

**WELFARE BENEFIT TRUST**

**GUIDELINES TO SUBMIT FOR BENEFITS**

**EFFECTIVE 7-1-2007**

***APPLICATIONS WILL BE PROCESSED ON OR ABOUT THE 1<sup>ST</sup> & 15<sup>TH</sup> OF EACH MONTH***

THE FOLLOWING ITEMS MUST BE MADE AVAILABLE:

**BENEVOLENCE REQUEST FORM**

1. Submit your first bills of the year on the **YELLOW** Benevolence Request Form.  
**Complete the entire form.**
2. Submit other bills throughout the year with the **PINK** Benevolence Request Form.  
**Complete the entire form.**
3. If you are submitting bills to be paid for one of your employees from your eligibility benefits submit the **BLUE** form. **Complete the entire form**
4. **PLEASE** submit the entire bill showing services rendered
5. **PLEASE** assemble your bills/prescriptions in a neat and orderly fashion
6. **For reimbursement** proof of any payments (receipts, cancelled checks) must be submitted at the time of request, the member's name must be on all receipts and bills.
7. Bills must be submitted within **90 days** of occurrence, or may not be covered.

**SUBMIT ALL INFORMATION TO THE HBPA SECRETARY**

**THESE FORMS ARE TRUE, SUBJECT TO FORFEITURE OF BENEFITS.**

**THE FOLLOWING ARE THE LIMITS FOR  
THE WELFARE BENEFIT TRUST**

**MEDICAL - \$10,000** (PER FAMILY, PER YEAR, THIS INCLUDES EMPLOYEES AND THEIR FAMILY)

**PRESCRIPTIONS - \$1500.00** TOTAL (PER FAMILY, PER YEAR, THIS INCLUDES EMPLOYEES AND THEIR FAMILY)

**DENTAL - \$200.00 EMERGENCY – MAXIMUM \$2,500.00** (PER FAMILY, PER YEAR. THIS INCLUDES EMPLOYEES AND THEIR FAMILY)

**VISION – EXAM/GLASSES – \$800.00** (PER FAMILY, PER YEAR, THIS INCLUDES EMPLOYEES AND THEIR FAMILY) **ONE PAIR OF GLASSES ALLOWED PER PERSON.**

**AUDIOLOGY – HEARING AID - \$1,000**

**BILLS OF \$20.00 OR LESS WILL NOT BE PROCESSED, EXCEPT PRESCRIPTIONS.**

**(FAMILY = PERMIT HOLDER SPOUSE AND DEPENDENTS)  
(YEAR = JANUARY 1 THROUGH DECEMBER 31)**

\*\*\*All benevolence is subject to availability of funds\*\*\*

**CHARLES TOWN HBPA, INC  
HEALTH BENEFITS PLAN**

**THIS PROGRAM THE CHARLES TOWN WELFARE BENEFIT TRUST, IS A NON-PROFIT ORGANIZATION, PROVIDED AS A MEANS OF EASING FINANCIAL BURDEN CREATED BY ILLNESS OR INJURY NOT COVERED BY ANY TYPE OF INSURANCE. IT IS NOT AN INSURANCE COMPANY AND DOES NOT ASSUME RESPONSIBILITY FOR ANY INCURRED CHARGES NOR DOES IT GUARANTEE APPROVAL FOR ANY REQUEST OF ASSISTANCE. THIS PROGRAM IS PROVIDED WITHOUT COST TO ELIGIBLE MEMBERS THEIR FAMILIES, THEIR EMPLOYEES AND THEIR FAMILIES IN ACCORDANCE WITH THE TERMS, LIMITS, CONDITIONS AND BENEFITS STATED.**

THE CHARLES TOWN HBPA WELFARE BENEFIT TRUST IS NOT INTENDED TO BE A SUBSTIUTE FOR PRIVATE HEALTH AND MEDICAL INSURANCE

**THIS PROGRAM IS ADMINISTERED BY A BOARD OF TRUSTEES CONSISTING OF TWO (2) MEMBERS OF THE BOARD OF DIRECTORS OF THE CHARLES TOWN HBPA, INC., EACH SERVING THREE (3) YEAR TERMS AND THREE (3) MEMBERS SELECTED FROM THE CHARLES TOWN HBPA, INC. MEMBERSHIP AND VOTED ON BY THE GENERAL MEMBERSHIP. THESE THREE (3) TERMS WILL BE FOR ONE (1), TWO (2) THREE (3) YEARS, RESPECTFULLY.**

**NEW ELIGIBILITY: EFFECTIVE – 7-1-2007**

ALL CHARLES TOWN HBPA INC. OWNERS, TRAINERS, THEIR FAMILIES, THEIR EMPLOYEES AND THEIR FAMILIES WHO MEET THE FOLLOWNG CRITERIA:

1. **PARTICIPANTS CANNOT BE STABLED AT ANY OTHER RACE TRACK THAT CONDUCTS LIVE RACING.**

2. PARTICIPATION BY A MEMBER SHALL BE VOLUNTARY
3. MEMBER MUST HAVE AN APPLICATION ON FILE IN THE HBPA OFFICE
4. MEMBER/EMPLOYEE OF AN HBPA MEMBER MUST HAVE BEEN STABLED OR EMPLOYED FULL TIME AT THE CHARLES TOWN RACES FOR A MINIMUM OF SIXTY (60) DAYS
5. MEMBER MUST HAVE STARTED A MINIMUM OF ONE (1) HORSE A MONTH FOR **SIX (6) MONTHS** OF THE PREVIOUS TWELVE (12) MONTHS.
6. **IN ADDITION, SEVENTY-FIVE PERCENT (75%)** OF MEMBER'S STARTS IN THE LAST TWELVE (12) MONTHS MUST HAVE BEEN AT THE CHARLES TOWN RACES.
7. **PROOF OF ALL STARTS** IS TO BE SUBMITTED WHEN REQUESTS FOR BENEFITS ARE APPLIED FOR. IF NOT STABLED AT CHARLES TOWN OR SURROUNDING AREAS IN WEST VIRGINIA.
8. **IF A MEMBER LOSES ELIGIBILITY, ALL EMPLOYEES AND ALL DEPENDENTS LOSE ELIGIBILITY.**
9. MEMBERS AND EMPLOYEES OF AN HBPA MEMBER MUST HAVE A CURRENT WV LICENSE ISSUED BY THE WV RACING COMMISSION AND **MUST BE IN GOOD STANDING**
10. MEMBERS ELIGIBLE FOR MEDICARE MUST USE MEDICARE IN CONJUNCTION WITH THE HEALTH BENEFIT PLAN
11. SPOUSES OF MEMBERS AND EMPLOYEES
12. DEPENDENTS OF MEMBERS OR MEMBER'S EMPLOYEES WHO ARE EIGHTEEN (18) YEARS OF AGE AND LIVING AT HOME.
13. DEPENDENTS OF MEMBERS OR MEMBER'S EMPLOYEES WHO ARE TWENTY-THREE (23) YEARS OF AGE AND UNDER AND ARE FULL TIME STUDENTS IN COLLEGE OR AT A UNIVERSITY, WITH PROPER PAPERWORK TO SUBSTANTIATE THIS.
14. HANDICAPPED DEPENDENTS OF ALL AGES WHO ARE INCAPABLE OF SELF SUPPORT
15. FOR ELIGIBILITY PURPOSES, EMPLOYEE IS DEFINED AS EXCLUDING BARN AREA AND TRACK VENDORS AND CASUAL LABOR, SUCH AS JOCKEYS, EXERCISE PERSONS, FARRIERS, ETC.

<b>BENEFITS:</b>
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THE FOLLOWING WILL BE PAID TO THE LIMITS ALLOWED:

1. HOSPITAL BILLS
2. HOSPITAL-RELATED DOCTOR BILLS

3. OUT-PATIENT SURGERY
4. PRESCRIPTIONS
5. DENTAL
6. VISION
7. AUDIOLOGY

THE FOLLOWING WILL **NOT BE PAID**

1. OCCUPATIONAL INJURY OR DISEASE
2. COSMETIC/ELECTIVE SURGERY OR PROCEDURE
3. ALCOHOL OR DRUG ADDICTION OR RELATED INJURY OR ILLNESS
4. NON-THERAPEUTIC ABORTION OR BIRTH CONTROL MEDICINE
5. INJURY OR ILLNESS WHICH RESULTS FROM THE COMMISSION OF A CRIME
6. SELF-INFLICTED INJURY
7. INJURY RESULTING FROM AN ALTERCATION
8. NERVOUS, MENTAL OR STRESS RELATED DISORDERS
9. ORTHODONTIC PROCEDURES AND APPLIANCES
10. COSMETIC DENTAL SERVICES.
11. EMERGENCY ROOM FEES FOR NON-EMERGENCY SITUATIONS
12. INJURIES RESULTING FROM A VEHICLE ACCIDENT

<b>LIMITS</b>
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**MEDICAL - \$5,000.00 TOTAL** (PER FAMILY, PER YEAR, THIS INCLUDES EMPLOYEES AND THEIR FAMILY)

**PRESCRIPTIONS - \$500.00 TOTAL** (PER FAMILY, PER YEAR, THIS INCLUDES EMPLOYEES AND THEIR FAMILY)

**AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION**

I hereby authorize Charles Town WELFARE BENEFIT TRUST to obtain individually identifiable health information from health providers (including) pharmacist, who have rendered services to me and consent to those health care providers disclosure of such information to the trust for purposes of claims processing, payment and/or reimbursements.

I hereby authorize Charles Town HBPA Welfare Benefit Trust to obtain individual information pertaining to the status of eligibility rendered to my dependants.

I understand that this authorization will expire on 12/31/08.

I understand that I may revoke this authorization at any time by notifying the Trust in writing. The revocation will have no affect on actions taken by the Trust prior to receipt of the revocations.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**