspect any plan documents which affect your claim. If you do not send your appeal within the 60-day period, no further action will be taken, and you cannot request an appeal later. Send your request to:

Boy Scouts of America
HR Compensation and Benefits Department
1325 West Walnut Hill Lane
P.O. Box 152079
Irving, TX 75015-2079

The plan administrator will review your claim and make a decision within 60 days. If additional time is needed, you will be notified during the initial 60-day period, and the plan administrator may take up to an additional 60 days to make a decision. If the plan administrator denies the claim, you will be notified of the specific reasons and the plan provisions upon which the decision is based. The decision of the plan administrator is final.
Your Rights

ERISA INFORMATION AND NOTICE OF RIGHTS

If you participate in the BSA Thrift Plan, you are entitled to certain rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Refer to the Legal Notices chapter for more information.

LEGAL INFORMATION

PLAN IDENTIFICATION NUMBERS AND SPONSOR

The employer identification number assigned to Boy Scouts of America by the Internal Revenue Service is EIN 22-1576300. The number assigned to the plan by Boy Scouts of America is 002.

The plan is sponsored by:

Boy Scouts of America
1325 West Walnut Hill Lane
P.O. Box 152079
Irving, TX 75015-2079
Telephone: 972-580-2000

Boy Scouts of America is the plan administrator of the plan. Service of legal process for the plan may be made upon the plan administrator at the foregoing address. A list of the local councils participating in the plan may be obtained from the plan administrator upon request.
125 Plan

Boy Scouts of America has established the 125 Premium Only Plan (POP). This plan is governed by Section 125 of the Internal Revenue Code.

The POP allows active employees to reduce their taxable income. It does this by subtracting your cost for coverage under certain BSA benefit plans from your salary before taxes are calculated. This salary reduction cannot change during the plan year unless you have a qualifying life event.

These plans are eligible for the POP:

- Medical
- Dental Assistance
- Vision Care
- Optional Life Insurance
- Accidental Death and Dismemberment (AD&D)
- Scout Executives’ Alliance

The BSA Dependent Life and Long-Term Disability plans are not included in the POP.

ELIGIBILITY

You may enroll in the POP immediately upon your employment with BSA or a local council in a position that is eligible for benefits.

ENROLLMENT PERIOD

You have 30 days from the date you are employed in an eligible position to enroll.

If you do not want to change your election for the next plan year, it is not necessary to re-enroll each year. Your election will continue unless you change it during the annual enrollment period.

Enrollment after the end of the applicable enrollment period will not be accepted and deductions will be post-tax.

125 PLAN OVERVIEW

Plan Year

The plan year for the POP is the calendar year (Jan. 1 through Dec. 31).

Benefit

Under the POP, your salary will be reduced before taxes are withheld. It will be equal to the required contributions for the coverage you elected under the BSA Medical, Dental, Vision, Optional Life, and AD&D plans and the Scout Executives’ Alliance.

CHANGING YOUR ELECTIONS

Qualifying Life Events

Once you complete enrollment, you cannot change your election (the amount of your salary reduction) during the plan year unless you have a qualifying life event or meet other conditions as prescribed by law. Otherwise you may change your election during the annual enrollment period.

Any change you make must be consistent with your qualifying life event. For example, if you legally adopt a child and elect coverage for medical and dental, you may change your POP election to reflect this change. However, this would not allow you to add or drop your spouse from the coverage because you adopted a child.

Another example: A dependent child reaches age 26 and is therefore no longer eligible for coverage under the BSA benefits program. You may change your POP election to no longer cover the over-age dependent, but the change would not allow you to drop any coverage for your spouse.

A qualifying life event occurs under the POP only in the following instances:

- Your marriage
- Your divorce or annulment of a marriage
- Birth of your child
- Your legal adoption or placement for legal adoption of a child
- Termination of your employment
- Termination or commencement of your spouse’s or dependent’s employment that changes their eligibility for health-care coverage through that employer
• A reduction or increase in the hours of employment by you, your spouse, or your dependent (including the commencement of or return from an unpaid leave of absence) that changes their eligibility for health-care coverage through that employer.
• Death of your spouse or dependent.
• Entitlement or loss of entitlement to Medicare.
• Entitlement or loss of entitlement to Medicaid or Children’s Health Insurance Program (CHIP) coverage.
• Eligibility for a premium assistance subsidy under Medicaid or CHIP.
• Circumstances requiring a special enrollment period, as described on page 7.
• Dependent who no longer meets the eligibility requirements.
• A judgment decree or order resulting from a divorce, annulment, or change in legal custody (including a qualified medical child support order [QMCSO]).

Qualifying life events apply only to adding or dropping dependents outside of the annual enrollment period. You cannot change your medical plan election as the result of a qualifying life event.

Please note that completing your enrollment incorrectly, forgetting to enroll or change your election, or being unable to continue paying for your benefits are not qualifying life events and do not permit you to change your benefits elections outside of the annual enrollment period.

When a Qualifying Life Event Occurs

If you have a qualifying life event, you will need to contact the BSA Benefits Center within 30 days of the date the life event occurred. This includes birth or adoption of a child even if you already have family coverage. You may reach the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com. Proof of the life event may be requested at any time.

After 30 days, you cannot make a change in your election until the next annual enrollment period.

The following events will also be considered a change in family status:
• Termination of your or your dependent’s Medicaid or Children’s Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the BSA Benefits Center within 60 days of termination).
• You or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the BSA Benefits Center within 60 days of determination of subsidy eligibility).

Other Qualifying Circumstances

You may also change or revoke your election in the following instances:
• If coverage provided under any of the insured benefit plans eligible for the POP is significantly curtailed or terminated, you will be allowed to revoke your POP election and elect coverage offered by BSA or your local council under another related benefit plan providing similar coverage, if any.
• If your employment is terminated, you will no longer be eligible to participate in this plan and your election to participate will automatically terminate. If you become a participant in this plan again within 30 days of the date you stopped being a participant and before the end of the same plan year, the elections you previously had in effect will automatically be reinstated for the balance of the plan year.
• If your employment is terminated, you may revoke your election for the remaining portion of the plan year. If you return to work for BSA or a local council before the end of that plan year, you cannot make a new election for the remainder of that plan year.

For example, assume you elected not to make pretax contributions. Your employment is terminated on March 5. You are then re-employed with BSA or a local council on Aug. 20. Your contributions will be deducted after taxes for the remainder of the plan year; i.e., you cannot elect to have them deducted before taxes.
• If the cost of any of the insured benefit plans eligible for the POP increases or decreases during a plan year, this plan may, on a reasonable and consistent basis, automatically increase or decrease all affected participants’ required contributions under the POP.

If the contribution amount for an insured benefit plan increases significantly, the POP may permit participants to change their election under the plan accordingly, or to revoke such election and receive coverage under another related benefit plan offered by BSA or a local council providing similar coverage, if any.
YOUR RIGHTS

ERISA Information And Notice Of Rights

If you participate in the POP, you are entitled to certain rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Please refer to the next section of this chapter for more information.

Plan Administration

Boy Scouts of America will administer the terms of this plan. In doing so, BSA may use discretion in determining eligibility for benefits and in construing the terms of the plan.

125 Plan Supplement for Certain Massachusetts Employees

(Effective July 1, 2007)

This plan description provides an overview of the requirements for participation in the Boy Scouts of America Premium Only Plan through the 125 Plan Supplement for Certain Massachusetts Employees and is intended to be a brief summary. The Boy Scouts of America Premium Only Plan is governed by a formal plan document. If there are any differences between this summary and the official plan document, the plan document will govern.

Boy Scouts of America has amended the Boy Scouts of America Premium Only Plan by adding the 125 Plan Supplement for Certain Massachusetts Employees (together, “the plan”) under which you may pay medical care coverage premiums for coverage you purchase through the Commonwealth Health Insurance Connector Authority (“the connector”) on a pre-tax basis. You may be eligible for favorable tax treatment of your medical care coverage premiums even though you are not eligible for medical care coverage through your employer. Your participation in this plan is completely voluntary.

PARTICIPATION IN THE PLAN

Under the plan, you may choose to receive your entire compensation in cash or use a portion of it to pay for certain medical care coverage premiums (See “Medical Care Coverage” below). When you elect to pay for your medical care coverage premiums, your regular compensation will be reduced on a pre-tax basis by the amount of your premium payment for the coverage you have selected. This means that you will pay less in taxes each year.

Note: If you decide to pay for medical care coverage using pre-tax income, the amount withheld from your pay will not be subject to federal income or Social Security (“FICA”) taxes. This could result in a reduction in the Social Security benefits you receive at retirement if you earn less than the “taxable wage base.” The taxable wage base for 2013 is $113,700 and is adjusted annually. The tax advantages you gain by paying your medical care coverage premiums with pre-tax income may, however, offset any possible reduction in Social Security benefits, and you should consult a tax adviser to determine whether in your situation the benefits achieved outweigh any potential reduction of Social Security benefits.

MEDICAL CARE COVERAGE

You can use pre-tax dollars to purchase any medical care coverage that has been granted the seal of approval by the connector. This coverage is not offered through this plan or through your employer, is not endorsed by your employer, and is not a part of your employer’s benefit program. Your eligibility for the medical care coverage is determined by the connector and the applicable insurance carrier.

Additionally, although the connector has granted its seal of approval to these medical care coverage options, coverage is provided by the insurance carrier issuing the applicable medical insurance policy. Neither the connector nor your employer has any liability for any benefits due, or alleged to be due, under any such medical insurance policies.
ELIGIBILITY

You are eligible to participate in this plan if you are a Massachusetts-based employee of the Boy Scouts of America or one of its affiliates that has adopted this plan (“the employer”), and you are not an “excluded employee.”

You are an “excluded employee” if you are any of the following:

- Eligible to participate in the Boy Scouts of America Premium Only Plan
- Less than 18 years of age
- A temporary employee (meaning your employment is explicitly temporary in nature and does not exceed 12 consecutive weeks during the period from Oct. 1 through Sept. 30)
- Regularly scheduled to work fewer than 64 hours per month (approximately 15 hours per week)
- A student employee employed as an intern or a cooperative education student worker
- A seasonal employee who is an international worker with either a U.S. J-1 student visa or a U.S. H2B visa and you have travel health insurance

ELECTING TO PARTICIPATE IN THE PLAN

If you are eligible to participate in the plan and you wish to use pre-tax dollars to pay for medical care coverage offered through the connector, you must complete a Participation Election Form within 30 days following the date you become eligible. You will also need to select a medical care coverage plan and complete an enrollment form. This must be done through the connector. More than one method of enrollment may be available, such as a written enrollment form, electronic enrollment on a website, or via telephone. For more information on medical care coverage options offered through the connector and/or to enroll in medical care coverage, please visit the connector’s website at www.mahealthconnector.org.

Your election under the plan will be effective as soon as administratively practicable and will remain in effect until you cancel it or you otherwise become ineligible to participate in the plan.

If you are eligible to participate in the plan but you decide not to use pre-tax dollars to pay for medical care coverage, or you do not enroll in medical care coverage within 30 days following the date you become eligible, you will be deemed to be a participant in the plan who has elected the cash option. This means that, absent a change in status event (described in the next section below), you will not be able to elect to use pre-tax dollars to purchase medical care coverage until the plan’s next annual enrollment period.

Before the start of each plan year, you will be offered an annual enrollment period to change your existing election. The plan year is the same as the calendar year. If you do not make a new election, your existing election will remain in effect.

CHANGING YOUR ELECTION

Generally, you cannot change the elections you have made under the plan after the beginning of the plan year. However, you are permitted to change certain elections if you experience a “change in status” as defined by regulations issued by the Internal Revenue Service or other special events as described below.

These are some examples of status changes:

- Marriage
- Divorce, legal separation, or annulment
- Death of your spouse or dependent child
- Birth, adoption, or placement for adoption of a child
- Termination of the employment of your spouse or dependent child
- Commencement of the employment of your spouse or dependent child
- Your or your spouse’s or dependent child’s commencement of or return from an unpaid leave of absence from employment
- Adjustment to your or your spouse’s or dependent child’s work schedule, such as a switch between part-time and full-time work, a strike, a lockout, or an increase or reduction in hours of employment that causes a loss of coverage
- A change in your or your spouse’s or dependent child’s worksite or residence that causes a loss of current coverage eligibility
• Adjustments in dependent status through satisfying or ceasing to satisfy the age, student status, or other requirements to qualify as a dependent under the plan
• Significant change in your or your spouse’s health coverage attributable to the spouse’s employment
• Leave of absence under the Family Medical and Leave Act

Your election may also be changed if one of these special events occurs:
• The issuance of a judgment, decree, or order that requires accident or health coverage for your dependent child
• Your or your spouse’s or dependent child’s entitlement to Medicare or Medicaid that causes a loss of coverage
• A significant increase in the cost of any benefit under the plan
• Elimination or significant cutback in coverage provided by an insurance company or other third party (You may cancel your election and receive coverage under a similar plan, provided both plans agree to make the change.)
• Your separation from service (If you terminate employment, your election will be terminated.)

If you have a status change and/or other special event and you want to cancel or modify your election for the remainder of a plan year, you must file a request with your employer within 30 days of the event. Keep in mind that any change to your election must be consistent with your status change. Your employer will consider your application and inform you of the decision.

Any change request received more than 30 days after the date the event occurred will not be processed. To make the change after this 30-day period, you will have to wait until the next annual enrollment period or a subsequent status change event, whichever occurs sooner.

INDIVIDUALS NOT COVERED BY THIS PLAN

There are certain instances where an individual is a dependent for medical care coverage purposes but may not be your dependent for purposes of this plan. For example, if you cannot claim the individual as a dependent on your federal income tax return, but the individual is eligible for coverage under your medical care coverage, the value of the medical coverage for this individual must be paid on an after-tax basis. In addition, domestic partners and same-sex spouses are not eligible for the favorable tax treatment unless you can claim them as dependents on your federal income tax return.

PARTICIPATION WHILE ON LEAVE

If you take a leave of absence for your own serious health condition or to care for family members with a serious health condition or to care for a newborn or adopted child, you may be able to revoke your election. If you revoke your election, you may also reinstate your election when you return to work. See your employer for more information about your rights.

TERMINATION OF EMPLOYMENT

If you stop working for your employer, you will no longer be eligible to participate in this plan and your election to participate will automatically terminate. This means that your medical care coverage premiums payable after you stop working for your employer will be paid for on an after-tax basis (unless you subsequently become employed and enroll in another employer’s “cafeteria” plan). If you become a participant in this plan again within 30 days of the date you stopped being a participant and before the end of the same plan year, the elections you previously had in effect will automatically be reinstated for the balance of the plan year.

Keep in mind that your termination of employment does not affect your underlying medical care coverage. You can keep your medical care coverage in effect by simply continuing to make the required monthly premium contributions by sending after-tax payment directly to the connector by the applicable due date.
ERISA Information and Notice of Rights

The following information and notice of rights and protections is furnished by the plan administrator as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

This summary plan description is expressly made part of the plan and is legally enforceable as part of the plan with respect to its terms and conditions. In the event there is no other plan document, this document shall serve as a summary plan description and shall constitute the plan.

A. Termination or Amendment of the Plan

The plan sponsor may terminate the plan, in whole or in part, at any time. Benefits under the plan are limited to its terms, including any valid amendment. The plan sponsor may change the plan in whole or in part, at any time and for any reason.

B. Statement of Your Rights Under ERISA

1. Right to Examine Plan Documents

You have the right to examine all plan documents, including any insurance contracts or collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration. These documents may be examined free of charge at the plan administrator's office.

2. Right to Obtain Copies of Plan Documents

You have the right to obtain copies of all plan documents, including any collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and updated summary plan description upon written request to the plan administrator. The plan administrator may make a reasonable charge for these copies.

3. Right to Receive a Copy of Annual Report

The plan administrator must give you a copy of the plan's summary annual financial report, if the plan was required to file an annual report. There will be no charge for the report.

4. Right to Review of Denied Claims

If your claim for a plan benefit is denied or ignored, in whole or in part, you have the right: a) to know why this was done; b) to obtain copies of documents relating to the decision, without charge; and c) to have your claim reviewed and reconsidered, all within certain time schedules.

C. Obligations of Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate the plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of all plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

D. Enforcing ERISA Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request 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 plan administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or 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.

E. Plan and ERISA Questions

If you have any questions about the plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution 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 Employee Benefits Security Administration.
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## BENEFIT PLAN INFORMATION

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| Employer ID Number | 22-1576300 |

| Policy/Contract Number | 1136003-G | 586528 | 594664 | 2136003 | GA-136003 | 12003918 | 93215 | 95721 | 100336 |

| Plan Year | Jan. 1–Dec. 31 |


| Source of Contributions | Employee and/or Employer |

| Plan Administrator and Sponsor | Boy Scouts of America, 1325 West Walnut Hill Lane, Irving, TX 75038 |

| Agent for Service of Legal Process for Disputes Arising Under This Plan | MetLife Group Claims P.O. Box 6100 Scranton, PA 18505-6100 | MetLife Group Disability Unit P.O. Box 14590 Lexington, KY 40511 | MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 | UnitedHealthcare (also known as UnitedHealthcare Services Inc.) 185 Asylum St. Hartford, CT 06103-3408 | Vision Service Plan 3333 Quality Dr. Rancho Cordova, CA 95670 | MetLife Group Claims P.O. Box 6100 Scranton, PA 18505-6100 |
Health Insurance Portability and Accountability Act (HIPAA)

Privacy of Your Information

How Boy Scouts of America May Use Your Health Information

Boy Scouts of America (BSA), as the plan sponsor of the Group Health Plans (the Plans) listed below, may use and disclose your personal medical information (also called Protected Health Information or PHI) it receives from the plans as permitted and/or required by, and consistent with the federal HIPAA Privacy and Security regulations found at 45 CFR Parts 160 and 164. This includes, but is not limited to, the right to use and disclose a participant’s PHI (including electronic PHI) in connection with your health-care treatment, the payment of your health-care claims, and the health-care operations of the plans.

The BSA Group Health Plans include:
- BSA Medical Plan
- Dental Assistance Plan
- Vision Care Plan
- Employee Assistance Plan (EAP)

This applies to:

The HIPAA information in this chapter applies only to health-related benefit plans. For the plans listed above, only health-related benefits, including medical, dental, vision, prescription drug, mental health, and EAP benefits, are subject to the HIPAA information in this chapter.

This does not apply to:

By law, the HIPAA privacy rules and information in this chapter, do not apply to these benefit plans:
- Disability plans (short-term and long-term disability)
- Life insurance plans, including accidental death & dismemberment (AD&D)
- Workers’ compensation plans, which provide benefits for employment-related accidents and injuries

In addition, BSA may have personal medical information about you that is used for routine employment activities. Medical information held or used by BSA in its employment records for employment purposes is not subject to the HIPAA privacy rules.

This includes, but is not limited to, medical information, files, or records related to compliance with government occupational and safety requirements, Americans with Disability Act (ADA) or other employment law requirements, occupational injury, disability insurance eligibility, sick leave requests or justifications, drug or alcohol screening results, workplace medical surveillance, fitness-for-duty test results, or other medical information needed to meet organizational policy or government requirements.

The plans and BSA are separate legal entities that exchange information to coordinate your coverage under the plans. To receive PHI from the plans, BSA must agree to and does hereby certify to the plans that BSA will:
- Not use or further disclose the information other than as permitted or required by the plan documents or as required by law.
- Ensure that any agent, including a subcontractor, to whom it gives PHI received from the plans, agrees to the same restrictions and conditions that apply to BSA with respect to such information.
- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plans.
- Ensure that any agent, including a subcontractor, to whom it gives electronic PHI, agrees to implement reasonable and appropriate security measures to protect such information.
- Not use or disclose PHI that is related to genetics for underwriting or employment purposes.
• Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of BSA, unless that use or disclosure is permitted or required by law (for example, for workers’ compensation programs).
• Report to the plans any use or disclosure of the information that is inconsistent with the uses or disclosures provided for, and any security incidents, of which BSA becomes aware.
• Make available PHI in accordance with individuals’ rights to review their PHI.
• Make available PHI for amendment and, if requests for amendment are approved, incorporate any amendments to PHI consistent with the HIPAA privacy rules.
• Make available the information required to provide an accounting of disclosures in accordance with the HIPAA privacy rules.
• Make its internal practices, books, and records relating to the use and disclosure of PHI received from the plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the plans with the HIPAA privacy rules.
• If feasible, return or destroy all PHI received from the plans that BSA still maintains in any form. BSA will retain no copies of PHI when no longer needed for the purpose for which disclosure was made. An exception may apply if such return or destruction is not feasible, but the plans must limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Separation of Boy Scouts of America and the Plans

The following employees or classes of employees of BSA shall be given access to PHI:
• HR Compensation and Benefits Department employees at the BSA national office involved in group health plan design, vendor selection, financial plan management, and day-to-day plan operations, and including the director, Human Resources Administration Department; retirement plan personnel who may assist with retiree medical issues; compensation specialists within the division; and the PeopleSoft HRIS functional team
• The director of Human Resources at the BSA national office
• Legal Department employees at the BSA national office, due to their potential involvement in group health plan legal matters
• Internal Audit employees, but only for purposes of auditing processes and functions related to the group health plans
• The Plans’ Privacy and Security officers
• Designated Information Systems Division personnel who maintain key human resource and benefit systems and manage the IT infrastructure, including network and email servers as well as hardware, for systems used by the HR Compensation and Benefits Department
• Records Management department personnel responsible for managing group health plan record storage
• Mailroom employees who receive and distribute group health plan correspondence
• Administrative support staff for the divisions and employees listed above

BSA shall restrict the access to and use of PHI by such employees to the plan administration functions that BSA performs for the plans, including payment and health-care operations. No other persons shall have access to PHI. BSA shall ensure that the separation between the group health plans and BSA is supported by reasonable and appropriate security measures.

BSA shall provide an effective mechanism for resolving any issues of noncompliance by such employees. Violations of BSA policies regarding privacy issues can result in verbal warnings, written warnings, or discharge of the employee, depending on the nature and repetition of infractions.
HIPAA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice only pertains to those benefits under the plans which are covered under the Health Insurance Portability and Accountability Act of 1996. These plans are:

- BSA Medical Plan—the Choice Plus Traditional PPO, Choice Plus High Deductible Health Plan With Health Savings Account, Options PPO Traditional PPO, Options PPO High Deductible Health Plan With Health Savings Account, and Medicare Supplement, including prescription drug coverage
- Dental Assistance Plan
- Vision Care Plan
- Employee Assistance Plan (EAP)

As we work every day to operate your health plans, protecting the confidentiality of your personal medical information is (and has always been) a high priority. The plans have adopted policies to safeguard the privacy of your medical information and comply with federal law (specifically, the Health Insurance Portability and Accountability Act, known as “HIPAA”).

Note: “We” refers to the Boy Scouts of America group health plans listed above. “You” or “yours” refers to the individual participants in the plans. If you are covered by an insured health option under the plans, you may have or will also receive a separate notice from your insurer or HMO.

This notice explains:
- How your personal medical information may be used or disclosed, and
- What rights you have regarding this information

How The Plans May Use Your Information

To manage your health plans effectively, we are permitted by law to use and disclose your personal medical information (called “Protected Health Information”) in certain ways without your authorization:

- **For Treatment.** So that you receive appropriate treatment and care, providers may use your Protected Health Information to coordinate or manage your health-care services. The plans may disclose your Protected Health Information to a health-care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the plans may advise an emergency room physician about the types of prescription drugs you currently take.
- **For Payment.** To make sure that claims are paid accurately and you receive the correct benefits, we may use and disclose your Protected Health Information to determine plan eligibility and responsibility for coverage and benefits. For example, we may use your information when we confer with other health plans to resolve a coordination of benefits issue. We may also use your Protected Health Information for utilization review activities.
- **For Health-Care Operations.** To ensure quality and efficient plan operations, we may use your Protected Health Information in several ways, including plan administration, quality assessment and improvement, and vendor review. Your information could be used, for example, to assist in the evaluation of a vendor who supports us. We also may contact you with appointment reminders or to provide information about treatment alternatives or other health-related benefits and services available under the plans.

We may share your Protected Health Information across the health plans covered by this notice for health-care operations activities, since the health plans are maintained and managed by the same plan sponsor (Boy Scouts of America). We may also disclose your Protected Health Information to Boy Scouts of America (the plan sponsor) in connection with these activities.

If you are covered under an insured health plan, the insurer also may disclose Protected Health Information to the plan sponsor in connection with payment, treatment, or health care operations. Boy Scouts of America has designated a limited number of employees who are the only ones permitted to access and use your Protected Health Information for plan operations and administration. When appropriate, we may share two types of Health Information with other Boy Scouts of America employees:

- Enrollment/unenrollment data—information on whether you and your dependents participate in the plans
We may disclose your protected Health Information to a family member, relative, close personal friend, or any other person whom you identify, when that information is directly relevant to the person’s involvement with your care or payment related to your care.

We also may use your protected Health Information to notify a family member, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only information that is directly relevant to the person’s involvement with your health care.

We will make other uses and disclosures only after you authorize them in writing. You may revoke your authorization in writing at any time.

Your rights regarding protected health information

You have the right to:

- Inspect and copy your protected Health Information
- Amend or correct inaccurate information
- Receive a paper copy of this notice, even if you agreed to receive it electronically
- Receive a copy of your record in electronic format for a fee, to the extent we maintain an electronic record of the information.
- Receive an accounting of certain disclosures of your information made by us

However, you are not entitled to an accounting of several types of disclosures including, but not limited to:

- Disclosures made for payment, treatment, or health-care operations
- Disclosures you authorized in writing
- Disclosures made before April 14, 2003

In special situations

The plans are prohibited from using or disclosing genetic information for underwriting or employment purposes, and will not use or disclose any of your protected Health Information that contains genetic information for underwriting or employment purposes.

Other permitted uses and disclosures

Federal regulations allow us to use and disclose your protected Health Information, without your authorization, for several additional purposes, in accordance with law, including:

- Public health
- Reporting and notification of abuse, neglect, or domestic violence
- Oversight activities of a health oversight agency
- Judicial and administrative proceedings
- Law enforcement
- Research, as long as certain privacy-related standards are satisfied
- To a coroner or medical examiner
- To organ, eye, or tissue donation programs
- To avert a serious threat to health or safety
- Specialized government functions (e.g., military and veterans’ activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions, and other law enforcement custodial situations)
- Workers’ compensation or similar programs established by law that provide benefits for work-related injuries or illness
- Other purposes required by law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law.
You have the right to receive an accounting of disclosures of your Protected Health Information through an electronic health record by the plans to carry out treatment, payment, and health-care operations during the three (3) years prior to your request. This right applies to:

- Electronic health records acquired by the plans as of Jan. 1, 2010—disclosures made on or after Jan. 1, 2015
- Electronic health records acquired by the plans after Jan. 1, 2010—disclosures made after the later of Jan. 1, 2012, or the date the plans acquire the electronic health record

**Right to Request Restrictions**

You may ask us to restrict how we use and disclose your Protected Health Information as we carry out payment, treatment, or health-care operations. You may also ask us to restrict uses and disclosures to your family members, relatives, friends, or other persons you identify who are involved in your care or payment for your care. However, we are not required to agree to these requests.

**Right to Request Confidential Communications**

You may request to receive your Protected Health Information by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. For example, you may only want to have information sent by mail or to an address other than your home.

**Notification of a Breach**

We are required to notify you in the event that we (or one of our business associates) discover a breach of your unsecured protected health information as defined by HIPAA.

**Authorizations**

Other uses or disclosures of your Protected Health Information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of Protected Health Information for fundraising or marketing purposes, will not be made without your written authorization.

You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

You may elect to opt out of receiving fundraising communications from us at any time.

*For more information about exercising these rights, contact the office below.*

**Complaints**

If you believe that your privacy rights have been violated, or that the privacy or security of your unsecured Protected Health Information has been compromised, you may file a written complaint without fear of retaliation. Direct your complaint to the Plan Administrator at the address listed below under “Contacting Us” or to the appropriate regional office of the Office of Civil Rights, U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

**About This Notice**

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information we maintain. If we change this notice, you will receive a copy of the new notice from the plans. A copy of the current notice will be posted on the BSA Benefits Center website at all times.

**Contacting Us**

You may exercise the rights described in this notice by contacting the Boy Scouts of America office identified below, which will provide you with more information. The contact is:

Privacy Officer
Boy Scouts of America
1325 West Walnut Hill Lane
Irving, TX 75038
972-580-2039

Complaints about our health plan privacy practices should be submitted in writing to the address above.

*Effective date of revised notice: July 31, 2015*

Keep this notice with your other important papers.
IMPORTANT NOTICE FROM THE BOY SCOUTS OF AMERICA ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

For Active Employees

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Boy Scouts of America (BSA) and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Important Things to Know about Current Coverage and Medicare’s Prescription Drug Coverage

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or a Medicare Advantage plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. BSA has determined that the prescription drug coverage offered by the BSA Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare prescription drug plan.

Joining a Medicare Prescription Drug Plan

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 through Dec. 7. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

Effect on Current Coverage When Joining a Medicare Prescription Drug Plan

If you and/or your Medicare-eligible dependent join a Medicare prescription drug plan, the BSA Medical Plan will be considered primary to Medicare, so the BSA Medical Plan will pay benefits first.

Paying a Higher Premium (Penalty) When Joining a Medicare Prescription Drug Plan

If you are eligible for Medicare and drop or lose your coverage under the BSA Medical Plan and don’t join a Medicare prescription drug plan within 63 consecutive days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare prescription drug plan later.

If you go 63 consecutive days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or about your current prescription drug coverage, contact the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com.

Note: You will receive this notice each year. You will also receive it before the next period you can join a Medicare prescription drug plan and if this coverage through BSA changes. You may also request a copy of this notice at any time.
**More Information About Your Options Under Medicare Prescription Drug Coverage**

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Call your state health insurance assistance program for personalized help. (See the inside back cover of your copy of the *Medicare & You* handbook for their telephone number).
- Call 800-MEDICARE (800-633-4227); TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this help, visit Social Security online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call 800-772-1213 (TTY 800-325-0778).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

Date Reviewed: July 31, 2015  
Name of Entity/Sender: Boy Scouts of America  
Contact—Position/Office: BSA Benefits Center  
Address: P.O. Box 9735, Providence, RI 02940  
Phone Number: 800-444-4416

**IMPORTANT NOTICE FROM THE BOY SCOUTS OF AMERICA ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE**

**For COBRA Participants**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Boy Scouts of America (BSA) and about your options under Medicare prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

**Important Things to Know about Your Current Coverage and Medicare’s Prescription Drug Coverage**

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. BSA has determined that the prescription drug coverage offered by the BSA Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered to be “creditable coverage.” Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare prescription drug plan.

**Joining a Medicare Prescription Drug Plan**

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from Oct. 15 through Dec. 7. However, if you lose your
current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

**Effect on Current Coverage When Joining a Medicare Prescription Drug Plan**

If you and/or your Medicare-eligible dependent decide to join a Medicare prescription drug plan, you will not be eligible to receive any of your current health and prescription drug benefits.

**Paying a Higher Premium (Penalty) When Joining a Medicare Prescription Drug Plan**

If you drop or lose your coverage under the BSA Medical Plan and don’t join a Medicare prescription drug plan within 63 consecutive days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare prescription drug plan later.

If you go 63 consecutive days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or about your current prescription drug coverage, contact the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com.

**Note:** You will receive this notice each year. You will also receive it before the next period you can join a Medicare prescription drug plan, and if this coverage through BSA changes. You may also request a copy at any time.

**Your Options Under Medicare Prescription Drug Coverage**

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. If you and/or your dependents are eligible for Medicare, you’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by companies that offer Medicare prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your state health insurance assistance program for personalized help. (See the inside back cover of your copy of the *Medicare & You* handbook for their telephone number.)
- Call 800-MEDICARE (800-633-4227); TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For more information about this help, visit Social Security online at www.socialsecurity.gov, or call 800-772-1213 (TTY 800-325-0778).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

Date Reviewed: July 31, 2015

Name of Entity/Sender: Boy Scouts of America
Contact—Position/Office: BSA Benefits Center
Address: P.O. Box 9735, Providence, RI 02940
Phone Number: 800-444-4416
IMPORTANT NOTICE FROM
THE BOY SCOUTS OF AMERICA ABOUT YOUR
PRESCRIPTION DRUG COVERAGE AND MEDICARE

For Those Pending or Receiving LTD, Retirees,
and Survivors Under Age 65

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Boy Scouts of America (BSA) and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Important Things to Know about Current Coverage and Medicare’s Prescription Drug Coverage

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or a Medicare Advantage plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. BSA has determined that the prescription drug coverage offered by the BSA Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Joining a Medicare Prescription Drug Plan

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 through Dec. 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

Effect on Current Coverage When Joining a Medicare Prescription Drug Plan

If you and/or your Medicare-eligible dependent join a Medicare prescription drug plan, the medical coverage for you and/or your dependent(s) through the BSA Medical Plan will be terminated, and you will not be able to re-enroll in the future.

Paying a Higher Premium (Penalty) When Joining a Medicare Prescription Drug Plan

If you drop or lose your current coverage under the BSA Medical Plan and don’t join a Medicare drug plan within 63 consecutive days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 consecutive days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or about your current prescription drug coverage, contact the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com.

Note: You will receive this notice each year. You will also receive it before the next period in which you can join
a Medicare drug plan, and if this coverage through BSA changes. You may also request a copy of this notice at any time.

**More Information About Your Options Under Medicare Prescription Drug Coverage**

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. If you and/or your dependents are eligible for Medicare, you'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your state health insurance assistance program for personalized help. (See the inside back cover of your copy of the *Medicare & You* handbook for their telephone number)

Call 800-MEDICARE (800-633-4227); TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this help, visit Social Security online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call 800-772-1213 (TTY 800-325-0778).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

Date Reviewed: July 31, 2015

Name of Entity/Sender: Boy Scouts of America
Contact—Position/Office: BSA Benefits Center
Address: P.O. Box 9735, Providence, RI 02940
Phone Number: 800-444-4416

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**Consolidated Omnibus Budget Reconciliation Act (COBRA)**

The right to COBRA continuation coverage was created by a federal law, the *Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)*. COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the BSA Employee Welfare Benefits Plan (the plan) when they would otherwise lose their group health coverage (called continuation coverage) at group rates plus administrative fees in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully.

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.”

Specific qualifying events are listed later in this chapter. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualifying beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

In addition to COBRA coverage, there may be other coverage options for you and your family in the Health Insurance Marketplace.

In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace. For more information about your eligibility for the tax credit and what your possible premiums, deductibles, and out-of-pocket costs would be, go to [www.healthcare.gov](http://www.healthcare.gov) and review your options before making a decision on which health insurance would be best for you and your family.

You may also qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan).
LENGTH OF CONTINUATION COVERAGE—18 MONTHS

If you are an employee of BSA or a local council covered by the BSA Medical Plan, the Dental Assistance Plan, and/or the Vision Care Plan, you have a right to choose this continuation coverage if you lose your group coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part) or because your employer files for bankruptcy under Title 11 of the United States Bankruptcy Code.

Coverage will continue for 18 months from the date your group coverage ends. The COBRA continuation may be elected for the spouse or a dependent child only for the 18-month period. The employee does not have to continue.

You may add a newborn or legally adopted child/children within 30 days of the date of birth for a newborn or within 30 days of the legal adoption or placement for legal adoption. A child is considered as “placed for legal adoption” when the adoptive parent assumes and retains the legal obligation for the total or partial support of the child in accordance with applicable state law.

You must provide a written request to CONEXIS, P.O. Box 223886, Dallas, TX 75222 within 30 days of the birth, legal adoption, or placement for legal adoption. Coverage will continue through the original 18-month period only. Exception to this is if there is a second qualifying event—death of the covered employee, divorce of the employee from his or her spouse, or the dependent child ceasing being a dependent under the group health plan—that allows a qualified COBRA beneficiary to elect as much as 36 months of coverage after the date of the original qualifying event.

LENGTH OF CONTINUATION COVERAGE—36 MONTHS

If you are the spouse of an employee covered by the BSA Medical Plan, the Dental Assistance Plan, and/or the Vision Care Plan, you have the right to continue coverage for yourself for any of the following reasons:

- Your spouse dies.
- Your spouse’s hours of employment are reduced.
- Your spouse’s employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes entitled to Medicare benefits.
- You become divorced or legally separated from your spouse.

In the case of a dependent child of an employee covered by the BSA Medical Plan, the Dental Assistance Plan and/or the Vision Care Plan, he or she has the right to continue coverage for any of the following reasons:

- The parent-employee dies.
- The parent-employee’s hours of employment are reduced.
- The parent-employee’s employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits.
- The parents become divorced or legally separated.
- The child stops being eligible for coverage under the plan as a dependent child.

If you choose continuation coverage, Boy Scouts of America is required to give you coverage that is identical to the coverage provided under the plan to similarly situated employees or family members. You will be given the opportunity to maintain continuation coverage for 36 months, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. If during these 18 months another event occurs that also entitles you to coverage, coverage may be extended.
LENGTH OF CONTINUATION COVERAGE—29 MONTHS

Social Security Disability—The 18 months of continuation coverage will be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title 11 or XVI of the Social Security Act on the date of the qualifying event or becomes disabled at any time during the first 60 days of continuation coverage. It is the qualified beneficiary’s responsibility to obtain the disability determination from the Social Security Administration and to provide a copy of the Social Security Disability determination to CONEXIS within 60 days of the date of termination and before the original 18 months of COBRA expires. If these time frames are not compiled by the qualified beneficiary, then the 11-month extension of COBRA coverage will not be provided. It is also the qualified beneficiary's responsibility to notify CONEXIS within 30 days if a final determination has been made that they are no longer disabled.

Secondary Events—An extension of the original 18-month or above-mentioned 29-month continuation period can also occur, if during the 18 or 29 months of continuation coverage, a second event takes place (divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent). If a second event occurs, then the 18 or 29 months of coverage can be extended to 36 months from the date of the original qualifying event for eligible qualified beneficiaries. If a second event occurs, it is the qualified beneficiary’s responsibility to notify CONEXIS in writing within 60 days of the second event and within the original 18- or 29-month COBRA timeline. In no event, will continuation coverage last beyond three years from the date of the event that originally made the qualified beneficiary eligible for continuation coverage. However, the law also provides that your continuation coverage may be cut short for any of the following reasons:

- After the date of your election to continue coverage you become entitled to Medicare or covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of yours.

Under the law, the employee or a family member has the responsibility to inform the BSA Benefits Center or the local council of a divorce, a legal separation, or a child losing dependent status under BSA Plans within 60 days of any such event. If notice is not postmarked within that 60-day period, the dependent will not be entitled to continuation coverage. BSA or the local council has the responsibility of notifying the BSA Benefits Center of the employee’s death, termination of employment, or reduction in hours. To contact the BSA Benefits Center call 800-444-4416 or go to http://bsabenefits.mercerhrs.com.

The BSA Benefits Center, when notified, will inform CONEXIS of your right to choose continuation coverage. You have 60 days from the date you receive the request for continuation of group coverage to choose continuation coverage and send your election to:

CONEXIS
P.O. Box 223886
Dallas, TX 75222

You do not have to show that you are insurable to choose continuation coverage. Under the law, you may have to pay all or part of the cost for your continuation coverage plus an additional administrative fee. You will have a grace period of 45 days to pay any retroactive premium for the period from the date continuation coverage starts until the date you choose continuation coverage, and you will have a grace period of 30 days to pay any subsequent premiums.

If you do not choose continuation coverage, your group medical, dental, and/or vision coverage will end at midnight the day you terminate employment. If you do choose continuation coverage, the applicable benefit will be reinstated once the initial premium is received within 45 days of your election.

If you have any questions about this law, please contact CONEXIS at 877-722-2667 or go to www.conexis.org.
CONTINUATION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT (USERRA)

If you are absent from employment for more than 30 days by reason of active military service, you may elect to continue group health coverage for you and your dependents in accordance with USERRA. You may continue group health coverage under USERRA at your expense for up to 24 months beginning on the date of your absence from work, but not later than the date on which you fail to apply for, or return to, a position of employment.

Even if you do not elect to continue group health coverage during military service, you have the right to be reinstated in your group health coverage when you are re-employed, generally without any waiting period or exclusions except for service-connected illnesses or injuries.

WOMEN’S HEALTH AND CANCER RIGHTS

Your BSA Medical Plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). For more information, call UnitedHealthcare at 800-632-3203.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to purchase individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS-NOW (1-877-543-7669), or visit www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).
If you live in one of the following states, you may be eligible for assistance in paying your employer’s health plan premiums. The following list of states is current as of January 31, 2015. You should contact your state for more information on eligibility requirements.

**ALABAMA**—Medicaid  
Website: [http://www.myalhipp.com](http://www.myalhipp.com)  
Phone: 1-855-692-5447

**ALASKA**—Medicaid  
Website: [http://health.hss.state.ak.us/dpa/programs/medicaid/](http://health.hss.state.ak.us/dpa/programs/medicaid/)  
Phone (outside of Anchorage): 1-888-318-8890  
Phone (Anchorage): 907-269-6529

**COLORADO**—Medicaid  
Website: [http://www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)  
Phone: 1-800-221-3943

**FLORIDA**—Medicaid  
Website: [https://www.flmedicaidtplrecovery.com/](https://www.flmedicaidtplrecovery.com/)  
Phone: 1-877-357-3268

**GEORGIA**—Medicaid  
Website: [http://dch.georgia.gov/](http://dch.georgia.gov/)  
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)  
Phone: 404-656-4507

**INDIANA**—Medicaid  
Website: [http://www.in.gov/fssa](http://www.in.gov/fssa)  
Phone: 1-800-889-9949

**IOWA**—Medicaid  
Website: [www.dhs.state.ia.us/hipp/](http://www.dhs.state.ia.us/hipp/)  
Phone: 1-888-346-9562

**KANSAS**—Medicaid  
Website: [http://www.kdheks.gov/hcf/](http://www.kdheks.gov/hcf/)  
Phone: 1-800-792-4884

**KENTUCKY**—Medicaid  
Website: [http://chfs.ky.gov/dms/default.htm](http://chfs.ky.gov/dms/default.htm)  
Phone: 1-800-635-2570

**LOUISIANA**—Medicaid  
Website: [http://dhh.louisiana.gov/index.cfm/subhome/1/n/331](http://dhh.louisiana.gov/index.cfm/subhome/1/n/331)  
Phone: 1-888-695-2447

**MAINE**—Medicaid  
Phone: 1-800-977-6740  
TTY: 1-800-977-6741

**MASSACHUSETTS**—Medicaid and CHIP  
Website: [http://www.mass.gov/MassHealth](http://www.mass.gov/MassHealth)  
Phone: 1-800-462-1120

**MINNESOTA**—Medicaid  
Website: [http://www.dhs.state.mn.us/id_006254](http://www.dhs.state.mn.us/id_006254)  
Click on Health Care, then Medical Assistance  
Phone: 1-800-657-3739

**MISSOURI**—Medicaid  
Website: [http://www.dss.mo.gov/mhd/participants/pages/hipp.htm](http://www.dss.mo.gov/mhd/participants/pages/hipp.htm)  
Phone: 573-751-2005

**MONTANA**—Medicaid  
Website: [http://medicaid.mt.gov/member](http://medicaid.mt.gov/member)  
Phone: 1-800-694-3084

**NEBRASKA**—Medicaid  
Website: [www.accessnebraska.ne.gov](http://www.accessnebraska.ne.gov)  
Phone: 1-855-632-7633

**NEVADA**—Medicaid  
Website: [http://dwss.nv.gov/](http://dwss.nv.gov/)  
Phone: 1-800-992-0900

**NEW HAMPSHIRE**—Medicaid  
Phone: 603-271-5218

**NEW JERSEY**—Medicaid and CHIP  
Medicaid Website: [http://www.state.nj.us/humanservices/dmahs/clients/medicaid/](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/)  
Medicaid Phone: 609-631-2392  
CHIP Website: [http://www.njfamilycare.org/index.html](http://www.njfamilycare.org/index.html)  
CHIP Phone: 1-800-701-0710

**NEW YORK**—Medicaid  
Website: [http://www.nyhealth.gov/health_care/medicaid/](http://www.nyhealth.gov/health_care/medicaid/)  
Phone: 1-800-541-2831

**NORTH CAROLINA**—Medicaid  
Website: [http://www.ncdhhs.gov/dma](http://www.ncdhhs.gov/dma)  
Phone: 919-855-4100

**NORTH DAKOTA**—Medicaid  
Website: [http://www.nd.gov/dhs/services/medicalserv/medicaid/](http://www.nd.gov/dhs/services/medicalserv/medicaid/)  
Phone: 1-800-755-2604
OKLAHOMA—Medicaid and CHIP  
Website: http://www.insureoklahoma.org  
Phone: 1-888-365-3742

OREGON—Medicaid  
Website: http://www.oregonhealthykids.gov  
http://www.hijossaludablesoregon.gov  
Phone: 1-800-699-9075

PENNSYLVANIA—Medicaid  
Website: http://www.dpw.state.pa.us/hipp  
Phone: 1-800-692-7462

RHODE ISLAND—Medicaid  
Website: http://www.eohhs.ri.gov/  
Phone: 401-462-5300

SOUTH CAROLINA—Medicaid  
Website: http://www.scdhhs.gov  
Phone: 1-888-549-0820

SOUTH DAKOTA—Medicaid  
Website: http://dss.sd.gov  
Phone: 1-888-828-0059

TEXAS—Medicaid  
Website: http://gethipptexas.com/  
Phone: 1-800-440-0493

UTAH—Medicaid and CHIP  
Medicaid Website: http://health.utah.gov/medicaid  
CHIP Website: http://health.utah.gov/chip  
Phone: 1-866-435-7414

VERMONT—Medicaid  
Website: http://www.greenmountaincare.org/  
Phone: 1-800-250-8427

VIRGINIA—Medicaid and CHIP  
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm  
Medicaid Phone: 1-800-432-5924  
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm  
CHIP Phone: 1-855-242-8282

WASHINGTON—Medicaid  
Website: http://www.hca.wa.gov/medicaid/premium pymt/pages/index.aspx  
Phone: 1-800-562-3022, ext. 15473

WEST VIRGINIA—Medicaid  
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx  
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN—Medicaid and CHIP  
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm  
Phone: 1-800-362-3002

WYOMING—Medicaid  
Website: https://wyequalitycare.acs-inc.com/  
Phone: 307-777-7531

To see if any more states have added premium assistance programs since July 31, 2015, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
http://www.dol.gov/ebsa  
866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
http://www.cms.hhs.gov  
877-267-2323, menu option 4, ext. 61565
THE HEALTH INSURANCE MARKETPLACE

We are sending this notice to all employees to raise awareness of a new way to buy health insurance through the Health Insurance Marketplace (the “Marketplace”). The Marketplace is a key part of the Affordable Care Act, also known as the health care reform law. To assist you as you evaluate medical coverage options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by the BSA medical plan.

Basic Information About the Marketplace

What is the Health Insurance Marketplace?

The Marketplace is a place where you can buy individual health insurance for yourself and your family. The Marketplace allows you to find and compare many different private health insurance options in one place. If you purchase health insurance through the Marketplace, you may qualify for a new premium tax credit that lowers your monthly premium immediately.

Federal law dictates that insurance plans offered in the Marketplace cannot deny coverage or charge higher rates based on pre-existing conditions or gender. Premiums can be based only on where you live, your age, and the level of coverage in the health plan you choose.

Can individuals save money on health insurance premiums in the Marketplace?

Some people who do not have access to affordable, minimum value health coverage through their employer may be eligible for a federal subsidy in order to make buying insurance through the Marketplace more affordable. The savings these individuals would be eligible for depends on their household income.

You may find more affordable coverage through the BSA medical plan or, if available, through your spouse's employer medical plan or through your parent's employer medical plan (if you are under the age of 26).

Does health coverage offered by the BSA affect eligibility for premium savings for myself or my family through the Marketplace?

Yes. You may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing for coverage you buy through the Marketplace if you are not eligible for the BSA medical plan.

If you are eligible for the BSA medical plan and the cost for employee-only coverage is more than 9.5 percent of your household income for the year, or if the plan fails to meet the “minimum value” standard set by the health care reform law, you may be eligible for a tax credit.

Can I buy insurance through the Marketplace if I am a retiree but not yet Medicare eligible?

Yes. The Marketplace will benefit millions of Americans who need affordable health insurance but are not yet eligible for Medicare.

Please note: If you are a retiree enrolled in the BSA medical plan and you end BSA medical coverage to enroll in an individual health plan offered in the Marketplace, you will not be able to re-enroll in the BSA medical plan in the future.

How can I qualify for the new tax credit on health insurance premiums in the Marketplace?

To qualify for the new tax credit that lowers monthly premiums for individual health insurance purchased through the Marketplace, you must not be eligible for your employer-provided health coverage or you must be eligible only for coverage that does not meet certain standards described above. Also, your household income must be less than 400 percent of the poverty level for the taxable year (note that for 2015, 400 percent of the poverty level applicable in the 48 contiguous states is $47,080 for a single person and $63,720 for a couple).

It is important to note that because the BSA medical plan meets the government's standards for minimum value and affordability, it is likely you will not qualify for a federal subsidy if you are eligible for benefits through the BSA.
To find out if you qualify for the new tax credit or to see how much a tax credit would reduce your monthly premium costs, you will need to submit a Marketplace health insurance application during the enrollment period.

**COBRA and the New Health Insurance Marketplace**

**How does the new Health Insurance Marketplace affect COBRA?**

In general, under COBRA, an individual who was covered by a group health plan on the day before a qualifying event occurred (termination of employment, a dependent's loss of eligibility, etc.) may be able to elect COBRA continuation coverage.

Those who become COBRA eligible may also qualify for a premium tax credit that will pay for some, or all, of the cost of health insurance coverage in plans offered through the Marketplace.

**Three Types of Applications in the Marketplace**

**How do I know which application to complete?**

**Application for Health Coverage and Help Paying Costs (Short Version)**

This application is for unmarried adults who are not offered health insurance at their employer, do not have dependents, cannot be claimed as a dependent, and do not have items that can be deducted from their taxable income.

**Application for Health Coverage and Help Paying Costs (Long Version)**

This application is for those who are eligible for federal premium tax credits, cost-sharing subsidies, Medicaid, or the Children's Health Insurance Program.

**Application for Health Coverage**

This application is for those who are not eligible for federal premium tax credits, cost-sharing subsidies, Medicaid, or CHIP.

**What if I’m not eligible for benefits at the Boy Scouts of America?**

If you are not eligible for the BSA medical plan, you should consider other options available to you, such as coverage through your spouse's employer plan, your parent's employer plan, Medicaid, Medicare, or your state's Marketplace. If you decide to enroll through the Marketplace, you will need to provide the Marketplace with the following information about the BSA and our medical plan:

**Employer Name:** Boy Scouts of America  
**Employer Identification Number:** 22-1576300  
**Employer Address:** 1325 W. Walnut Hill Lane, Irving, TX 75038  
**Employer Phone Number:** 972-580-2000  
**Employer Health Insurance Contact:**  
BSA Benefits Center  
1-800-444-4416

The BSA offers health benefits to employees scheduled to work 30 or more hours weekly, and to their eligible spouses and/or children, immediately upon hire or becoming benefit eligible, whichever occurs last. As of Jan. 1, 2015, in compliance with the PPACA, the BSA will offer health benefits to persons who were hired to work less than 30 hours per week but have actually worked 30 hours or more each week in a prior 12-month period. The BSA medical plan meets the minimum value standard and is intended to be affordable, based on employee wages.

The employee-only cost for the High Deductible Health Plan with an HSA, without a wellness participation discount, is $158 per month. The BSA will continue to offer this coverage in 2016 with no major plan changes from the 2015 offering.

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by the BSA, you will lose the company contribution to the company-offered coverage. Also, this contribution, as well as your employee contribution, is excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.
How Can I Get More Information?

About the Marketplace

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.HealthCare.gov for more information or to complete an online application to purchase individual/private health insurance through the Marketplace.

Contact information for assistance with the Marketplace in your state can be found at http://www.healthcare.gov/using-insurance/managing/consumer-help/index.html. One-on-one assistance with the Marketplace is available with a Navigator. Navigators are trained to provide unbiased information in a culturally competent manner to consumers about health insurance, the new Health Insurance Marketplace, qualified health plans, and public programs including Medicaid and CHIP. For information about Navigators in your area, please visit http://cciio.cms.gov/programs/exchanges/assistance.html.

About the BSA Medical Plan

For more information about health benefits offered by the BSA medical plan, contact the BSA Benefits Center at 800-444-4416 or at http://bsabenefits.mercerhrs.com.
MONTHLY PREMIUMS
2016 Monthly Premiums

All rates are subject to change upon provision of written notice.

Medical Plan

ACTIVE EMPLOYEE

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With Wellness Incentive*

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<td>Self, spouse &amp; 2+ children</td>
<td>$915.00</td>
<td>$853.00</td>
<td>$771.00</td>
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</table>

* 2016 incentive rates are earned by employees and covered spouses who completed health activities specified in the Personal Rewards Program.
## 2016 Monthly Premiums

### EMPLOYEE ON LONG-TERM DISABILITY; NOT ON MEDICARE

This coverage is no longer available for those who are age 65 or over.

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
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<tbody>
<tr>
<td></td>
<td>Employee</td>
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</tr>
<tr>
<td>Self</td>
<td>$90.00</td>
<td>$511.00</td>
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<tr>
<td>Self &amp; non-Medicare spouse</td>
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<td>$702.00</td>
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<td>Self &amp; 1 child</td>
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<td>Self &amp; 2+ children</td>
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<tr>
<td>Self, non-Medicare spouse, &amp; 1 child</td>
<td>$732.00</td>
<td>$777.00</td>
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<tr>
<td>Self, non-Medicare spouse, &amp; 2+ children</td>
<td>$915.00</td>
<td>$853.00</td>
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</table>

### EMPLOYEE ON LONG-TERM DISABILITY; ON MEDICARE

This coverage is no longer available for those who are age 65 or over.

<table>
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<th>Medicare Supplement &amp; Traditional</th>
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<td>Self</td>
<td>$90.00</td>
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<tr>
<td>Self &amp; Medicare spouse</td>
<td>$547.00</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Medicare Supplement &amp; Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employee</td>
</tr>
<tr>
<td>Self or spouse or child</td>
<td>$90.00</td>
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<tr>
<td>Self &amp; non-Medicare spouse</td>
<td>$547.00</td>
</tr>
<tr>
<td>Self or spouse or child + 1 child</td>
<td>$205.00</td>
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<tr>
<td>Self &amp; 2+ children</td>
<td>$454.00</td>
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<td>Self, non-Medicare spouse, &amp; 1 child</td>
<td>$732.00</td>
</tr>
<tr>
<td>Self, non-Medicare spouse, &amp; 2+ children</td>
<td>$915.00</td>
</tr>
<tr>
<td>Self, Medicare spouse</td>
<td>$547.00</td>
</tr>
<tr>
<td>Self, Medicare spouse, &amp; 1 child</td>
<td>$732.00</td>
</tr>
<tr>
<td>Self, Medicare spouse, &amp; 2+ children</td>
<td>$915.00</td>
</tr>
</tbody>
</table>
2016 Monthly Premiums

RETIREE OR SURVIVOR NOT ON MEDICARE

Retirement on or before Dec. 1, 2004
OR
Retirement on or after Jan. 1, 2005,
with at least 20 years of benefit-eligible service

<table>
<thead>
<tr>
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<th>Traditional</th>
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<tbody>
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<td></td>
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<td>Retiree</td>
<td>BSA</td>
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<td>$929.00</td>
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<td>Self &amp; 2+ children</td>
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RETIREE OR SURVIVOR ON MEDICARE
This coverage is no longer available for those who are age 65 or over.

Retirement on or before Dec. 1, 2004
OR
Retirement on or after Jan. 1, 2005,
with at least 20 years of benefit-eligible service

<table>
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<td>Self &amp; 2+ children</td>
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<tr>
<td>Self, Medicare spouse, &amp; 2+ children</td>
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# 2016 Monthly Premiums

## RETIREE OR SURVIVOR NOT ON MEDICARE

Retirement on or after Jan. 1, 2005, with at least 10 but less than 20 years of benefit-eligible service

<table>
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<tr>
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<th>HDHP Retiree</th>
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<td>$1,325.00</td>
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## RETIREE OR SURVIVOR ON MEDICARE

This coverage is no longer available for those who are age 65 or over.

Retirement on or after Jan. 1, 2005, with at least 10 but less than 20 years of benefit-eligible service

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<td>$898.00</td>
<td>$385.00</td>
<td>$634.00</td>
<td>$275.00</td>
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<tr>
<td>Self, Medicare spouse, &amp; 2+ children</td>
<td>$1,065.00</td>
<td>$456.00</td>
<td>$801.00</td>
<td>$361.00</td>
</tr>
</tbody>
</table>
# 2016 Monthly Premiums
## Dental Assistance Plan

### ACTIVE EMPLOYEE

<table>
<thead>
<tr>
<th>EMPLOYEE</th>
<th>EMPLOYEE</th>
<th>BSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>$0.00</td>
<td>$34.00</td>
</tr>
<tr>
<td>Self &amp; spouse</td>
<td>$35.00</td>
<td>$34.00</td>
</tr>
<tr>
<td>Self &amp; 1 child</td>
<td>$33.00</td>
<td>$34.00</td>
</tr>
<tr>
<td>Self &amp; 2+ children</td>
<td>$61.00</td>
<td>$34.00</td>
</tr>
<tr>
<td>Self, spouse, &amp; 1 child</td>
<td>$61.00</td>
<td>$34.00</td>
</tr>
<tr>
<td>Self, spouse, &amp; 2+ children</td>
<td>$93.00</td>
<td>$34.00</td>
</tr>
</tbody>
</table>

### NATIONAL COUNCIL EMPLOYEE ON LTD

<table>
<thead>
<tr>
<th>EMPLOYEE</th>
<th>EMPLOYEE</th>
<th>BSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
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<td>$34.00</td>
</tr>
<tr>
<td>Self &amp; spouse</td>
<td>$35.00</td>
<td>$34.00</td>
</tr>
<tr>
<td>Self &amp; 1 child</td>
<td>$33.00</td>
<td>$34.00</td>
</tr>
<tr>
<td>Self &amp; 2+ children</td>
<td>$61.00</td>
<td>$34.00</td>
</tr>
<tr>
<td>Self, spouse, &amp; 1 child</td>
<td>$61.00</td>
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</tr>
<tr>
<td>Self, spouse, &amp; 2+ children</td>
<td>$93.00</td>
<td>$34.00</td>
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### LOCAL COUNCIL EMPLOYEE ON LTD

<table>
<thead>
<tr>
<th>PREMIUM</th>
<th>PREMIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>$34.00</td>
</tr>
<tr>
<td>Self &amp; spouse</td>
<td>$69.00</td>
</tr>
<tr>
<td>Self &amp; 1 child</td>
<td>$67.00</td>
</tr>
<tr>
<td>Self &amp; 2+ children</td>
<td>$95.00</td>
</tr>
<tr>
<td>Self, spouse, &amp; 1 child</td>
<td>$95.00</td>
</tr>
<tr>
<td>Self, spouse, &amp; 2+ children</td>
<td>$127.00</td>
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</table>

### NATIONAL OR LOCAL COUNCIL RETIREE OR SURVIVOR

<table>
<thead>
<tr>
<th>PREMIUM</th>
<th>PREMIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
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<tr>
<td>Self &amp; spouse</td>
<td>$69.00</td>
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<tr>
<td>Self &amp; 1 child</td>
<td>$67.00</td>
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<tr>
<td>Self &amp; 2+ children</td>
<td>$95.00</td>
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<tr>
<td>Self, spouse, &amp; 1 child</td>
<td>$95.00</td>
</tr>
<tr>
<td>Self, spouse, &amp; 2+ children</td>
<td>$127.00</td>
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</tbody>
</table>
2016 Monthly Premiums

Vision Care Plan
ALL GROUPS

<table>
<thead>
<tr>
<th>Plan</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>$11.08</td>
</tr>
<tr>
<td>Self &amp; spouse</td>
<td>$17.75</td>
</tr>
<tr>
<td>Self &amp; 1 child</td>
<td>$18.13</td>
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<tr>
<td>Self &amp; 2+ children</td>
<td>$18.13</td>
</tr>
<tr>
<td>Self, spouse, &amp; 1 child</td>
<td>$30.58</td>
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<tr>
<td>Self, spouse, &amp; 2+children</td>
<td>$30.58</td>
</tr>
</tbody>
</table>

Long-Term Disability Plan (Monthly)

(for anyone with an annual benefit base rate less than $265,000)

<table>
<thead>
<tr>
<th>Employees in Non-Statutory States</th>
<th>Maximum Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>$.511 per $100 of monthly benefit base rate</td>
<td>$112.85</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employees in Statutory States*</th>
<th>Maximum Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>$.504 per $100 of monthly benefit base rate</td>
<td>$111.30</td>
</tr>
</tbody>
</table>

*New York, New Jersey, California, Rhode Island, Hawaii, and Puerto Rico—rate is based on where the employee works.

Group Life Insurance

BASIC LIFE (1X SALARY)

$.550/$1,000 of coverage

OPTIONAL LIFE
(1X – 6X SALARY)

Premium per thousand dollars is age-based, as follows:

<table>
<thead>
<tr>
<th>Age</th>
<th>Active/ LTD Non-Tobacco</th>
<th>Active/ LTD Tobacco</th>
<th>Retiree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>$0.047</td>
<td>$0.060</td>
<td>$0.050</td>
</tr>
<tr>
<td>30–34</td>
<td>$0.066</td>
<td>$0.081</td>
<td>$0.068</td>
</tr>
<tr>
<td>35–39</td>
<td>$0.075</td>
<td>$0.092</td>
<td>$0.078</td>
</tr>
<tr>
<td>40–44</td>
<td>$0.085</td>
<td>$0.104</td>
<td>$0.090</td>
</tr>
<tr>
<td>45–49</td>
<td>$0.122</td>
<td>$0.150</td>
<td>$0.127</td>
</tr>
<tr>
<td>50–54</td>
<td>$0.207</td>
<td>$0.254</td>
<td>$0.215</td>
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<tr>
<td>55–59</td>
<td>$0.376</td>
<td>$0.462</td>
<td>$0.400</td>
</tr>
<tr>
<td>60–64</td>
<td>$0.584</td>
<td>$0.715</td>
<td>$0.615</td>
</tr>
<tr>
<td>65–69</td>
<td>$1.100</td>
<td>$1.350</td>
<td>$1.172</td>
</tr>
<tr>
<td>70–74</td>
<td>$1.685</td>
<td>$2.065</td>
<td>$1.788</td>
</tr>
<tr>
<td>75+</td>
<td>$2.600</td>
<td>$3.185</td>
<td>$2.764</td>
</tr>
</tbody>
</table>

Scout Executives’ Alliance

MEMBERSHIP RATES

All employees who join the Scout Executives’ Alliance when first eligible will have the first 12 months of membership contribution waived.

After the first 12 months of membership, the contribution is based on the member’s annual salary or annual pension per the following:

Active Members

$.28 per $1,000 of annual salary (maximum premium per month of $32.00)

Retired Members

$.28 per $1,000 of annual pension (maximum premium per month of $17.50)

DEPENDENT LIFE

Option 1—$2.30
Option 2—$4.60
2016 Monthly Premiums

Accidental Death and Dismemberment Insurance

EMPLOYER-PAID COVERAGE

National and local council staff employees—$0.017 per $1,000 of coverage

National and local council commissioned professionals, certified executives, and professional-technical employees —$0.017 per $1,000 of coverage

EMPLOYEE-PAID COVERAGE

$0.023 per $1,000 for employee only

$0.036 per $1,000 for family

<table>
<thead>
<tr>
<th>ADDITIONAL COVERAGE AMOUNT</th>
<th>PREMIUM FOR EMPLOYEE ONLY</th>
<th>PREMIUM FOR FAMILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000</td>
<td>$0.58</td>
<td>$0.90</td>
</tr>
<tr>
<td>$50,000</td>
<td>$1.15</td>
<td>$1.80</td>
</tr>
<tr>
<td>$75,000</td>
<td>$1.73</td>
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<td>$3.60</td>
</tr>
<tr>
<td>$125,000</td>
<td>$2.88</td>
<td>$4.50</td>
</tr>
<tr>
<td>$150,000</td>
<td>$3.45</td>
<td>$5.40</td>
</tr>
<tr>
<td>$175,000</td>
<td>$4.03</td>
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<td>$9.90</td>
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<tr>
<td>$300,000</td>
<td>$6.90</td>
<td>$10.80</td>
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<td>$325,000</td>
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<tr>
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<td>$17.10</td>
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<tr>
<td>$500,000</td>
<td>$11.50</td>
<td>$18.00</td>
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</table>

Retiree coverage maximum is $250,000.
### 2016 COBRA Monthly Premiums

#### ACTIVE EMPLOYEES

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
<th>HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>$661.98</td>
<td>$566.44</td>
</tr>
<tr>
<td>Self &amp; spouse</td>
<td>$1,322.94</td>
<td>$1,174.36</td>
</tr>
<tr>
<td>Self &amp; 1 child</td>
<td>$926.16</td>
<td>$809.20</td>
</tr>
<tr>
<td>Self &amp; 2+ children</td>
<td>$1,189.32</td>
<td>$1,051.96</td>
</tr>
<tr>
<td>Self, spouse, &amp; 1 child</td>
<td>$1,588.14</td>
<td>$1,418.14</td>
</tr>
<tr>
<td>Self, spouse, &amp; 2+ children</td>
<td>$1,852.32</td>
<td>$1,662.94</td>
</tr>
<tr>
<td>Per child</td>
<td>$264.18</td>
<td>$242.76</td>
</tr>
</tbody>
</table>

#### EMPLOYEE ON LONG-TERM DISABILITY; NOT ON MEDICARE

<table>
<thead>
<tr>
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<th>Traditional</th>
<th>HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>$613.02</td>
<td>$559.98</td>
</tr>
<tr>
<td>Self &amp; spouse</td>
<td>$1,273.98</td>
<td>$1,167.90</td>
</tr>
<tr>
<td>Self &amp; 1 child</td>
<td>$877.20</td>
<td>$802.74</td>
</tr>
<tr>
<td>Self &amp; 2+ children</td>
<td>$1,140.36</td>
<td>$1,045.50</td>
</tr>
<tr>
<td>Self, spouse, &amp; 1 child</td>
<td>$1,539.18</td>
<td>$1,411.68</td>
</tr>
<tr>
<td>Self, spouse, &amp; 2+ children</td>
<td>$1,803.36</td>
<td>$1,656.48</td>
</tr>
<tr>
<td>Per child</td>
<td>$264.18</td>
<td>$242.76</td>
</tr>
</tbody>
</table>

#### EMPLOYEE ON LONG-TERM DISABILITY; ON MEDICARE

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>$613.02</td>
</tr>
<tr>
<td>Self &amp; non-Medicare spouse</td>
<td>$1,273.98</td>
</tr>
<tr>
<td>Self &amp; 1 child</td>
<td>$877.20</td>
</tr>
<tr>
<td>Self &amp; 2+ children</td>
<td>$1,140.36</td>
</tr>
<tr>
<td>Self, non-Medicare spouse, &amp; 1 child</td>
<td>$1,539.18</td>
</tr>
<tr>
<td>Self, non-Medicare spouse, &amp; 2+ children</td>
<td>$1,803.36</td>
</tr>
<tr>
<td>Self &amp; Medicare spouse</td>
<td>$1,273.98</td>
</tr>
<tr>
<td>Self, Medicare spouse &amp; 1 child</td>
<td>$1,539.18</td>
</tr>
<tr>
<td>Self, Medicare spouse &amp; 2+ children</td>
<td>$1,803.36</td>
</tr>
<tr>
<td>Per child</td>
<td>$264.18</td>
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</table>
## COBRA premiums continued

### RETIREE NOT ON MEDICARE

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>$1,330.08</td>
<td>$1,224.00</td>
</tr>
<tr>
<td>Self &amp; non-Medicare spouse</td>
<td>$2,724.42</td>
<td>$2,506.14</td>
</tr>
<tr>
<td>Self &amp; 1 child</td>
<td>$1,572.84</td>
<td>$1,447.38</td>
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<tr>
<td>Self &amp; 2+ children</td>
<td>$1,865.58</td>
<td>$1,716.66</td>
</tr>
<tr>
<td>Self, non-Medicare spouse, &amp; 1 child</td>
<td>$2,969.22</td>
<td>$2,731.56</td>
</tr>
<tr>
<td>Self, non-Medicare spouse, &amp; 2+ children</td>
<td>$3,258.90</td>
<td>$2,997.78</td>
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<tr>
<td>Self &amp; Medicare spouse</td>
<td>$1,567.74</td>
<td>$1,442.28</td>
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<tr>
<td>Self, Medicare spouse, &amp; 1 child</td>
<td>$1,811.52</td>
<td>$1,666.68</td>
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<tr>
<td>Self, Medicare spouse, &amp; 2+ children</td>
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<td>$1,934.94</td>
</tr>
<tr>
<td>Per child</td>
<td>$242.76</td>
<td>$223.38</td>
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### RETIREE ON MEDICARE

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>$507.96</td>
</tr>
<tr>
<td>Self &amp; non-Medicare spouse</td>
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</tr>
<tr>
<td>Self &amp; 1 child</td>
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<tr>
<td>Self, non-Medicare spouse, &amp; 1 child</td>
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<tr>
<td>Self, non-Medicare spouse, &amp; 2+ children</td>
<td>$2,373.54</td>
</tr>
<tr>
<td>Self &amp; Medicare spouse</td>
<td>$1,015.92</td>
</tr>
<tr>
<td>Self, Medicare spouse, &amp; 1 child</td>
<td>$1,308.66</td>
</tr>
<tr>
<td>Self, Medicare spouse, &amp; 2+ children</td>
<td>$1,551.42</td>
</tr>
<tr>
<td>Per child</td>
<td>$242.76</td>
</tr>
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</table>

### DENTAL ASSISTANCE PLAN

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
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<td>$34.68</td>
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<tr>
<td>Self &amp; spouse</td>
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<tr>
<td>Self &amp; 1 child</td>
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</tr>
<tr>
<td>Self &amp; 2+ children</td>
<td>$96.90</td>
</tr>
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<td>Self, spouse, &amp; 1 child</td>
<td>$96.90</td>
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<tr>
<td>Self, spouse, &amp; 2+ children</td>
<td>$129.54</td>
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<tr>
<td>Per child</td>
<td>$33.66</td>
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### VISION CARE PLAN

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>$11.30</td>
</tr>
<tr>
<td>Self &amp; spouse</td>
<td>$18.11</td>
</tr>
<tr>
<td>Self &amp; 1 child</td>
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<td>Self &amp; 2+ children</td>
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<td>$31.19</td>
</tr>
<tr>
<td>Per child</td>
<td>$7.19</td>
</tr>
</tbody>
</table>
THIS PAGE
INTENTIONALLY
LEFT BLANK.
GLOSSARY
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active employment. You are working for BSA or a local council for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under the “Eligibility” section in the Long-term Disability chapter.

Your work site must be:

• BSA’s or a local council’s usual place of business
• An alternative work site at the direction of BSA or a local council, including your home
• A location to which your job requires you to travel

Normal vacation is considered active employment. Temporary and seasonal workers are excluded from coverage.

ambulatory surgical center. A specialized facility that is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures, and that fully meets one of the following criteria:

• It is licensed as an ambulatory surgical center by the regulatory authority having responsibility for licensing under the laws of the jurisdiction in which it is located.

• Where licensing is not required, it meets all of the following requirements:
  — It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who devotes full time to supervision.
  — It permits surgical procedures to be performed only by a duly qualified physician who, at the time a procedure is performed, is privileged to perform the procedure in at least one hospital in the area.
  — It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.

• It provides at least one operating room and at least one post-anesthesia recovery room.

• It is equipped to perform diagnostic X-rays and laboratory examinations or has an arrangement to obtain these services.

• It has trained personnel and the necessary equipment to handle emergency situations.

• It has immediate access to a blood bank or blood supplies.

• It provides the full-time service of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room.

• It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis, including, for all patients except those undergoing a procedure under local anesthetic, a pre-operative examination report, medical history, laboratory tests and/or X-rays, an operative report, and a discharge summary.

An ambulatory surgical center that is part of a hospital, as defined herein, will be considered an ambulatory surgical center.

assignment/assigned claims. Benefits are paid to the provider of services.

beneficiary. The individual or recipient of life insurance benefits as named by the employee or retiree.

benefit period (Medicare). Starts when the patient enters the hospital and ends when he or she has been out of the hospital for 60 days in a row, including the day he or she was discharged.

brand-name drug. A brand-name drug has only one manufacturer and is patented. The patent for a brand lasts 17 years. When 17 years have passed, any manufacturer can produce and sell a generic equivalent of the brand-name drug, provided that all of these are true:

• It complies with Food and Drug Administration (FDA) standards.

• It is an innovator drug.

• It is, or was at one time, under patent protection.

calendar year. A period of one year beginning with Jan. 1 and ending Dec. 31.

claims administrator. A company that processes claims submitted for a benefit plan. The claims administrator does not necessarily insure the benefits.

coinsurance. A specific percentage of the total cost of the service or product for which the patient is responsible. (See copay, which is an amount rather than a percentage.)

congenital heart disease. Any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:
• be passed from a parent to a child (inherited);
• develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her pregnancy; or
• have no known cause.

Consolidated Omnibus Budget Reconciliation Act (COBRA). This federal law, enacted in 1986, requires that most employers sponsoring health plans offer employees and their families the opportunity for a temporary extension of health-care coverage at group rates in certain instances where coverage under the plan would otherwise end.

conversion privilege. The opportunity for a covered member to convert group life insurance to an individual policy when group coverage is no longer available.

coordination of benefits. A system for determining order of payment when a member is covered by two plans covering the same type of benefit.

copay. A specific amount paid by the patient for a visit to the doctor or for a prescription. (See coinsurance, which is a percentage rather than an amount.)

covered health service(s). Those health services, supplies, or equipment provided for the purpose of preventing, diagnosing, or treating a sickness, injury, mental illness, substance use disorder, or symptoms. Health services are covered only when the following conditions are met:
• The plan is in effect at the time the health services are provided.
• Health services are provided before the date that any of the individual termination conditions set forth in this plan document take effect.
• The person who receives the services is a covered person and meets all eligibility requirements specified in the plan.

A covered health service must meet each of the following criteria:
• It is supported by national medical standards of practice.
• It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes and is based on trials that meet the following designs:
  — Well-controlled randomized controlled trials (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
  — Well-conducted cohort studies (Patients who receive study treatment are compared to a group of patients who received standard therapy. The comparison group must be nearly identical to the study treatment group.)
• It is the most cost-effective method and yields a similar outcome to other available alternatives.
• It is a health service or supply that is described in “Medical Expenses Covered” and that is not excluded under “Medical Expenses Not Covered.” Decisions about whether to cover new technologies, procedures, and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized controlled trials or cohort studies, as described.

covered member. The employee/retiree and dependents enrolled under the agreement and entitled to coverage.

creditable coverage. Prescription drug coverage (for example, from an employee or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.

custodial care/nursing home. A facility that helps a patient with daily living or personal needs.

deductible (noun). The amount of eligible expenses that must be incurred before benefits are payable.

deductible income. Income from deductible sources listed in the disability plan that you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

dependent child. Your child and/or stepchild from birth to age 26 who is not eligible to enroll in another employer-sponsored plan, including:
• Your children related by blood or marriage
• Children you have legally adopted (including a child for whom legal adoption proceedings have been started)
• Children of whom you have legal custody
• Children for whom you are required to provide coverage as part of a divorce decree, if otherwise eligible
designated virtual network provider. A provider or facility contracted with UnitedHealthcare to deliver covered health services via interactive audio and video communications technology outside of a medical facility.

eligibility waiting period. The continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

eligible expenses. Charges for covered health services that are provided while the BSA Medical Plan is in effect, determined as follows:

• Network benefits: contracted rates with the provider.
• Out-of-network, non-emergency benefits:
  — Negotiated rates agreed to by the out-of-network provider and either the claims administrator or one of its vendors, affiliates, or subcontractors
  — For covered health services other than pharmaceutical products, an amount that, in the judgment of the claims administrator, represents competitive fees in that geographic area
  — For pharmaceutical products, 100 percent of the amount that the Centers for Medicare and Medicaid Services (CMS) would have paid under the Medicare program for the drug, determined either by reference to available CMS schedules or by applying methods similar to those used by CMS
  — A fee schedule that the claims administrator develops
• Out-of-network emergency benefits: for covered health services from an out-of-network provider in an emergency, eligible expenses are the amounts billed by the provider, unless the claims administrator negotiates lower rates.

elimination period. A period of continuous disability that must be satisfied before you are eligible to receive benefits from MetLife.

emergency care. Medical services and supplies provided after the sudden onset of a medical condition manifested by acute symptoms (including severe pain) which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

• Placement of the patient’s health in serious jeopardy
• Serious impairment of bodily function
• Serious dysfunction of a bodily organ or part

In addition, emergency care includes immediate treatment for mental health or substance use disorder when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other people.

employee. A person who is in active employment in the United States with BSA or a local council.

employer. The policyholder, including any division, subsidiary, or affiliated company named in the policy.

enhanced autism spectrum disorder benefit. Services that are focused on educational and behavioral intervention that demonstrates a measurable and beneficial effect on health outcomes. Intensive behavioral therapies.

experimental, investigational, or unproven services. Medical, surgical, diagnostic, psychiatric, substance use disorder, or other health-care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be any of the following:

• Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use
• Subject to review and approval by any institutional review board for the proposed use
• The subject on an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight
• A service that does not meet the definition of a covered health service

If you have a “life-threatening” sickness or condition (one that is likely to cause death within one year of the request for treatment) UnitedHealthcare may determine that an experimental, investigational, or unproven service meets the definition of a covered health service for that sickness or condition. For this to take place, United Healthcare must determine that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.
hospital. An institution that is engaged primarily in providing medical care and treatment of sick and injured people on an inpatient basis at the patient's expense and that fully meets one of the following tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Hospitals.
- It is approved by Medicare as a hospital.
- It meets all of the following tests:
  - It maintains, on the premises, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured people by or under the supervision of a staff of duly qualified physicians.
  - It continuously provides on-the-premises, 24-hours-a-day nursing service by, or under the supervision of, registered graduate nurses.
  - It is operated continuously with organized facilities for operative surgery on the premises.

injury. A bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

in-network. Describes hospitals, pharmacies, physicians, and other health-care providers that are under contract with the plan administrator to provide services to members of managed care plans.

inpatient. Describes Services in a hospital or other licensed institution that require an overnight stay for which a room-and-board charge is customarily assessed. (See outpatient.)

Intermediate care. Mental health or substance use disorder treatment that encompasses care at a residential treatment facility, care at a partial hospitalization/day treatment program, or care through an intensive outpatient treatment program.

layoff. A period of time during which you are temporarily absent from active employment that has been communicated in advance in writing by BSA or a local council. Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

leave of absence. A period of time during which you are temporarily absent from active employment that has been agreed to in advance in writing by BSA or a local council.
council. Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

**licensed counselor.** A person who specializes in the treatment of mental health or substance use disorder and is licensed as a licensed professional counselor (LPC) or master of social work (MSW) by the appropriate authority.

**life-threatening.** Describes a condition such as (1) a major illness or injury, a heart attack, or a serious wound; (2) unconsciousness; (3) bleeding that will not respond to elevation or direct pressure; (4) stupor, drowsiness, or disorientation that cannot be explained; (5) shortness of breath; (6) severe pain; and (7) poisoning.

**Medicare.** The Health Insurance for the Aged and Disabled program, under Title XVIII of the Social Security Act.

**Medicare crossover.** A process that allows Medicare to automatically forward Part B and durable medical equipment claims to a secondary insurance company or plan administrator.

**Medicare Part A.** Hospital insurance that helps pay for inpatient hospital care, inpatient care in a skilled-nursing facility, home health care, and hospice care.

**Medicare Part B.** Medical insurance that helps pay for physicians’ services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by Medicare Part A.

**member.** A person who is enrolled under the agreement as a subscriber or as a dependent and is entitled to coverage.

**mental illness.** A psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to psychotic, emotional or behavioral disorders, or disorders relatable to stress. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability. The treatment for it is primarily the use of psychotherapy or other psychotherapeutic methods.

**monthly benefit.** The total benefit amount for which an employee is insured under a plan subject to the maximum benefit.

**monthly earnings.** Your gross monthly income from BSA or a local council as defined in a plan.

**network.** Hospitals, pharmacies, physicians, and other health-care professionals in an area that are under contract with the plan administrator to provide services to members of the plan administrator’s managed care plans.

**non-notification penalty.** Benefits are reduced if you do not follow the proper notification procedures as required by the plan administrator.

**nurse.** A licensed health-care professional who practices independently or is supervised by a physician, surgeon, or dentist and who is skilled in promoting and maintaining health. A nurse may be a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN).

**nurse-midwife.** A registered nurse with additional training as a midwife who delivers infants and provides prenatal and postpartum care, newborn care, and some routine care (as gynecological exams) of women.

**nurse-practitioner.** A registered nurse who is qualified through advanced training to assume some of the duties and responsibilities formerly assumed only by a physician. The nurse-practitioner must fulfill both of these requirements:
- Is licensed by a board of nursing as a registered nurse.
- Has completed a state-approved program for the preparation of nurse-practitioners.

**other services and supplies.** Services and supplies furnished to the individual and required for treatment other than the professional services of any physician and any private-duty or special nursing services (including intensive nursing care).

**out-of-network.** Describes hospitals, pharmacies, physicians, and other health-care professionals that are not under contract with the plan administrator but are located within the plan administrator’s network area.
out-of-pocket maximum. The amount a participant must pay per calendar year that is not covered or reimbursed by the plan.

outpatient. Describes services rendered at hospitals and/or physician's offices that do not require an overnight stay.

palliative. Treatment/medication that reduces the intensity of a disease, easing it without curing it.

payable claim. A claim for which an insurance company is liable under the terms of a policy.

physical therapy. The treatment of disease by physical and mechanical means (i.e., massage, regulated exercise, water, light, heat, and electricity); also called physiotherapy.

physician. A legally qualified:
- Doctor of medicine (M.D.)
- Doctor of chiropody (D.P.M.; D.S.C.)
- Doctor of chiropractic (D.C.)
- Doctor of dental surgery (D.D.S.)
- Doctor of medical dentistry (D.M.D.)
- Doctor of osteopathy (D.O.)
- Doctor of podiatry (D.P.M.)

physician (regarding disability)
- A person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery and who is performing tasks that are within the limits of his or her medical license; or
- A person with a doctoral degree (Ph.D. or Psy.D.) in psychology whose primary practice is treating patients; or
- A person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction

MetLife will not recognize you, your spouse, children, parents, or siblings as a physician for a claim that you send to MetLife.

policyholder. BSA or a local council to whom a policy is issued.

pre-existing condition. A condition for which you received medical treatment, consultation, care, or services including diagnostic measures, or for which you took prescribed drugs or medicines during the given period of time as stated in the plan.

preventive drug list. List of medications meeting clinical guidelines which include the following therapeutic categories: anti-estrogen, anti-platelet, vitamins, anti-hypertensives, anti-coagulant, lipid/cholesterol lowering agents, osteoporosis therapy, multivitamins/fluoride, and immunosuppressants.

primary care physician (PCP). Typically an internist or family practice physician who coordinates and monitors the delivery of care to an individual.

provider. Any physician, facility, or vendor that delivers a medical service or supply to the patient.

reasonable and customary. The fee charged is reasonable when the fee for a specific service falls within the range of usual charges by providers in the same geographical area who have similar training and experience. The fee is considered customary when it is the fee that your provider most frequently charges to the majority of patients for a similar service or procedure. In determining whether a charge is reasonable and customary, consideration is given to unusual circumstances or complications requiring additional time, skills, and/or experience in connection with the particular service or procedure.

reconstructive. Refers to surgery and other medical procedures that are incidental to an injury, sickness, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of reconstructive surgery does not classify such surgery as cosmetic when a physical impairment exists and the surgery restores or improves function. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness, or congenital anomaly does not classify surgery done to relieve such consequences or behavior as reconstructive surgery.

rehabilitation. Describes services that physically restore a sick or disabled person by therapeutic measures and re-education to participate in the activities of a normal life within the limitations of his or her physical disability.

rehabilitation facility. A facility accredited by the Commission on Accreditation of Rehabilitation Facilities.
retiree/retirement. An employee who retires from BSA or a local council and satisfies all of the following criteria:
- Is a member of the BSA Retirement Plan
- Is age 55 or older
- Meets the retirement vesting rules as stated in the BSA Retirement Plan

retirement plan. A defined contribution plan or defined benefit plan. These are plans that provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement plan includes but is not limited to any plan that is part of any federal, state, county, municipal, or association retirement system.

salary continuation or accumulated sick leave. Continued payments to you by BSA and a local council of all or part of your monthly earnings, after you become disabled as defined by the policy. This continued payment must be part of an established plan maintained by BSA and a local council for the benefits of all employees covered under the policy. Salary continuation or accumulated sick leave does not include compensation paid to you by BSA and a local council or work you actually perform after your disability begins. Such compensation is considered disability earnings and would be taken into account in calculating your monthly payment.

skilled-nursing facility. If the facility is approved by Medicare as a skilled-nursing facility, then it is covered by the BSA Medical Plan. If not approved by Medicare, the facility may be covered if it meets the following tests:
- It is operated under applicable licensing and other laws.
- It is under the supervision of a licensed physician or registered graduate nurse (RN) who devotes full time to supervision.
- It is regularly engaged in providing room and board and continuously provides 24-hours-a-day skilled-nursing care of sick and injured people at the patient’s expense during the convalescent stage of an injury or sickness.
- It maintains a daily medical record of each patient, who is under the care of a duly licensed physician.
- It is authorized to administer medication to patients on the order of a duly licensed physician.
- It is not, other than incidentally, a home for the aged, the blind, or the deaf; a hotel; a domiciliary care home; a maternity home; or a home for alcoholics, drug addicts, or the mentally ill.

A skilled-nursing facility that is part of a hospital, as defined herein, will be considered a skilled-nursing facility for the purposes of this plan.

social worker. A person who is concerned with the investigation, treatment, and material aid of the economically underprivileged and socially maladjusted and is licensed or certified as a social worker by the appropriate authority.

specialist. A physician who has extensive post–medical school training in a particular field of medicine. Neurologists, oncologists, and gastroenterologists are examples of specialists.

substance use disorder. A condition of psychological and/or physiological dependence on or addiction to alcohol or psychoactive drugs or medicines, which results in functional (physical, cognitive, mental, affective, social, or behavioral) impairment.

surgery. A procedure performed by a doctor that is specifically listed in the American Medical Association Schedule of Procedures or is in one of the following categories:
- The incision, excision, or electrocauterization of any organ or part of the body
- The manipulative reduction of a fracture or dislocation
- The suturing of a wound
- The removal by endoscopic means of a stone or other foreign object from the larynx bronchus, trachea, esophagus, stomach, urinary bladder, or ureter

survivor. The spouse and/or dependent children of:
- A deceased BSA or local council employee who was enrolled and vested in the BSA Retirement Plan at the time of death
- A deceased BSA or local council retiree, as “retiree” is defined in this glossary

treatment center. A facility that meets the following requirements:
- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a physician and the plan administrator.
- It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient.
• It provides at least the following basic services:
  — Room and board (if the plan provides inpatient benefits at a treatment center)
  — Evaluation and diagnosis
  — Counseling
  — Referral and orientation to specialized community resources

Treatment centers that qualify as hospitals (as defined in this plan) are covered as hospitals and not as treatment centers.

**treatment plan.** The length and intensity level of treatment for:
  • Home health care
  • Private-duty nursing
  • Chiropractic care
  • Physical therapy

**virtual visits.** Virtual visits for covered health services that include diagnosis and treatment of low-acuity medical conditions for covered persons through the use of interactive audio and video technology outside of a medical facility.

**well-woman exam.** Routine exam performed by a physician that includes a pap smear, pelvic exam, and mammogram, if necessary.
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<thead>
<tr>
<th>Contact</th>
<th>Telephone No.</th>
<th>Website</th>
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<tbody>
<tr>
<td>BSA Benefits Center</td>
<td>800-444-4416 Mon.–Fri. 9 a.m.–6 p.m. Central Standard Time</td>
<td><a href="http://bsabenefits.mercerhrs.com">http://bsabenefits.mercerhrs.com</a></td>
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<tr>
<td>UnitedHealthcare Virtual Visits</td>
<td></td>
<td><a href="http://www.myuhc.com">www.myuhc.com (group: 136003)</a></td>
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<tr>
<td>Personal Rewards (UHC)</td>
<td>Phone: 877-818-5826 Fax: 855-247-0586</td>
<td><a href="http://www.myuhc.com">www.myuhc.com</a></td>
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<td>Optum Health Bank (HSA)</td>
<td>800-791-9361, option 1</td>
<td></td>
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<tr>
<td>Cancer Resource Services</td>
<td>866-936-6002</td>
<td><a href="http://www.myoptumhealthcomplexmedical.com">www.myoptumhealthcomplexmedical.com</a></td>
</tr>
<tr>
<td>Personal Health Support</td>
<td>Phone: 877-818-5826 Fax: 855-247-0586</td>
<td><a href="http://www.myuhc.com">www.myuhc.com</a></td>
</tr>
<tr>
<td>Optum NurseLine</td>
<td>866-529-1680</td>
<td><a href="http://www.myuhc.com">www.myuhc.com</a></td>
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<tr>
<td>Employee Assistance Plan (EAP) and United Behavioral Health (UBH)</td>
<td>800-788-5614</td>
<td><a href="http://www.liveandworkwell.com">www.liveandworkwell.com (pin: 136003)</a></td>
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<tr>
<td>OptumRx</td>
<td>855-842-6337</td>
<td><a href="http://www.myuhc.com">www.myuhc.com</a></td>
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<td>Naturally Slim</td>
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<td><a href="http://www.naturallyslim.com">www.naturallyslim.com</a></td>
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<td>Scouting2Health</td>
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<td><a href="http://www.mercerhrs.com/scouting2health">www.mercerhrs.com/scouting2health</a></td>
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<td>MetLife</td>
<td>Dental 800-942-0854</td>
<td><a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></td>
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<td></td>
<td>Life/AD+D 800-638-6420</td>
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<td></td>
<td>Disability 866-729-9201</td>
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<tr>
<td>Vision Service Plan (VSP)</td>
<td>800-877-7195</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
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<tr>
<td>Fidelity Investments</td>
<td>800-343-0860</td>
<td><a href="http://www.fidelity.com/atwork">www.fidelity.com/atwork</a></td>
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<tr>
<td>Mutual of America</td>
<td>800-468-3785</td>
<td><a href="http://www.mutualofamerica.com">www.mutualofamerica.com</a></td>
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<tr>
<td>Health Insurance Marketplace</td>
<td>800-318-2596</td>
<td><a href="http://www.healthcare.gov">www.healthcare.gov</a></td>
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<tr>
<td>Social Security Administration</td>
<td>800-772-1213</td>
<td><a href="http://www.ssa.gov">www.ssa.gov</a></td>
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<td>Medicare</td>
<td>800-633-4227</td>
<td><a href="http://www.medicare.gov">www.medicare.gov</a></td>
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<td>Department of Health &amp; Human Services</td>
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<td><a href="http://www.hhs.gov">www.hhs.gov</a></td>
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