NFL PLAYER BENEFITS

PLAYER INSURANCE PLAN

Summary Plan Description

NFL Player
Insurance Plan

www.nflplayerbenefits.com

NFL Player Insurance Plan

NFL Player Insurance Plan
Alight Solutions
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November 2020

Dear Participant:

The NFL Player Insurance Plan ("Plan") provides health and welfare benefits to eligible Players and their Eligible Dependents in accordance with the collective bargaining agreement between the NFL Management Council and the NFL Players Association. The member clubs of the National Football League pay for the benefits through contributions to the NFL Player Insurance Trust. This Summary Plan Description ("SPD") summarizes important provisions of the Plan.

The SPD provides a summary of:

- who is eligible for benefits
- what benefits are provided
- when benefits become available
- how long benefits are available

Cigna maintains an extensive national network of physicians, dentists, hospitals and other health care providers. You can take advantage of automatic claims submission and you may have lower out-of-pocket costs by using a Provider in Cigna's network. You may always choose an out-of-network health care provider, but you may incur higher out-of-pocket costs. You can contact the Plan's service center (the "Customer Service Center") by telephone at 800-635-9671 or you may access myCigna.com for help in locating a network Provider, and can access online appointments with health care providers at MDLiveforCigna.com.

New this Plan Year, the Plan is now providing a Vision Benefit through an Insurance Policy currently issued and administered by MetLife. For general questions about your eligibility for the Vision Benefit, you can contact the Customer Service Center, or for more specific information about the benefit itself, you may access metlife.com/mybenefits.

Your benefits are fully described in a separate document (the "Plan Document"). In the event of any inconsistencies between this SPD and the Plan Document, the Plan Document governs. Additional copies of this SPD and the Plan Document are available by calling the Customer Service Center or at nflplayerbenefits.com.

This SPD describes the Plan in effect beginning on September 1, 2020, as amended by the March 15, 2020 collective bargaining agreement, and Side Letters dated August 3, 2020. For benefits for services received or events occurring prior to September 1, 2020, please refer to the SPD in effect during the date of service or the occurrence of such event.

We know these benefits will provide an important measure of security for you and your family.

Belinda Lerner
NFL Management Council

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Overview of the Plan

Benefits in Brief

The National Football League ("NFL"), through agreement with the National Football League Players Association ("NFLPA"), provides the following benefits under the NFL Player Insurance Plan ("Plan"):

- Life insurance
- Accidental death and dismemberment insurance ("AD&D")
- Medical coverage
- Dental coverage
- Vision coverage
- Work/Life Resources

Highlights of Your Benefits

The Plan's Life and AD&D benefits and Vision benefits are currently provided through insurance contracts, the premiums for which are paid by contributions from the member clubs of the NFL (the "Clubs"). The Life and AD&D benefits are currently provided and adminstered under an Insurance Policy issued by Prudential Insurance Company of America ("Prudential"). The Vision Benefits are are currently provided through an Insurance Policy issued and administered by MetLife.

Dental and Medical benefits (including prescription drugs) and the Work/Life Resources benefits are self-funded by contributions from the member clubs of the NFL (the "Clubs") and are currently administered in part by Cigna in its capacity as a third-party Claims Administrator. The following chart briefly describes the benefits provided under the Plan. Each benefit is described in more detail in its respective section. Certain capitalized terms used in this SPD have a special meaning, which is provided where the term appears in the text of the SPD, in the introductory letter, and/or in the Glossary of Terms.

BENEFIT	DESCRIPTION	MORE INFORMATION
Life insurance	The amount of your life insurance coverage is based on the number of your Credited Seasons.	Beginning on page 12
AD&D	Your AD&D coverage protects you and your family if you are injured or die in an accident.	Beginning on page 13

BENEFIT	DESCRIPTION	MORE INFORMATION
Medical Coverage	Your medical program provides coverage to you and your Eligible Dependents for a broad range of services and supplies for Injuries and Illnesses that are not work related. Discounts are available if you use Preferred Providers.	Beginning on page 21
Dental Coverage	Your dental program, after payment of the Deductible, covers 100% of you and your Eligible Dependents preventive and diagnostic services and a part of your basic, major restorative and orthodontic expenses.	Beginning on page 39
Vision Benefits	Your Vision Benefits for you and your eligible dependents cover some or all of the cost of exams, corrective lenses, frames and contact lenses.	Beginning on page 45
Work/Life Resources Benefit	Your Work/Life Resources benefit provides counseling and referral assistance to you, your Dependent or Household Member.	Beginning on page 51

Paying for Your Benefits

The Clubs fund the NFL Player Trust ("Trust") that pays for the benefits provided and insurance premiums owed under the Plan. Eligible Players pay the applicable medical, dental or vision Deductibles, Coinsurance, any costs greater than the Maximum Reimbursable Charges that a non-Preferred Provider may charge or the Allowable Vision Expense provided under the Vision Benefit, any penalties, such as the penalties imposed for a failure to pre-certify (see page 26), and any premiums for COBRA or extended coverage (see pages 65-66). The NFL Management Council ("Management Council") appoints the trustees of the Trust.

Future of the Plan

The NFL and NFLPA intend to continue the Plan for the duration of the CBA, but reserve the right to amend or terminate the Plan or to change the cost sharing arrangements between the NFL and participants. This may be done at any time and without prior notice pursuant to the CBA, however, no benefit provided under the Plan shall be changed without mutual consent of the NFL and NFLPA. If a change is made to the Plan, or if the Plan is terminated, a different plan providing similar or identical benefits may or may not be established. Benefits for claims occurring after the effective date of any Plan modification or termination are payable in accordance with the revised provisions. Although the NFL and NFLPA intend to continue the Plan, the Plan shall terminate as to all players as of the last day of the 2030 League Year unless continued under future collective bargaining agreements. If the Plan is not continued, Claims for services received but not submitted prior to the end of the 2030 League Year shall be paid in accordance with the terms of the Plan in effect prior to the termination.

All statements in this SPD and all representations by the NFL and the NFLPA are subject to this right of termination and amendment. This right applies without limitation, even after a Participant's circumstances have changed by retirement or otherwise.

Importance of the SPD

This SPD summarizes the Plan in effect on September 1, 2020. It will help you understand your benefits and the circumstances under which restrictions or exclusions may apply.

Some of the benefits require you to make certain individual decisions (for example, beneficiary designations) which may affect your financial planning. In order to ensure that these decisions satisfy your individual needs, you may wish to consult with your attorney or financial advisor.

The Plan may be amended from time to time. These amendments will be described in an updated SPD or a Summary of Material Modification ("SMM"), but there likely will be a delay between the date a change to the Plan becomes effective, and the date that such change is described in an SPD or an SMM. However, you will be notified 60 days before the effective date of any amendment that materially reduces your benefits under the Plan. Accordingly, the terms of the changed Plan Document or insurance contracts will be controlling in the event of any differences between the terms of the changed Plan Document or insurance contracts and the terms of this SPD or an SMM. As changes to the Plan may affect your decisions, before taking any action you should contact the Customer Service Center at 800-635-9671 to determine whether there have been any changes to the Plan Document or insurance contracts since this SPD was printed.

Your benefits are described in full in the Plan Document. In the event of any inconsistencies between this SPD and the Plan Document, the Plan Document governs.

The Benefits Administration section of this SPD explains your rights under ERISA.

Eligibility and Coverage

Eligibility

In general, a Player is eligible for benefits if, on a regular or post-season game date of his Club, he has a Qualifying Benefit Status, which is limited to the following designations:

- Active
- Higher Risk Opt-Out Player (2020 Plan Year Only)
- Inactive
- Opt-Out Player who either earned a Credited Season under the Pension Plan and/or for Minimum Salary purposes for the 2019 Season or is a 2020 College Drafted Player (2020 Plan Year Only)
- Reserve/COVID-19 (2020 Plan Year Only)
- Reserve/Injured
- Reserve/Physically Unable to Perform
- Practice Squad
- International Practice Squad
- Practice Squad Exception
- Practice Squad; Injured

However, any Player in the Substances of Abuse Program is eligible for substances of abuse treatment benefits and any Player who violates the NFL Personal Conduct Policy is eligible for the Behavior Management Benefit.

When Coverage Begins

Your life, AD&D, medical, dental, vision, and work/life resources coverages are effective on the first day you are on a Game Day Roster in a Qualifying Benefit Status, **except as follows:**

IF YOU	THEN
Never had coverage under this Plan	Your life insurance, AD&D and work/life resources coverages are effective on the first day you report to pre-season training camp. Your medical, dental and vision coverage are effective on the first day your are on a Game Day Roster on a qualifying list.
Had medical and dental coverage under this Plan in the immediately prior Plan Year	Life, AD&D, medical, dental, vision, and work/life resources coverages are effective on the first day you are on a Game Day Roster in a Qualifying Benefit Status or if that game occurs prior to October 1, the first day of the Plan Year.
Had coverage in any Plan Year other than the immediately prior Plan Year and it ended	Life, AD&D, medical, dental, vision, and work/life resources coverages are effective on the **earlier** of: • the day you report to pre-season training camp; or • the first day you are on a Game Day Roster in a Qualifying Benefit Status
For the 2020 Plan year only, are an Opt-Out Player who either: (1) earned a Credited Season under the Pension Plan and/or for Minimum Salary purposes for the 2019 Season; (2) is a Drafted Player (2020 College Draft only); and/or (3) is a Higher-Risk Opt-Out Player	If not otherwise effective on an earlier date as described above, your Life, AD&D, medical, dental, vision, and work/life resources coverages are effective on the date of your Club's first Game of the 2020 Season.

The mere fact that you receive a payment or benefit for an injury will not automatically make you eligible for any Plan benefits. However, you may obtain coverage for a Plan Year if you did not otherwise qualify for coverage in that Plan Year because of an injury in the preseason, but only if you received payment for one or more regular season Game as the result of an Injury Grievance or settlement of a potential Injury Grievance.

Covering Your Eligible Dependents

Your dependents also may be covered by the medical, dental, vision, and work/life resources programs. An Eligible Dependent must be either your spouse or your Child. A Child means: a natural child, a legally adopted child, a child for whom you become legally obligated to support prior to adoption, a child for whom entry of an order granting permanent custody or permanent legal guardianship to **you** has been made, or a stepchild who lives in your household. However, in each case the Child's eligibility ends as of the last day of the month that the Child reaches the age of 26, unless the Child depends on you for support and the Claims Administrator, currently Cigna, has determined the Child was mentally or physically incapacitated before age 26.

To enroll a natural child, you must comply with the Plan's documentation requirements to establish paternity. Normally, this consists of either a birth certificate naming you as the Child's father, DNA evidence establishing you as the father, or a court order declaring you as the Child's father. The documentation requirements apply even if a qualified medical child support order ("QMCSO") requires you to cover the Child unless such QMCSO also declares that you are the child's father. (Contact the Customer Service Center at 800-635-9671 for a free copy of the Plan's procedures for administering a QMCSO.)

When Dependent Coverage Begins

Coverage for your Eligible Dependents, and with respect to Work/Life resources coverage Household Members, begins when:

- you meet the Player's eligibility requirements for coverage as stated above; and
- for Eligible Dependents, completed the enrollment process.

For example:

IF YOU	THEN
Are a Dependent	Your medical, dental, vision, and work/life resources coverages are effective on the **later** of: • the day the Player becomes eligible for coverage or • the day you become a Dependent of a Player covered by the Plan
Are a Household Member	Your work/life resources coverage is effective on the **later** of: • the day the Player becomes eligible for coverage or • the day you become a Household Member of a Player covered by the Plan.

Adding Dependents to Your Coverage

In order to add Eligible Dependents to your coverage, you must notify the Customer Service Center and supply required documentation within 31 days of any of the following events:

- the date you first become eligible under the Plan if you already have Eligible Dependents as of that date
- your marriage
- the birth or adoption of a Child or your becoming the permanent legal guardian of a Child
- your Dependent loses other medical insurance coverage

If you do not notify Customer Service within 31 days of any of the above events, coverage for your Dependents will not be effective until you notify Customer Service of such event.

Removing Dependents from Your Coverage

Your Dependents also cease to be eligible immediately upon certain events. You must notify the Customer Service Center at 800-635-9671 within 31 days of the date of any of the following events:

- divorce from your spouse
- your child ceases to satisfy the eligibility conditions set out above.

Please also timely notify the Customer Service Center of the death of a dependent.

If you fail to provide proper notice of a divorce or your child's loss of eligibility, **YOU MAY SUFFER SEVERE CONSEQUENCES.** For example, the Plan does not provide benefits to an ex-spouse, except pursuant to COBRA. Therefore, if your ex-spouse receives benefits from the Plan after your divorce because neither of you gave timely notice, **you will be personally responsible to reimburse the Plan for the cost of providing those benefits;** and the Plan will take legal action if necessary to collect from you, to include reducing the value of any credit you may have under the Gene Upshaw NFL Player Health Reimbursement Account. Also, your ex-spouse will forfeit any right to elect COBRA if the NFL COBRA Administrator is not notified within 60 days of the date of your divorce. See page 55 for a summary of your obligation to notify the NFL COBRA Administrator to obtain COBRA coverage.

Some jurisdictions recognize common law marriage, which may affect your rights and obligations under this Plan. Further, other jurisdictions may recognize common law relationships formed in states that allow such marriages. The requirements for the formation and recognition of such marriages vary and change from time to time. You should contact your attorney to determine your rights and obligations under local law.

In certain cases, you also must notify the NFL COBRA Administrator to obtain COBRA coverage (see page 55).

When Coverage Ends

Except to the extent the CBA may otherwise provide, your coverage under this Plan will end on the earliest of the following dates:

- the date the CBA expires or is terminated
- the date the Plan is terminated
- the date your Club stops contributing to the Trust
- the Coverage Ending Date that applies to you and your Dependents, plus any extensions shown on the chart below

If you have never before had coverage under the Plan and your NFL contract terminates on or before the first game of the regular season, your life, AD&D and Work/Life Resources coverage end on the later of (1) the date your contract terminates, or (2) August 31 immediately preceding the regular season.

If you are in the Substances of Abuse Program or are receiving Behavior Management Benefits and are not otherwise eligible for coverage under the Plan, your coverage under either program ends when you are discharged from the program.

Generally, your Coverage Ending Date is the last day of the Plan Year (August 31) immediately following the last Game Day Roster for which you had a Qualifying Benefit Status. If you have coverage for the 2020 Plan Year because you are an Opt-Out Player, and you are not eligible for coverage for any subsequent Plan Year, your Coverage Ending Date is August 31, 2021. However, your coverage may be extended to August 31 of a subsequent Plan Year, depending on your status as described on page 9.

Non-vested Players (a Player that is not vested in the Pension Plan based solely on his Credited Seasons) **and Eligible Dependents of Any Non-vested Player Who is Not Deceased:**

IF YOU ARE	THEN YOUR LIFE AND AD&D COVERAGE ENDS ON	AND YOUR MEDICAL, DENTAL, VISION, AND WORK/LIFE RESOURCES COVERAGE ENDS ON
Not a Vested Player and you are released or otherwise sever employment	Your Coverage Ending Date	Your Coverage Ending Date
An Eligible Dependent	Not applicable	The earlier of: • the date the Player is no longer covered or • the date you no longer meet the requirements of an Eligible Dependent

Covered Veteran Players

Medical, dental, vision, and work/life resources coverage provided to every terminated Vested Player (a Player vested under the Pension Plan based solely on his Credited Seasons) will be extended to the fifth anniversary of his Coverage Ending Date; life and AD&D coverage ends on his Coverage Ending Date. When this additional coverage ends, a Vested Player will be offered the right to continue that coverage pursuant to COBRA as discussed on pages 54-58. A Vested Player who earns a Credited Season for a season beginning in 2011 or thereafter also has the option to extend coverage beyond the 18-month standard period provided under COBRA by either electing to continue coverage under the Standard Plan or by electing coverage under the Lower Cost Plan as discussed on pages 59-67. A Vested Player may elect coverage under the Lower Cost Plan prior to the expiration of the 18-month standard period under COBRA. A Vested Player who elects either alternative will be able to continue the coverage for the duration of the current CBA, unless the Plan is otherwise terminated, provided there is no break-in-coverage and the Vested Player satisfies the applicable requirements to maintain this extended coverage. Once a Vested Player elects coverage under the Lower Cost Plan he may not change his coverage to the Standard Plan for either himself or his dependents.

Vested Players Eligible for Medicare

A Vested Player who is eligible for Medicare, and who obtains coverage under Medicare, must notify the Customer Service Center at 800-635-9671 within thirty (30) days of the effective date of his coverage under Medicare. If a Vested Player does not inform Customer Service of his coverage under Medicare, the Plan may recover from the Vested Player any and all claims paid by the Plan on the Vested Player's behalf to the extent, if any, such claims should have been paid by Medicare under the Plan's Coordination of Benefits provisions explained on pages 74-75.

Common Eligibility Questions and Answers

Q. What if this is my first year in the NFL and I am released after the regular season has begun?

A. If you were on a Game Day Roster with a Qualifying Benefit Status, you have benefits from then until the end of the Plan Year (August 31st).

Q. What if I am a Vested Active Player and I am not on the First Game Day Roster?

A. You become a Covered Veteran and your health insurance benefits will continue under the terms summarized above. You will also have the option of converting your life insurance benefit.

Q. What if I am a Non-vested Player with benefits and I am not on the First Game Day Roster?

A. You will have the opportunity to elect COBRA. You will also have the option of converting your life insurance benefit.

Q. What if I am a Covered Veteran and I am on a Game Day Roster after the season has begun?

A. If you have a Qualifying Benefit Status, you will receive your benefits as a Qualified Player rather than as a Covered Veteran until the end of the Plan Year.

Q. What if I have elected COBRA and I get on a Game Day Roster after the season has begun?

A. The Plan will cancel your COBRA election if you have a Qualifying Benefit Status. In that case your coverage will be reinstated and continue until the end of the Plan Year.

Q. What if I had previous benefits as a Player with the NFL and report to training camp?

A. Then you will have benefits from the day you report to training camp until the end of the Plan Year in which you report to training camp.

Q. What if I elected to Opt-Out of the 2020 Season under the COVID Amendments?

A. If you earned a Credited Season under the Pension Plan and/or for purposes of the Minimum Salary for the 2019 Season, if you were drafted in the 2020 NFL College Draft, and/or if you are a Higher-Risk Opt-Out Player, you are eligible for the benefits under this Plan effective September 1, 2020, for the entire 2020 Plan Year.

Q. What if the 2020 Season is cancelled after the First Game of the 2020 Season?

A. If the 2020 Season is cancelled after the First Game of the 2020 Season, and your are not otherwise eligible based on your being on a Qualifying List for the First Game of the Season, you must be on a Qualifying List for one Game before the remainder of the 2020 Season is cancelled to be eligible for benefits under the Plan for the 2020 Plan Year.

Continuance of Coverage for Surviving Dependents of a Deceased Player

If a Qualified Player or Covered Veteran dies while covered under the Plan, coverage will continue for his Eligible Dependents (including any child born to his wife within 10 months of his death) as follows:

AT THE TIME OF YOUR DEATH, IF YOU ARE	THEN COVERAGE FOR YOUR SURVIVING DEPENDENTS WILL CONTINUE
A Qualified Player	For the period of time you would have had coverage if you had been released or otherwise severed employment on the date of your death
A Covered Veteran	For the period of time remaining that you would have had coverage had your death not occurred

Life Insurance and AD&D

Life insurance and AD&D coverage protects you and your Eligible Dependents should you die or have an accidental injury. The following charts highlight your life insurance and AD&D benefits. You will find details about your life insurance and AD&D coverage on the following pages.

Life Insurance Amount

NUMBER OF CREDITED SEASONS	BENEFIT AMOUNT
6 or more	$2,000,000
5	$1,800,000
4	$1,600,000
3	$1,400,000
2	$1,200,000
1	$1,000,000
0	$1,000,000

Changes in the Amount of Your Life Insurance

The amount of your life insurance is based on the number of your Credited Seasons as defined by the Bert Bell/Pete Rozelle NFL Retirement Plan ("Pension Plan"). Any change in the amount of your life insurance will be effective on the date you earn an additional Credited Season.

AD&D Amount

The full amount of personal AD&D coverage is $50,000, payable according to the following schedule:

COVERED LOSS	BENEFIT AMOUNT
Life	**100%**
A hand or a foot	**50% of full amount**
One arm or one leg (by severance, above the elbow or above the knee)	**75% of full amount**
Sight of an eye	**50% of full amount**
Sight in both eyes	**100% of full amount**
Any combination of a hand, a foot, and or sight of an eye	**100% of full amount**
Thumb and index finger on same hand or four fingers on same hand	**25% of full amount**
All toes on one foot	**25%**
Big toe	**13%**
Speech and hearing in both ears	**100% of full amount**
Speech	**50% of full amount**
Hearing in both ears	**50% of full amount**
Hearing in one ear	**25% of full amount**
Paralysis of both arms and legs (quadriplegia)	**100% of full amount**
Paralysis of both legs (paraplegia)	**75% of full amount**
Paralysis of both legs and one arm, or both arms and one leg (triplegia)	**75% of full amount**
Paralysis of one arm and one leg on the same side of the body (hemiplegia)	**50% of full amount**
Paralysis of one arm or leg (uniplegia)	**25% of full amount**

Eligibility for AD&D benefits may result in additional benefits, such as a child care benefit, a child education benefit, a brain damage benefit, a common carrier benefit, a coma benefit, a seat belt benefit, and an airbag benefit. Call the Customer Service Center at 800-635-9671 for more details.

Payment of AD&D benefits is subject to certain exclusions, the most significant of which are:

- If you lose a hand or foot, the loss must be a permanent severance at or above the wrist or ankle joint.
- If you lose eyesight in one or both eyes, the loss must be total, permanent and irrecoverable.
- The loss must be accidental, as determined by Prudential, and occur within 365 days of the accident.

Your Beneficiary

Life insurance and AD&D benefits will be paid as shown in the following chart:

INSURANCE PROGRAM	BENEFIT WILL BE PAID TO
Life	Your designated Beneficiary
AD&D • Your death • A qualifying injury to you	• Your designated Beneficiary • You

Designating Your Beneficiary

Designating a Beneficiary gives you control over the payment of your life insurance and accidental death benefits. Your Beneficiary is the person or persons you name to receive the life insurance and AD&D benefit. If you have any questions or concerns about designating your Beneficiary, you should consult your attorney or financial advisor. You should remember the following when designating your Beneficiary:

- You can designate anyone you wish as your Beneficiary. You can change your Beneficiary at any time. To change your Beneficiary, log onto myCigna.com to access the eligibility site (you may also access myCigna.com through NFLPlayerBenefits.com) or contact the Customer Service Center at 800-635-9671 for assistance. If you designate two or more Beneficiaries and you do not indicate the share each should receive, or the designated shares do not equal 100%, **they will share equally in the proceeds at your death.** If you designate a primary Beneficiary who does not survive you, payment will be made in equal shares to each secondary Beneficiary that survives you.

- If your circumstances change (for example, if you get married or divorced), you should update your Beneficiary designation by logging onto myCigna.com to access the eligibility site or contacting the Customer Service Center. Otherwise, your benefits could be paid to a former spouse rather than your current spouse.
- You may also affirmatively elect the default rule and your beneficiary will automatically be your spouse. Under the default rule, if you have no surviving spouse, your beneficiary will be the first surviving class of the following: child(ren), parents, siblings, with benefits paid equally to each surviving member of the class. If there are no such surviving relatives, your benefit will be paid to your estate.

When You Have No Beneficiary

If you do not designate a specific Beneficiary of your life insurance and accidental death benefits on a paper or electronic form provided by the Plan, the Plan will assume you have elected to determine your Beneficiary under its default rule.

Paying for Your Coverage

The Clubs pay the entire cost of your life insurance and AD&D coverage.

Imputed Income

The federal government requires an employer to report as income to you the premium on life insurance over $50,000 that it pays for your coverage. This amount is taxable to you and is reported as additional earnings on your Form W-2.

Imputed income is determined by subtracting $50,000 from your life insurance amount and multiplying the remaining amount by premium rates found in a standard table issued by the IRS. The table is age related, so as you get older, your imputed income increases.

Claims Procedures for Life and AD&D Benefits

You should contact Customer Service at 800-635-9671 before filing a claim for life or AD&D benefits. They will help you or your Beneficiary complete the necessary claim forms.

When your claim form is filed with Prudential, you or your Beneficiary must provide proof of loss. For example, if you lose limbs in an accident, you must provide proof of that loss (such as a doctor's statement); if you die, your Beneficiary must provide proof of your death (such as a certified death certificate) and, if applicable, proof that your death was accidental.

Prudential will respond to the claim within 90 days (45 days for a dismemberment or accelerated benefit claim), although Prudential may extend this deadline to 180 days upon timely notification (105 days for a dismemberment or accelerated benefit claim). You may file an appeal of Prudential's determination with Prudential, provided you do so within 60 days of the date Prudential's initial determination is received (180 days for a dismemberment or accelerated benefit claim). Prudential will respond to your appeal within 60 days (45 days for a dismemberment or accelerated benefit claim), although Prudential may extend this deadline to 120 days upon timely notification (no extension for a dismemberment or accelerated benefit claim). Prudential's decision is final and binding, except that you may file a claim in federal district court; but you must do so within 3 years of the date of the initial denial.

When AD&D Benefits Will Not Be Paid

A Loss is not covered if it results from any of these:

- Suicide or attempted suicide, while sane or insane.
- Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries.
- Sickness or Medical or surgical treatment of Sickness
- Any bacterial or viral infection.
- Taking part in any riot or insurrection.
- War, or any act of war.
- An accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces.
- Travel or flight in any vehicle used for aerial navigation unless traveling as a passenger in an aircraft licensed for the transportation of passengers unless such aircraft is owned, operated, controlled or leased by or on behalf of the NFL or a Club.
- Commission of or attempt to commit an assault or a felony.
- Being under the influence of alcohol or alcohol intoxication, including but not limited to having a blood alcohol level above the limit for permissible operation of a motor vehicle in the jurisdiction where the Loss occurred.
- Being under the influence of or taking any non-prescription drug, medication, narcotic, stimulant, hallucinogen, barbiturate, amphetamine, gas, fumes or inhalants, poison or any other controlled substance unless prescribed by and administered in accordance with the advice of the insured's Doctor.

Extension of Coverage in the Event of Total Disability

If your employment as a Qualified Player ends because of Total Disability, your life insurance will be extended for 1 year from your date of Total Disability. Your insurance will be further extended for 1-year periods if you remain Totally Disabled. If you die while you are Totally Disabled, your Beneficiary will receive the amount of life insurance for which you were eligible on the day you became Totally Disabled.

When Extension of Coverage Ends

Your extended coverage will end when:

- you are no longer Totally Disabled; or
- you either begin to receive your retirement benefits or reach your Normal Retirement Date under the Pension Plan

Converting Your Life Insurance

If you have a right to convert to an individual policy, Prudential will notify you in writing within 45 days of the date your life insurance under the Plan ends. In general, you may convert your coverage to an individual policy if:

- your insurance ends because you are no longer eligible for life insurance under the Plan; or
- the Plan is terminated and you have been insured for at least 5 years

The amount of coverage you may convert will be no more than the amount you had at the time your coverage ended. If the Plan is terminated, the converted policy will be the lesser of:

- the amount of coverage you had MINUS the amount of any other group coverage that you may qualify for within 60 days of losing your coverage under the Plan; or
- $10,000

To apply for life insurance conversion, you must make your request to Prudential in writing and include your first payment within the earlier of (1) 60 days from the date of the letter notifying you that your life insurance ends or (2) 105 days from the date your coverage ends. If you do convert, your policy will be effective on the 61st day after the date of the letter notifying you that the group life insurance provided to you under the Plan has ended.

You may not convert your AD&D coverage.

Accelerated Benefits Option (ABO)

You may receive an amount up to 100% of your life insurance benefit if, as a result of injury or sickness, you are diagnosed as terminally ill with 12 months or less to live. The maximum amount that can be accelerated is $1,000,000. You may choose to accelerate a partial benefit. If you do so, the remaining coverage will stay in force. If you elect to receive only a partial accelerated benefit the remaining death benefit must be at least $25,000. You may reapply for the payment of the remaining amount of insurance at any time. However, you may be asked for further satisfactory evidence that you still met the requirements for the accelerated benefit. An interest, mortality and expense charge is not deducted from the accelerated payout. Exercising the ABO will result in a reduction of the life insurance benefit payable to your Beneficiary. The ABO is not available during the period your life insurance benefit is extended because of a Total Disability.

What You Need to Do

In order to make sure your life and AD&D coverage work for you, you must complete specific tasks at certain times. The following chart highlights those tasks (refer to the appropriate sections in this SPD for details about this information).

WHEN	THEN
You are first eligible for life and AD&D coverage	You should designate your Beneficiary immediately. Your Beneficiary will receive your insurance coverage amount if you die.
You are injured in an accident	You must make a claim in writing to Prudential.
You are Totally Disabled	You must contact the Customer Service Center. You may be eligible for an extension of your life insurance benefits.
You die	Your Beneficiary must make a claim in writing to Prudential.
Your employment as a Qualified Player ends	Your life and AD&D coverage will also end. You may convert your life insurance coverage to an individual policy within 60 days from the date of the letter notifying you that your coverage ends.

Common Life Insurance and AD&D Questions & Answers

Q. Can I increase my life insurance amount?

A. You may not elect an additional amount of life insurance. The only time your life insurance amount can increase is when the number of your Credited Seasons increases to the next level of benefits (see the chart on page 12).

Q. Why should I select a Beneficiary?

A. You should select a Beneficiary in order to ensure that your life insurance benefit goes to the person(s) YOU name. If you do not name a Beneficiary, or if your Beneficiary dies before you do, your Beneficiary will be determined under the Plan's "default" rule summarized on page 15 in the section entitled "When You Have No Beneficiary."

Q. May I select more than one Beneficiary?

A. Yes. You should specify the percentage of your benefit each is to receive. If you do not specify the percentage, or if the percentages do not equal 100%, the benefit will be paid in equal shares.

Q. How do I file claims?

A. You or your Beneficiary must complete a claim form and submit it to Prudential, along with proof of the dismemberment or a certified death certificate. Contact Customer Service at 800-635-9671 for assistance in completing and submitting the forms.

Q. How is my AD&D benefit paid if I have more than one loss?

A. The maximum amount normally payable under your AD&D coverage for any one accident is $50,000. For example, if you lose both hands and both feet in the same accident, you would receive $50,000. In addition, if you lose limbs in an accident, then later die from injuries sustained in that accident, the maximum total AD&D benefit paid would be $50,000. However, this maximum is increased in certain circumstances, such as if you are wearing a seat belt, your vehicle has an airbag, or you are travelling on a common carrier.

Q. If I am Totally Disabled, can my life insurance coverage continue?

A. Yes, if you provide the Plan Administrator with proof of your Total Disability, your life insurance coverage can continue for 1 year from the date of your Total Disability. If, within 3 months before the end of the year of extended coverage, you provide proof to the Plan Administrator that you are still Totally Disabled, your coverage will continue for another year. Your coverage can continue in 1-year increments until you no longer are Totally Disabled or until you either begin to receive your retirement benefits or reach Normal Retirement Age under the Pension Plan.

Q. How do I convert my life insurance coverage?

A. If you have a conversion right when your group life insurance ends, Prudential will send a letter and a conversion form to the address on file for you. You must request conversion in writing and submit your first payment within 60 days after the date of the letter.

Medical Coverage

Highlights of Your Medical Benefits

The following chart lists some highlights of your medical benefits. Note that in all cases, unless otherwise stated, you must pay the applicable Deductible, Coinsurance, and any cost that a non-Preferred Provider may charge that is greater than the Maximum Reimbursable Charge. You will find details about the medical program on the following pages and in the Plan Document.

FEATURES AND COVERED CHARGES	BENEFIT
Plan Year Deductible	$850 per person, $1,700 per family
Plan Year Out-of-Pocket maximum	$2,000 per person, $5,000 per family for Medical person, $2,000 per person, $5,000 per family for Prescription
Maximum lifetime benefit	Unlimited
Maximum lifetime transplant benefit	Unlimited
Semi-private hospital room and board	The Plan pays 80% in network; 70% otherwise
Infertility treatment	The Plan pays 80% in network; 70% otherwise
Maternity, including pre- and postnatal care	The Plan pays 80% in network; 70% otherwise
Office visits	The Plan pays 80% in network; 70% otherwise
Physical therapy	The Plan pays 80% in network; 70% otherwise

FEATURES AND COVERED CHARGES	BENEFIT
Hospice services and supplies	Outpatient: The Plan pays 80% in network; 70% otherwise Inpatient: The Plan pays 100% no deductible for first 30 days, then 80% in network; 70% otherwise
Transportation to medical facility (including professional ambulance)	The Plan pays 80%
X-ray exams and therapy, lab tests	The Plan pays 80% in network; 70% otherwise
Emergency and Urgent Care Services	The Plan pays 80%
MD Live Telehealth	Cost varies based on type of telehealth services*
Prescription drugs: retail	At participating pharmacies the Plan pays all but: • $15 for generic drugs • $25 for preferred brand name drugs • $50 for non-preferred brand name drugs At nonparticipating pharmacies, the Plan pays 70% with no Deductible
Prescription drugs: mail order	The Plan pays 100% with no Deductible for: • Generic Preventive Maintenance Prescriptions*** • Diabetic Testing Strips (Generic and Preferred Brand) • FDA Approved Generic drugs used to treat ADHD (Attention Deficit/Hyper Activity) You pay 2x retail copay for 90 Days Supply for all other maintenance medications
Outpatient pre-admission testing, including diagnostic x-rays, lab exams and diagnostic x-rays, lab exams and second/ third surgical opinions	The Plan pays 100% with no Deductible

FEATURES AND COVERED CHARGES	BENEFIT
Home health care	The Plan pays 100% with no Deductible up to 100 visits (4 hours equals one visit) per Plan Year*** 16 hour maximum per day
Mammograms	The Plan pays 100% with no Deductible
PSA Testing	The Plan pays 100% in network; 70% otherwise
Preventative Well Child and Immunizations (to age 19)	The Plan pays 100% no deductible in network; 70% otherwise
Autism	The Plan pays 80% in network; 70% otherwise***
Mental Health	No Deductible
• **Inpatient**	The Plan pays 80% in network; 70% otherwise
• **Outpatient office visits (individual/group)**	The Plan pays 100% for visits 1 to 8, 80% for additional visits in network; 70% otherwise
• **Outpatient facility**	The Plan pays 100% with no Deductible
Substances of abuse**	No Deductible
• **Inpatient**	The Plan pays 80% in network; 70% otherwise
• **Outpatient office visits (individual/group)**	100% first 30 visits; 80% for additional visits in network; 70% otherwise
• **Outpatient facility**	The Plan pays 100% with no Deductible

* The Telehealth per appointment fee is subject to change each January 1st.

** Generic prescription medications used to prevent any of the following medical conditions are not subject to the co-pay: hypertension, high cholesterol, diabetes, asthma, osteoporosis, blood thinner, prenatal vitamins, and birth control

*** No limit on visits for certain forms of home health care to treat autism.

**** These co-pays/coinsurance factors do not apply to Players who are in the NFL's Substances of Abuse Program or receiving the Behavior Management Benefit.

Your Payment Responsibilities

The medical program is designed to cover the majority of your medical expenses for sicknesses and Injuries that are not work related. However, you are responsible for certain costs. The amounts of your Deductible, Coinsurance, Out-of-Pocket Limit and maximum benefits are detailed in the chart on pages 21-23.

The Deductible

You or your Eligible Dependents must pay a Deductible each Plan Year for most benefits before the Plan will pay. Any portion of your Plan Year Deductible that you pay during the last 3 months of the Plan Year is applied toward your Deductible for the next Plan Year (often referred to as the Deductible Carry-over).

Coinsurance

You are obligated to pay the percentage of covered charges that the Plan does not pay. The amount of Coinsurance you must pay is subject to an Out-of-Pocket Limit. After you reach your Out-of-Pocket Limit, you are no longer obligated to pay Coinsurance for the rest of the Plan Year.

Maximum Reimbursable Charges

If you elect not to be treated by a Preferred Provider, the Plan will pay a percentage of covered charges up to the Maximum Reimbursable Charges. You are responsible for all charges that exceed the Maximum Reimbursable Charges.

Managing Your Health Care Services

The Medical PPO

Through an arrangement with Cigna, you and your Eligible Dependents may use Preferred Providers, which include:

- physicians
- hospitals
- pharmacies
- labs

Preferred Providers have agreed to provide services for a discounted fee. The discounted fee means you pay less for your health care. Using a Preferred Provider is completely voluntary — it is your decision to make each time you need medical services.

The following chart compares the cost of using Preferred Providers to the cost of using other Providers.

Example:
Ron and John are twins. They both have the same medical condition and receive identical treatment. Ron goes to a Preferred Provider. John chooses to go to a Provider who is not a Preferred Provider. Because Ron used Cigna's PPO, he received a discount on his services. He paid **$756.10 LESS** than John paid.

DESCRIPTION	RON'S EXPENSES (IN NETWORK PROVIDERS)	JOHN'S EXPENSES (OUT OF NETWORK PROVIDERS)
a. Office visits	$240 (after PPO discount)	$300
b. Lab fees	$200 (after PPO discount)	$250
c. Outpatient hospital	$1,321 (after PPO discount)	$2,261 ($1,761 is the Maximum Reimbursable Charge, i.e. the maximum charge the Plan will cover)*
d. Total (a.+b.+c.)	$1,761	$2,811
e. Amount not covered*		$500 (difference between actual hospital charge ($2,261) and Maximum Reimbursable Charge ($1761)
f. Deductible	$850	$850
g. Covered amount*	$911	$1,461
h. Percentage covered by Plan (your Coinsurance)	80%	70% of Maximum Reimbursable Charge
i. Plan payment* (g. x h.)	$728.80	$1,022.70
j. Player's Payment (after deductible)	$182.20 (g-i)	$938.30 (g.-i.+e.)

* Player pays 100% of all amounts in excess of the Maximum Reimbursable Charges.

To locate Preferred Providers in your area, log onto myCigna.com for a Directory of Preferred Providers or contact the Customer Service Center at 800-635-9671.

It is recommended that you confirm with the Providers that they are current participants in the Cigna PPO before making an appointment.

Telehealth

Your medical program offers you access and options for online appointments with health care providers at MDLiveforCigna.com. You may access Behavioral Telehealth providers at MyCigna.com. You will see your current share of the costs for Telehealth services when you access MDLivefor Cigna. These per appointment charges are generraly subject to change each January 1st. The cost to you for MyCigna.com is the same as the cost for other mental health benefits. Telehealth benefits may be provided as either an online chat or a video conference, but the video conference option may not be available in all states.

Health Care Management Services

Your medical program offers many opportunities to help you manage your care. Cigna administers the management services to ensure the proper utilization of services by you and your Eligible Dependents. The utilization review services include:

Pre-admission Certification

When you certify your hospital admissions, qualified nurses and doctors review your diagnosis and treatment plan to determine if it is the most appropriate and effective for your condition. **In order to receive your full benefits, a pre-admission certification is required for all admissions other than an admission for the normal delivery of a Child (i.e., up to 48 hours following a vaginal delivery or 96 hours following delivery by cesarean section).** If you do not use a Preferred Provider and you fail to obtain a pre-admission certification, you will have to pay an additional $500 and the Plan payment for your treatment will be reduced by half. You or an Eligible Dependent (or your physician) must call the Customer Service Center to certify your stay before you are admitted to the hospital unless it is an emergency. You will be asked to provide your Cigna ID number, details regarding your hospitalization and your doctor's full name, address and phone number. If you are admitted to the hospital on an emergency basis, you or someone on your behalf must call the Customer Service Center within 48 hours of your hospitalization. You will be asked to provide your Cigna ID number, your condition and your doctor's full name, address and phone number.

Continued Stay Review

Whether or not you pre-certify, you are given a recommended number of days that is standard for the type of treatment you will receive. If you need to remain in the hospital longer than the recommended length of stay, you or an Eligible Dependent (or your physician) must obtain approval for the additional days by calling the Customer Service Center before the end of your scheduled stay. **If this is not done, you will have to pay an additional $500 (unless you already paid this amount by failing to pre-certify) and the benefits the Plan would otherwise pay for the additional days will be reduced by half. Please note that no payment will be made unless the additional days are Medically Necessary. If you choose an in-network provider, the provider is responsible for obtaining approval for additional days and no penalty would apply to the participant.**

Prior Authorization

A Provider must receive Prior Authorization (authorization from Cigna prior to medical items or services being provided) in order for certain services to be covered by the Plan. Medical items and services that require Prior Authorization include, but are not limited to: (1) inpatient services at a hospital or any other health care facility; (2) residential treatment; (3) intensive outpatient programs; (4) transplant services; and (5) prescriptions for human growth hormone. Please call the Customer Service Center at 800-635-9671 if you are uncertain whether Prior Authorization is required.

Second Opinions for Elective Surgery

The Plan will pay 100% of Preferred Provider contracted rates or the Maximum Reimbursable Charges of a non-Preferred Provider for a second opinion, including the office visit and fees for associated diagnostic or x-ray examinations. These expenses are not subject to the Deductible. If you decide you need a third opinion, notify the Customer Service Center at 800-635-9671 and the expenses of obtaining that opinion will be covered at the same rate.

Case Management

Case managers help you find medical resources, provide family support and help ensure that you receive high quality, cost effective care. While the case manager may recommend alternate treatment programs and help coordinate needed resources, your attending physician remains responsible for your medical care. You can call the Customer Service Center to speak with a case manager. In some instances, you may be referred to case management by your physician.

Healthy Babies

Healthy Babies is a Plan feature designed to promote good health for mothers and their babies during pregnancy. The goal is to identify high risk pregnancies and help prevent premature births. A nurse will ask a series of questions about the mother's lifestyle and health history and will monitor the mother's progress throughout the pregnancy. In order to receive benefits, you or your spouse must contact the Customer Service Center at 800-635-9671. A nurse will complete the pre-admission certification for you.

There are several advantages to using this feature:

- Contributes to the health of the mother and her baby
- Free integrated specialty case management if the pregnancy is high risk or if the baby is born prematurely
- Free copies of informative books on prenatal care
- Reimbursement of up to $600 ($300 if you enroll after the first 14 weeks, but within 28 weeks of your pregnancy) of medical expenses which the Plan would not otherwise cover

Substances of Abuse Treatment Benefits

The Plan provides the substances of abuse benefits listed on page 23. If you are in the Substances of Abuse Program, the cost of each required treatment session is covered under the Plan at 100% of Preferred Provider contracted rates or the Maximum Reimbursable Charges of a non-Preferred Provider. While you are in the Substances of Abuse Program, the cost of treatment will continue to be covered even if you are not otherwise covered by the Plan.

Claims for substances of abuse benefits for Players in the Substances of Abuse Program must be submitted to SWS, who will administer and file the claims with Cigna. The submission of claims for substances of abuse benefits will not be made known to your Club, the NFL or the NFLPA.

Therapeutic Use Exemption Benefit

The Therapeutic Use Exemption Benefit is designed to cover the cost of a Player's evaluation for a Therapeutic Use Exemption for the use of a substance otherwise on the League's Banned Substances List. This benefit pays for the cost of an evaluation by a Physician on the League's list of Physicians approved to provide a Player with a Therapeutic Use Exemption.

The Therapeutic Use Exemption Benefit shall be available to any Player, for as long as he is under contract to play football in the League, to any Player selected in the NFL College Draft, for one year after he is drafted, and to any individual who has commenced contract negotiations with a Club for a contract to play football in the League, as long as the Club has not terminated such negotiations.

Counseling Benefits for Certain Non-Participants

If you are not a Participant but you: 1) are under contract to play football for a Club; 2) are in contract negotiations with a Club, or 3) were drafted by a Club in the most recent NFL Draft; and you need Mental Health services and are not covered under another plan for these services, the Plan will cover the full cost of a Provider selected by Cigna. The cost of any prescription drugs determined by the Provider to be Medically Necessary is covered just as a Participant would be covered. The coverage shall be in effect and shall continue for as long as you are under contract to play football for a Club; are continuing contract negotiations with a Club, or are still within the one-year period since you were drafted by a Club. The coverage ends on the later of when: a) your contract terminates, b) the Club terminates contract negotiations; or c) the end of the one-year period since you were drafted by a Club. However, if the Provider determines that your treatment should not then be terminated, you may receive these benefits until the earlier of the date the Provider determines your treatment may be terminated or the date you become a Participant. In addition, the Plan sponsors certain group counseling sessions specially designed for rookies.

Behavior Management Benefit

Pursuant to its Personal Conduct Policy, the NFL prohibits violent and/or criminal activity. Players who violate this policy are required to undergo a clinical evaluation and attend a treatment program. The cost of the evaluation and each required treatment session is covered under the Plan at 100% of Preferred Provider contracted rates or the Maximum Reimbursable Charges of a non-Preferred Provider. The cost of treatment will continue to be covered even if you are not otherwise covered by the Plan.

Chiropractic Benefits

The Plan covers up to 35 chiropractic treatments per Plan Year without requiring that you establish they are Medically Necessary. The Plan does not cover any services provided for an injury or sickness that is work related. For purposes of chiropractic benefit, chiropractic services provided to an active Player in training camp or on or near a game day are presumed to be work related, absent proof they are not.

NFL Personal Health Care Team

This program provides without charge confidential, personalized support and information to help you manage many conditions, including asthma, heart disease, low back pain, COPD, diabetes, depression, and weight complications. Participants receive professional help in developing a personalized program for managing a condition in the most effective possible way. Participation is completely voluntary. You may be contacted directly by Cigna, if its experts determine the program could benefit you, or you may call 800-635-9671 for more information.

Preventive Care

The Plan covers a comprehensive list of preventive care benefits at 100%, with no Deductible, provided that you use a Preferred Provider. If you elect to use a non-Preferred Provider, the Plan will cover 70% of the Maximum Reimbursable Charge after you have met the Deductible. Call the Customer Service Center at 800-635-9671 for a copy of the complete list of covered benefits, which includes an annual physical examination of you and your spouse, including any related lab work, as well as many preventive care measures for your children.

Neurological and Spine Benefits

If you are a Covered Veteran, the Plan covers 100% of Preferred Provider contracted rates or the Maximum Reimbursable Charges of a non-Preferred Provider for medical care, medical service, or a medical supply provided while you are receiving either the Neurological Treatment Benefit or the Spine Treatment Benefit under the NFL Former Player Life Improvement Plan, provided the charge is approved in writing by the lead physician directing the Participant's treatment.

Benefits for Autism

Autism and autism spectrum disorders are defined as neurological disorders, usually appearing in the first 3 years of life, affecting normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive and stereotyped behaviors. Autism and autism spectrum disorders are covered at current standard benefit levels. Benefits shall include coverage for speech, occupational, physical and applied behavioral analysis (ABA) therapy by licensed providers. There is no visit limit for home health care for visits related to autism.

What the Medical Program Covers

The medical program covers the following services (subject to the terms and conditions of the Plan) as detailed in the Plan Document:

- inpatient hospital services
- emergency services
- charges related to maternity and pregnancy (including the first sonogram)
- physician charges
- skilled nursing facility charges
- hospice charges

- home health care services
- organ transplants (including certain related travel expenses)
- treatment for autism
- other services, such as:
  - mammograms (not subject to Deductible) and Pap smears
  - well baby visits
  - charges for a facility licensed to furnish outpatient Mental Health services
  - charges for a facility licensed to furnish outpatient treatment of substances of abuse
  - chemotherapy
  - PSA tests
  - prescription drugs, including birth control pills and vitamins for pregnancy and anemia
  - in certain cases, and with limitations: bariatric surgery, nutritional evaluation, genetic testing, and short term rehabilitation therapy
  - wigs for hair loss due to medical treatment
  - hearing aids ($5,000 annual limit) and Cochlear implants

This is not a complete list of covered services. Consult the Plan Document or contact the Customer Service Center if you have questions about whether a service is covered.

Women's Health and Cancer Rights Act of 1998

The Plan covers reconstructive surgery and prostheses following mastectomies, as follows:

- reconstruction of the breast on which the mastectomy has been performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications related to all stages of mastectomies, including lymphedemas

These benefits are provided in a manner determined by the attending physician in consultation with the patient, and may be subject to Deductibles and Coinsurance consistent with those for other benefits under the Plan.

Newborns' and Mothers' Health Protection Act

Under federal law, the Plan generally may not 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 delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending Provider (e.g., your physician, nurse-midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, the Plan may not set the level of benefits or out of pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

What the Medical Program Does Not Cover

The medical program does not cover the following:

- charges for services or supplies that are not Medically Necessary
- charges for an Injury resulting from your employment or occupation
- charges for an illness that is covered by Workers' Compensation or similar law
- charges that exceed the Maximum Reimbursable Charges
- charges for cosmetic surgery, except in very limited circumstances
- eyeglasses or examinations for prescription or fitting of eyeglasses, except the Plan covers the first pair of eyeglasses or contact lenses following cataract surgery
- services for the treatment of the teeth or periodontium unless they are:
  - » charges for an injury to sound natural teeth
  - » charges for inpatient hospital services, or
  - » charges for the outpatient department of a hospital for surgery
- charges for transsexual surgery, including hormonal therapy
- charges for a hospital owned or operated by the US government if such charges are directly related to a military service-connected illness or Injury
- charges that are unlawful where you live
- charges that you are not legally required to pay
- charges that would not have been made if you were not covered under the Plan

- charges for custodial services, education or training
- charges for which you or your Eligible Dependent is entitled to payment for, by or through a public program other than Medicaid
- charges for services, drug therapies, treatments, procedures, technologies, supplies or devices that are experimental, investigational or unproven
- charges for routine refractions, eye exercise and surgical treatment of the correction of a refractive error, including laser surgery, when eyeglasses or contact lenses will work
- supplies, care, treatment and surgery that are not considered essential for the necessary care and treatment of an injury or illness
- charges for tired, weak or strained feet, including the removal of calluses and corns or the trimming of nails unless Medically Necessary
- speech therapy if it is not restorative in nature and if such therapy is used to improve speech skills that have not fully developed, can be considered custodial or educational, or is intended to maintain speech communication. However, speech therapy to treat autism is covered.
- charges from a Provider who is a member of your or your Dependent's family
- charges made for or in connection with an injury or sickness that is due to war, declared or undeclared
- charges that are paid or payable under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law
- massage therapy
- hyperbaric oxygen therapy and related services

This is not a complete list of charges not covered by the Plan. If you have questions about whether a service is covered, contact the Customer Service Center at 800-635-9671.

FMLA

The FMLA may require your Club to continue health coverage during an approved FMLA leave. If you are eligible for FMLA leave, then the Plan may provide certain benefits. Contact the Customer Service Center for details about leave eligibility and conditions.

Job Benefits and Protection

- For the duration of FMLA leave, the NFL will maintain your health coverage under the Plan. Payment for this coverage will be required from the NFL, you or a combination of both.
- When you return from FMLA leave, your employment and benefits coverage will be restored. You will not be required to satisfy eligibility or benefit waiting periods if you satisfied those requirements before your leave.

Extension of Medical Benefits if You Are Totally Disabled

If you or your Eligible Dependent is Totally Disabled when medical coverage under the Plan ends and remain Totally Disabled, medical expenses related to that disability (and that disability only) will be covered for the lesser of 1 year thereafter or the period of the disability. This extension will not apply if (1) the Eligible Dependent is a Child born after your coverage ends; (2) the disabled person becomes covered under another group plan; or (3) the disability is work related.

COBRA

You and your Qualified Beneficiaries may continue medical coverage in certain cases when that coverage would otherwise end. See the explanation of COBRA beginning on page 54 and Extended Coverage on page 59 of this SPD.

Right of Reimbursement

The Plan does not provide any benefits that relate to an injury which gives rise to a claim against a third party or against any person or entity as the result of actions of a third party. The Plan also does not provide benefits to the extent that there is other coverage under non-group medical reimbursement mechanisms (including auto) or medical expense or similar type coverage to the extent of that coverage. As a result, the Plan has the right to be reimbursed, whether by subrogation or otherwise, from funds that are paid or payable to you or a Beneficiary by third parties, if those funds relate to any expenses the Plan pays, or would otherwise pay. Thus, for up to the amount paid by the Plan as medical claims, the Plan has a claim or lien against, and the first right to receive reimbursement from, funds you receive or have the right to receive from third parties, if the funds relate in any way to expenses the Plan would cover.

For example, if you were involved in an automobile accident, the Plan covered your treatment, and the person responsible had insurance that covered your injury, then the Plan could seek reimbursement from that insurance company for up to the full amount of any medical expenses paid by the Trust for treating that injury. The Plan also has the right to recover up to the full amount of its expenses from funds recovered as the result of any action brought by someone else against the responsible party, even if those funds are attributable to, or are earmarked for, nonmedical charges, attorney's fees, or other costs or expenses. In order to facilitate enforcement of the Plan's rights, you may be required to execute a reimbursement agreement, or an agreement to set aside funds from any recovery, as a condition of obtaining benefits under the Plan.

Common Medical Coverage Questions & Answers

Q. What is the advantage of using a Preferred Provider?

A. Cigna contracts with physicians, hospitals and labs in many communities. The contract specifies that the physician, hospital or lab will provide services to you at a discounted rate. That means the amount you and the Plan pay for services is lower. Also, if you use a Preferred Provider the provider is responsible for filing the claim, precertification and continued stay review.

Q. What should I do when I or an Eligible Dependent needs to see a doctor?

A. If you want to take advantage of the available discounts, you should select a Preferred Provider. Go to myCigna.com for a Directory of Preferred Providers. You may also call the Customer Service Center at 800-635-9671.

Q. What should I do when I or an Eligible Dependent needs to go into the hospital?

A. Hospitals in Cigna's PPO will offer you discounts for services and help you save on your medical expenses. In addition, you should call the Customer Service Center before your admission to start the pre-admission certification process.

Q. Do I have to pre-certify?

A. No. However, penalties apply when there is a failure to pre-certify any hospital admission other than an admission for the normal delivery of a Child.

Q. How do I obtain pre-admission certification?

A. If you use a Preferred Provider, this will be done for you. Otherwise, before your scheduled admission, you should call the Customer Service Center, identify yourself as a participant in the Cigna HealthCare PPO and give your Medical/Dental/[Vision?]Prescription Drug ID Card number. You then ask for a "pre-admission certification" and provide the facts of your upcoming hospitalization, including your doctor's full name, address, and phone number. Write down the file number given to you during your call. This is confirmation of your call, and you must retain this number for future reference.

Your request will be reviewed by a health care professional. You and your doctor will be notified quickly regarding the status of your admission and the length of stay that has been approved.

Q. How does the Confidential Claims Procedure work?

A. Claims for substances of abuse and Mental Health services are confidential when they are made through SWS or Cigna as described on page 28.

Q. How do I file claims for substances of abuse benefit services?

A. Claims for substances of abuse benefits should be filed as follows:

- Players in the Substances of Abuse Program must file their claims for substances of abuse benefits with SWS.
- Dependents and Players not in the Substances of Abuse Program must file their claims for substances of abuse benefits directly with Cigna.

Q. Why should I utilize any of the health care management services that are available?

A. In order to receive full benefits, a pre-admission certification is required for any hospital admission other than an admission to a Preferred Provider for the normal delivery of a Child. The pre-admission certification and Continued Stay Review help make sure that you receive the most appropriate treatment for your condition. When you utilize those services, you give nurses and physicians the opportunity to review your condition and look at the various ways in which it might be most effectively treated. For example, a hospitalization might not be necessary; sometimes home health care is more effective and less expensive.

Q. Why should my spouse and I use the Healthy Babies feature?

A. Healthy Babies provides an additional safety net to help prevent premature births and identify high risk pregnancies. In addition, unreimbursed medical expenses of up to $600 (the exact amount depends on when you enroll) will be reimbursed to you if you participate in this program feature.

Q. How do I add my new baby or spouse to my coverage?

A. Log onto myCigna.com to access the eligibility site or contact the Customer Service Center at 800-635-9671, option 1 then option 2, for assistance. You must supply the required documentation.

Q. I'm not married. When does coverage for my new baby begin?

A. Coverage for your Child begins on the date of his or her birth, the date your coverage begins or the date provided in a QMCSO, whichever is latest. However, coverage will not be effective until you have supplied the required documentation. Log onto myCigna.com to access the eligibility site or contact the Customer Service Center at 800-635-9671 for assistance.

Q. How do I find out if a treatment or service is covered?

A. Refer to pages 21-33, ask to review the Plan Document or call the Customer Service Center at 800-635-9671.

Q. I have a question about the Explanation of Benefits ("EOB") I received from Cigna. Whom do I call?

A. Call the Customer Service Center at 800-635-9671.

Q. When should I submit my claims?

A. All claims must be filed within 1 year of service to be covered by the Plan. However, you should submit your claim as soon as you receive the bill to ensure timely payment.

Q. How do I file medical claims?

A. You should submit your claims directly to Cigna at the address on your ID card. You will receive your reimbursement at your address of record.

Q. What if I disagree with how my claim has been paid?

A. You should first call the Customer Service Center at 800-635-9671 for a complete explanation. If you decide to appeal the denial, you must file a written request for review to Cigna Healthcare Service Center at the address listed on page 68. The written request must be received by Cigna within 180 days of receipt of your denial. Your request should state the reasons why your claim should be approved and provide any additional information that supports your request.

Q. What if I disagree with how Cigna decides my appeal?

A. You may seek review by an Independent Review Organization by notifying Cigna or the Customer Service Center at 800-635-9671 within 180 days of your receipt of Cigna's appeal review denial. You may also seek voluntary review by the Trustees by filing a written request to the Plan Administrator within 180 days of the date on the appeal denial letter from Cigna. You are not required to seek review by an Independent Review Organization or the Trustees. If you seek review by the Trustees, the time during which the Trustees are considering your voluntary appeal shall not count towards your time to file suit in federal court.

Q. Will the Plan pay for my treatment outside the United States?

A. Treatment is covered if the services are Medically Necessary. Services for experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society will not be covered.

Q. Are my football Injuries covered by the Plan?

A. Injuries you receive that are related to playing football are not covered by the Plan.

Q. What happens if I meet my medical Deductible at the end of the Plan Year?

A. If you meet all or part of your Deductible during the last 3 months of the Plan Year, that amount will carry over and be applied to your Deductible for the next Plan Year. For example, if you meet $50 of your medical Deductible in August, it will carry over into the next Plan Year. That means that you will have already met $50 of your $850 Deductible when the next Plan Year begins.

Q. Are well baby visits covered?

A. Yes. Visits for the routine preventive care of a child and immunizations are covered.

Q. Can I be required to cover someone?

A. Yes. See the discussion of QMCSOs (page 6).

Dental Coverage

Highlights of Your Dental Benefits

The following chart lists some highlights of your dental benefits. You will find details about the dental program on the following pages and in the Plan Document.

FEATURES AND COVERED CHARGES	BENEFIT
Plan Year Deductible	$50 per person $100 per family
Maximum Plan Year benefit	$2,000 per person
Diagnostic services	The Plan pays 100%
Preventive services	The Plan pays 100%
Basic services	The Plan pays 85%
Major services	The Plan pays 50%
Orthodontics	The Plan pays 50%

Your Payment Responsibilities

The Deductible

You or your Eligible Dependents must pay a Deductible each Plan Year. Any portion of the Plan Year Deductible that you pay during the last 3 months of the Plan Year is applied toward your Deductible for the next Plan Year (often called a Deductible Carryover).

Coinsurance

You are obligated to pay the percentage of covered charges that the Plan does not pay.

Maximum Reimbursable Charges

The Plan will pay a percentage of all charges, up to the Maximum Reimbursable Charges, for services that are covered by the dental program. If you do not use a Preferred Provider, you are obligated to pay any amount that exceeds the Maximum Reimbursable Charges.

The Dental PPO

Through an arrangement with Cigna, you and your Eligible Dependents may use the Preferred Providers in Cigna's Dental PPO, which includes dentists in most cities.

Preferred Providers have agreed to provide services for a discounted fee. The discounted fee means you pay less for your dental care. Using a Preferred Provider is completely voluntary — it is your decision to make each time you need dental care.

To locate Preferred Providers in your area, access myCigna.com for a Directory of Preferred Providers. You may also call the Customer Service Center at 800-635-9671.

What the Dental Program Covers

The dental program pays a portion of the charges, up to the Maximum Reimbursable Charges, for covered services in each category (subject to the terms and conditions of the Plan) as detailed in the Plan Document:

- Diagnostic and preventive services: includes routine checkups, x-rays and other dental maintenance
- Basic services: includes fillings, removing teeth and root canal therapy

Major services: includes crowns and bridges

When Services Begin

Only services that begin and end while you are eligible to participate in this Plan will be covered. A dental service starts on the actual date that services begin, except for:

- **fixed bridgework and full or partial dentures —** the dental service start date is the date the first impressions are taken and/or abutment teeth are fully prepared
- **a crown, inlay or onlay —** the dental service start date is the first date of preparation of the tooth involved
- **root canal therapy —** the dental service start date is the date the pulp chamber of the tooth is opened

Alternate Benefit Provision

Sometimes there will be more than one acceptable service that could provide suitable treatment based on common dental standards. When this happens, Cigna will determine in its discretion the service on which payment will be based. You are responsible for any charges that are greater than those approved by Cigna.

Pre-determination of Benefits

If you and your dentist are planning extensive dental work, you should get a pre-determination of benefits. A pre-determination of benefits means a review by Cigna of your dentist's description of planned treatment and the expected charges, including those for diagnostic x-rays.

When Cigna reviews the treatment plan, you and your dentist will be notified of the estimated benefit that will be payable. Then you and your dentist can discuss the benefit payment and any possible treatment alternatives before you incur the expense.

If you do not get a pre-determination of benefits, Cigna will determine the covered expenses when your claim is received. Where appropriate, the alternate benefit provision procedures, as described above, will apply.

Pre-determination of benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which you qualify at the time your services are completed.

Dental Expenses Not Covered

The dental program does not cover the following:

- services for an Injury related to your employment or occupation
- services for an illness that is covered by Workers' Compensation or similar law
- services for which payment is unlawful where you reside
- charges you are not legally required to pay
- charges that would not have been made if you had no coverage
- charges that exceed the Maximum Reimbursable Charges
- charges for unnecessary care, treatment or surgery
- charges for services that begin before you are covered under the Plan
- services provided by your relative or a relative of your Dependent
- services for which you or an Eligible Dependent are entitled to payment through a public program other than Medicaid
- services that are Experimental or not approved by the American Dental Association or the appropriate dental specialty society
- services performed solely for cosmetic reasons
- replacement of a lost or stolen appliance
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless:
  - the replacement is necessary because of the placement of an original opposing full denture or the necessary extraction of natural teeth or
  - the bridge, crown or denture has been damaged beyond repair as a result of an accidental Injury received while you are covered by the Plan
- replacement of a bridge, crown or denture that is or can be made useable according to common dental standards
- procedures, appliances or restorations (except full dentures) whose main purpose is to:
  - change vertical dimension
  - diagnose or treat conditions or dysfunction of the temporomandibular joint
  - stabilize periodontal involved teeth or
  - restore occlusion

- porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second and third molars
- bite registrations, precision or semi-precision attachments or splinting
- a surgical implant of any type, including any prosthetic device attached to it
- instruction for plaque control, oral hygiene and diet
- services that do not meet common dental standards
- services that are deemed to be medical services
- services and supplies received from a hospital

This is not a complete listing of dental items or services that are not covered. Call the Customer Service Center at 800-635-9671 if you have questions about coverage.

FMLA

If you go on a leave that qualifies under the provisions of the FMLA, your dental coverage may continue. Refer to page 33 of this SPD or contact the Customer Service Center for more information.

COBRA

You and your Qualified Beneficiaries may continue dental coverage in certain cases when that coverage would otherwise end. See the explanation of COBRA beginning on page 54 of this SPD.

Common Dental Coverage Questions & Answers

Q. I have a question about the EOB I received from Cigna. Whom do I call?

A. Call the Customer Service Center at 800-635-9671.

Q. When should I submit my claims?

A. All claims must be filed within 1 year of service to be covered by the Plan. However, you should file as soon as you receive the bill to ensure timely payment.

Q. How do I file dental claims?

A. You should submit your claims directly to Cigna at the address on your ID card. You will receive your reimbursement at your address of record.

Q. What if I disagree with how my claim has been paid?

A. You should first call the Customer Service Center for a complete explanation. If you decide to appeal the denial, you must file a written request for review to Cigna at the address listed on page 68 for dental coverage questions. The written request must be received by Cigna within 180 days of receipt of your denial. Your request should state the reasons why your claim should be approved and provide any additional information that supports your request.

You may also seek voluntary review by the Trustees by filing a written request to the Plan Administrator within 180 days of the date on the appeal denial letter from Cigna. You are not required to seek review by an Independent Review Organization or the Trustees. If you seek review by the Trustees, the time during which the Trustees are considering your voluntary appeal shall not count towards your time to file suit in federal court.

Q. What if I disagree with how Cigna decides my appeal?

A. You may seek voluntary review by the Trustees by filing a written request to the Plan Administrator within 180 days of the date on the appeal denial letter from Cigna. You are not required to seek review by an Independent Review Organization or the Trustees. If you seek review by the Trustees, the time during which the Trustees are considering your voluntary appeal shall not count towards your time to file suit in federal court.

Q. Will the Plan pay for my treatment outside of the United States?

A. Treatment for services that are Medically Necessary is covered; however, services for experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society will not be covered.

Q. What happens if I meet my dental Deductible at the end of the Plan Year?

A. If you meet all or part of your Deductible during the last 3 months of the Plan Year, that amount will carry over and be applied to your Deductible for the next Plan Year. For example, if you meet $25 of your dental Deductible in August, it will carry over into the next Plan Year. That means that you will have already met $25 of your $50 Deductible when the next Plan Year begins.

Vision Coverage

Highlights of Your Vision Benefits

The following chart lists some highlights of your vision benefits. You will find details about the vision program on the following pages and in the Plan Document.

FEATURES AND COVERED CHARGES	BENEFIT
Allowable Vision Expense	Depends on Service
Eye Exam	For In-Network Provider, Plan covers the cost of one eye exam per Participant every 12 months. For Out-of-Network Provider, Plan reimburses up to amounts listed on page 47.
Frames	For In-Network Provider, Plan covers the cost up to $215 ($120 at Costco) for one pair of frames per Participant every 12 months. For Out-of-Network Provider, Plan reimburses up to amounts listed on page 47
Lenses	For In-Network Provider, Plan covers the cost of one pair of single vision, lined bifocal, lined trifocal and lenticular lenses per Participant every 12 months. For Out-of-Network Provider, Plan reimburses up to amounts listed on page 47 per Participant once every 12 months.
Lenses Enhancements	For In-Network Provider, Plan covers the lense enhancements listed on page 48. For Out-of-Network Provider, Plan reimburses up to amounts and for the enhancements listed on page 48 per Participant once every 12 months.

FEATURES AND COVERED CHARGES	BENEFIT
Contact Lenses	For In-Network Provider, Plan covers the cost of one pair of lenses or a one-year supply of disposable lenses per Participant every 12 months. For Out-of-Network Provider, Plan reimburses up to amounts listed on page 48.
Diabetic Eye Care Plus Program	For In-Network Providers, exams and special ophthalmological services provided at no costs. For Out-of-Network Provider, Plan reimburses up to amounts list on page 48.

Your Payment Responsibilities

Allowable Vision Expense

For In-Network Providers, the Plan covers 100% of the Allowable Vision Expense, less any copay. You or your Eligible Dependents must pay any amount above the Allowable Vision Expense.

Copay

For certain vision benefits, You or your Eligible Dependents must pay the Provider a copay. Applicable copays listed on page 47, and are subject to change. For up-to-date copay amounts, go to metlife.com/mybenefits or call Customer Service 1-800-635-9671.

Reimbursable Charges

For Out-of-Network Providers, you our your Eligible Dependents must first pay the Provider for any services rendered and then file a claim with the Claims Administrator for reimbursement for the Allowable Vision Expense for an Out-of-Network Provider. Reimburseable amounts are listed on pages 47-48, but are subject to change. To obtain a claim form and for information for how to file a claim for reimbursement and up-to-date reimburseable amounts, you may access metlife.com/mybenefits, or for additional assistance, call Customer Service at 800-635-9671.

In-Network Providers

Through an Insurance Policy provided by MetLife, you and your Eligible Dependents may use the Providers in MetLife's Network, which includes Ophthalmologist, Optometrist and Opticians in most cities.

In-Network Providers have agreed to provide services for a discounted fee. The discounted fee means you pay less for your vision care. Using an In-Network Provider is completely voluntary — it is your decision to make each time you need vision care.

To locate In-Network Providers in your area, access metlife.com/vision for a Directory of In-Network Providers. You may also call Customer Service at 800-635-9671 for assistance.

In addition to Vision Benefits provided under the Plan, additional savings may be available for non-covered services at In-Network Providers including non-standard lens enhancements, additional pairs of glasses and sunglasses, and laser vision correction. For more information, go to metlife.com/vision.

For Costco, you should contact your local Costco for available services and pricing.

What the Vision Program Covers

Eye Exam

Vision benefit includes one eye exam with an In-Network Provider every 12 months per participant at no cost to the Participant. Eye exam benefit includes a retinal screening, with a $39 co-pay, if performed at a private practice. If Out-of-Network provider, plan will reimburse Participant up to $50 for the exam.

Frames

Vision benefit includes one pair of frames every 12 months per participant. If In-Network, the plan provides allowance of $215 ($120 if at Costco) of the cost of the frames. Plan provides additional 20% savings on cost of frames above $215 at participating providers, except for Costco, Walmart and Sam's Club. If out-of-network, plan reimburses up to $115.

Standard Corrective Lenses

Vision benefit includes one pair of standard corrective lenses per participant every 12 months. If in-network Provider, single vision, lined bifocal, lined trifocal and lenticular lenses provided at no cost. If out-of-network Provider, plan reimburses up to $48 for single vision lenses, up to $68 for lined bifocal lenses, $84 for lined trifocal lenses and $100 for lenticular lenses.

Standard Lenses Enhancements

Vision benefit includes standard lense enhancements for one pair of lenses per participant every 12 months. If in-network Provider, plan provides the following enhancements at no cost: ultraviolet (uv) coating, polycarbonate (child up to age 18), progressive standard, progressive premium/ custom, polycarbonate (adult), scratch resistant coating and tints. An anti-reflective enhancement is provided with a $40 copay and photochromic enhancement is provided at a $30 copay. If out-of-network, plan reimburses up to $10 for polycarbonate (child up to age 18), polycarbonate (adult), scratch resistant coating and tints and up to $68 for progressive standard and progressive premium/custom.

Contact Lenses

Vision benefit includes one pair of contact lenses per participant every 12 months. If disposable lenses, the vision benefit includes a one-year supply of contact lenses. If out-of-network, plan reimburses up to $120 per participant per year for elective contact lenses and $215 for necessary contact lenses.

Diabetic Eye Care Plus Program

Vision benefit provides exams and special ophthalmological services for participants who have been diagnosed with type 1 or type 2 diabetes and have specific ophthalmological conditions. It also provides benefits for those with glaucoma and age-related macular degeneration (AMD). In addition, participants who have diabetes but don't show signs of diabetic eye disease are eligible to receive preventive retinal screenings. This offer is available from all participating locations except Costco, Walmart and Sam's Club. For In-Network providers, these benefits are provided at no costs to the participant. For out-of-network providers, these services are provided at the lesser of the provider's fee or 80% of Medicare eligible.

Vision Expenses Not Covered

The vision program does not cover the following:

- Any services not included in the Insurance Policy issued by MetLife;
- Any portion of a charge above the Allowable Vision Expense or reimbursement indicated in the Insurance Policy;
- Any eye examination or corrective eyewear required as a condition of employment;
- Services and supplies received by Player or Eligible Dependent before September 1, 2020;
- Missed appointments;
- Services or materials resulting from or in the course of a Participant's regular occupation for pay or profit for which the Participant is entitled to benefits under any Worker's Compensation Law, Employer's Liability Law or similar law;

- Local, state, and/or federal taxes, except where Insurer is required by law to pay;
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony;
- Services and materials obtained while outside the United States, except for emergency vision care;
- Services, procedures, or materials for which a charge would not have been made in the absence of insurance;
- Service for which the employer of the person receiving such services is required to pay or services received at a facility maintained by the NFL, a member Club of the NFL, the NFLMC, the NFLPA, a mutual benefit association, or VA hospital;
- Services, to the extent such services, or benefits for such services, are available under a Government Plan;
- Plano lenses (lenses with refractive correction of less than ± 0.50 diopter);
- Two pairs of glasses instead of bifocals;
- Replacement of lenses, frames and/or contact lenses, furnished under this Plan which are lost, stolen, or damaged, except at the normal intervals when Vision Benefits are otherwise available;
- Insurance policies and service agreements;
- Refitting of contact lenses after the initial (90 day) fitting period;
- Contact lens modification, polishing, and cleaning;
- Corneal Refractive Therapy (CRT) or Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia);
- Replacement of lost or damaged lenses;
- Plano lenses to change eye color cosmetically;
- Artistically painted lenses;
- Additional office visits associated with contact lens pathology; contact lens modification, polishing or cleaning; and refitting after the initial (90 day) fitting period
- Orthoptics or vision training and any associated supplemental testing;
- Medical and surgical treatment of the eye;
- Prescription and non-prescription medications.

This is not a complete listing of dental items or services that are not covered. Call the Customer Service Center at 800-635-9671 or got to metlife.com/mybenefits if you have questions about coverage.

FMLA

If you go on a leave that qualifies under the provisions of the FMLA, your vision coverage may continue. Refer to page 33 of this SPD or contact the Customer Service Center for more information.

COBRA

You and your Qualified Beneficiaries may continue vision coverage in certain cases when that coverage would otherwise end. See the explanation of COBRA beginning on page 54 of this SPD.

Common Vision Coverage Questions & Answers

Q. When should I submit my claims?

A. You are not required to file a claim for In-Network Providers. All claims for reimbursement from Out-of-Network Providers must be filed within 12 months to be covered by the Plan. However, you should file as soon as you receive the bill to ensure timely payment.

Q. How do I file vision claims?

A. You are not required to file a claim for In-Network Providers. You should submit your claims directly to MetLife at the address on your ID card. You may obtain a claim form at metlife.com/mybenefits. You will receive your reimbursement at your address of record.

Q. What if I disagree with how my claim has been paid?

A. You should first call the Customer Service Center for a complete explanation. If you decide to appeal the denial, you must file a written request for review to MetLife at the address listed on page 69 for vision coverage questions. The written request must be received by MetLife within 180 days of receipt of your denial. Your request should state the reasons why your claim should be approved and provide any additional information that supports your request.

Work/Life Resources Benefit

Eligibility

You, your Eligible Dependents and your Household Members are eligible for the work/life resources benefit.

Highlight of Benefits

The benefit is an employee assistance program that provides 24 hours a day/7 days per week counseling and assistance that helps you, your Eligible Dependents or Household Members find the necessary resources to address issues affecting your daily lives.

Services provided under the Work/Life Resources Benefit

- **Clinical Services Program**
  Provides unlimited access to telephonic consultation with licensed clinicians for mental health, alcoholism or drug abuse services. If this does not meet the Participant's needs, the Participant will be referred to a local network counselor and receive at no charge up to eight (8) counseling sessions per diagnosed issue. This benefit is in addition to the eight office visits at no charge under your medical benefits described on page 23.
- **Work Life Program**
  Provides services to assist in resolving day-to-day work life issues. The following services are provided under the Work Life Program:

Child/Parenting Support Services

Provide referrals for child care providers, before-and-after school care, nanny agencies, sick-child care, special needs care, education services, adoption specialist and support groups, summer camps and programs, and parenting support groups. This service also includes telephonic access to counselors to discuss concerns or questions with child development or parenting, prenatal care and childhood illness or disabilities.

Elder Care Support Services

Provide referrals for adult/elder care providers, community assistance resources, senior centers, transportation services, home health programs, rehabilitation programs, independent or assisted living centers, Alzheimer's support, food and other visitation/assistance programs, grief support, caregiver support resources, adult day care, end-of-life resources, home medical equipment, elder-law attorneys and other adult/elder support services. This service also includes telephonic access to a counselor to discuss concerns or questions regarding Medicare or Medicaid, supplemental insurance, and the care and nurture of adult or elderly dependents.

Pet Care Services

Provides referrals for veterinarians, pet care providers, pet obedience training, pet supplies and boarding and kennel services.

Legal Services

Provides one (1) thirty-minute consultation with a network attorney per separate legal matter at no cost. Types of legal issues eligible for these services include family issues, general civil issues, elder law, motor vehicle law, IRS matters, tax preparation, and criminal matters. Legal assessment and referral services are not available if the issue is related to any potential cause of action against the National Football League, the Management Council, the NFLPA, any NFL football club (including without limitation club owners, managers, agents, and representatives), the NFL Player Insurance Plan or any other benefit program sponsored in whole or in part by the NFL Management Council, or any other entity affiliated with the National Football League.

Identity Theft Services

Provides a free 60-minute consultation with a fraud resolution specialist for Participants who think they might be victims of identity theft.

Accessing the Work/Life Resources Benefit

You, your Eligible Dependents and your Household Members may access the work/life resources benefit by contacting the EAP Program Provider at (866) 421-8628. You may also access the work/life resources benefitenefit at cignabehavioral.com and entering nflplayer as your Employer ID in the "Login to Access Your Benefits" tab.

Limitations

You, your Eligible Dependents or Household Members who utilize the referral services shall pay for any service provider selected, not including the eight in-person counseling sessions that are provided at no cost, or as otherwise noted above. The Plan's contracts with providers are for fixed terms; there is no guarantee that a contract will be renewed on the same terms when it expires.

COBRA

You and your Eligible Dependents will normally have the opportunity to purchase a temporary extension of medical, vision, or dental coverage, or both, at group rates in certain instances where your coverage under the Plan would otherwise end. This coverage is referred to as COBRA. You and your Eligible Dependents should have received a notice explaining your rights under COBRA. Please contact the NFL COBRA Administrator at Alight Solutions, Alight Solutions 1025 Boulders Parkway, Suite 405, Richmond, VA 23225 or call 800-635-9671 if you want another copy.

Qualifying Events and Length of Coverage

The maximum length of time for which you can continue coverage is either 18, 29 or 36 months, depending on the qualifying event. **A qualifying event ("Qualifying Event") is an event that would cause you to lose coverage under the Plan.** Note that the Qualifying Event does not have to cause an immediate loss of coverage. For example, Players who are entitled under the Plan to coverage for a period of time after their employment terminates become eligible for COBRA continuation coverage at the time their coverage period ends. The following chart shows the Qualifying Events and the maximum length of coverage available for each.

QUALIFYING EVENT	MAXIMUM LENGTH OF COVERAGE
Termination of employment for reasons other than gross misconduct on your part	18 months for you and your Eligible Dependents except as provided below
Disability (for Social Security purposes) • **At the time of the Qualifying Event or** • **At any time during the first 60 days of COBRA coverage**	29 months for the disabled person and covered Qualified Beneficiaries
• **Legal separation or divorce** • **Your death** • **Your entitlement to Medicare or** • **Your Child no longer meets the eligibility requirements (for example, turns age 26)**	36 months for the affected Eligible Dependent(s)

Qualified Beneficiaries

A Qualified Beneficiary is any individual correctly covered by the Plan on the day before a Qualifying Event. A Qualified Beneficiary may be you or your Eligible Dependent. In addition, if you have or adopt a Child while you are on COBRA, your newborn or adopted Child may be considered a Qualified Beneficiary. You must request the Child be added as a Qualified Beneficiary within 31 days of the event, or you must wait until the next annual "open enrollment" period. Each Qualified Beneficiary has independent COBRA rights.

If you marry after you begin your COBRA coverage, you may add your spouse to your coverage. However, such spouse would not be considered a Qualified Beneficiary and would not be eligible to make a separate election. Also, unless you request this addition be made within 31 days of the event, you must wait until the next annual "open enrollment" period.

Each Qualified Beneficiary has an independent right to elect to continue coverage that is identical to the coverage provided under the medical and dental programs. However, only you or your spouse needs to elect COBRA coverage for your Eligible Dependents who would otherwise lose coverage. Any changes made to the health coverage offered to active employees will generally apply to your COBRA coverage. You may make coverage changes during an annual "open enrollment" period or when you experience certain life events, such as marriage, divorce, or the birth or adoption of a Child, so long as you apply within 31 days of the event.

Responsibility for Notification

In the event of divorce or your Child's loss of Dependent status, you or your Eligible Dependent must provide notice to the NFL COBRA Administrator within 60 days of the Qualifying Event. Call the NFL COBRA Administrator to obtain the necessary forms and a description of the information you will need to provide. If neither you nor your Eligible Dependent provides the required notice, the right to elect COBRA coverage will be lost.

If you are disabled at the time your coverage ends, or if you become disabled during the first 60 days of COBRA coverage, contact the NFL COBRA Administrator at 800-635-9671 immediately for a complete explanation of the procedures you must follow to extend coverage. For example, you must provide the NFL COBRA Administrator with the Social Security Notice of Disability determination within 60 days of the date of the determination and before the end of the first 18 months of coverage in order to extend your COBRA coverage to a total of 29 months. You also are required to provide the NFL COBRA Administrator notice within 30 days of a determination that the disability no longer exists.

If any other Qualifying Event causes you to lose coverage under the Plan, you will be provided with the necessary notice and election forms within 75 days of the date coverage is lost.

Electing COBRA

To elect continued coverage, you or your Eligible Dependent has **60 days** from the later of:

- the date on the COBRA notice and election forms or
- the date of the Qualifying Event

The Cost of COBRA

You will be responsible for paying the entire cost of the COBRA coverage, plus an additional 2% to cover administrative costs. COBRA coverage for the work/life resources benefit is provided at no cost.

Coverage Limitations

COBRA coverage provided to a person under this Plan will end on the earliest of:

- the date the person has had his or her maximum length of coverage
- the date on which the person first becomes eligible under another group health plan
- the date the person becomes entitled to Medicare benefits
- **the date that any required premiums are due and unpaid, taking into account the following extension. The premium is due on the first day of each month, except for the first premium, which is due 45 days after electing COBRA. Full payment must be received by, or a letter that includes full payment must be posted and sent to, the NFL COBRA Administrator no later than 30 days after the due date**
- the date the NFL stops providing group medical and/or dental benefits to players

Extending Coverage if COBRA Terminates Due to Medicare Eligibility

If a Vested Player's COBRA coverage terminates because he becomes eligible for Medicare benefits, he may elect to extend coverage under the Plan's extended coverage provisions set forth on pages 59-67 of this SPD. If such Vested Player also obtains Medicare, he must notify the Customer Service Center at 800-635-9671 within thirty (30) days of the effective date of his coverage under Medicare. If a Vested Player does not inform Customer Service of his coverage under Medicare, the Plan may recover from the Vested Player any and all claims paid by the Plan on the Vested Player's behalf to the extent, if any, such claims should have been paid by Medicare under the Plan's Coordination of Benefits provisions explained on pages 74-75.

Common COBRA Questions & Answers

Q. What does COBRA mean for me?

A. COBRA is the federal law that requires employers to allow you and your Eligible Dependents to continue health care coverage for a certain length of time in specific instances when your coverage would otherwise end. This provides protection for you and your family during times such as termination, divorce and when your children reach the Plan's age limits.

Q. Whom can I cover under COBRA?

A. Each person who is covered under the Plan on the day before the Qualifying Event is called a Qualified Beneficiary. Each Qualified Beneficiary can make a separate COBRA election. For example, you may select medical coverage for yourself, but your spouse may select medical and dental coverage. In addition, if you have or adopt a Child while you are covered by COBRA, that Child is considered a Qualified Beneficiary. You may make the COBRA elections for your Eligible Dependent Children who are Qualified Beneficiaries. If you marry after you begin your COBRA coverage, you may add your spouse to your coverage, as long as you apply within 31 days of your marriage. However, your spouse would not be considered a Qualified Beneficiary and would not be eligible to make a separate election. Likewise, you may add a Child within 31 days of the Child's birth or adoption.

Q. Are benefits under COBRA different?

A. No.

Q. How much does COBRA cost?

A. You will pay the full cost of the coverage, plus an additional 2% of the cost to cover administrative fees.

Q. Can each Qualified Beneficiary make a separate election?

A. Yes. You may make the election for your Eligible Dependent Children.

Q. What happens if there are several Qualifying Events?

A. If you have several Qualifying Events that occur, the maximum length of coverage is 36 months. For example, if you terminate your employment, you and your covered Dependents are eligible for 18 months of COBRA. If your Child reaches the Plan's age limit 6 months after, he or she is eligible for a total of 36 months of coverage from the date of the first event (your termination).

Q. What happens if I do not return my COBRA enrollment form by the deadline set forth in the COBRA Notice?

A. You lose your right to elect COBRA coverage.

Q. What happens if my COBRA premium is late?

A. If your payment is late for any reason, including a reason related to a move, you will forfeit your right to COBRA coverage. It is your responsibility to notify the NFL COBRA Administrator of a change in your address.

Q. How do I appeal the denial or termination of COBRA coverage?

A. Write to the Trustees, following the procedures for appealing a denied claim for benefits. Address your letter to the Trustees in care of the Plan Administrator.

Q. What if my COBRA coverage terminates due to me becoming eligible for Medicare?

A. Your COBRA coverage terminates but if you are a Vested Player you are eligible to continue coverage under the extended coverage provisions. If you also obtain Medicare, you must notify the Customer Service Center at 800-635-9671 within thirty (30) days of the effective date of your coverage under Medicare. If you do not inform Customer Service of your coverage under Medicare, the Plan may recover from the Vested Player any and all claims paid by the Plan on the Vested Player's behalf to the extent, if any, such claims should have been paid by Medicare under the Plan's Coordination of Benefits provisions explained on pages 74-75.

USERRA

If you lose coverage under the Plan because you left the NFL to enter the military service of the United States, voluntarily or involuntarily, you may be entitled to continue coverage for a longer period than COBRA provides. Specifically, you and your Dependents may have the right to continue coverage under the Plan for up to 24 months while in the military. Other than its duration, the coverage provided under USERRA is identical to the coverage provided under COBRA. Contact the Customer Service Center for more details or if you believe you are entitled to exercise this right.

Extended Benefits Coverage

If you are vested in the Pension Plan because of your Credited Seasons and satisfy the requirements described below, you have options to continue your coverage under the Plan, at your expense, after your cost-free coverage as a Continuing Veteran ends. These options are in addition to your rights under COBRA, and allow you to extend coverage even after your COBRA coverage period ends. The Plan has two options for extending your coverage in addition to your COBRA rights. You may either elect to extend coverage and continue your coverage under the Standard Plan, or you may elect coverage under the Lower Cost Option Plan.

Standard Plan

The Standard Plan is the same benefit plan you have been covered under as an active player and as a Continuing Veteran, with the same rules, requirements and legal obligations described throughout this SPD. The only difference is that now because your coverage as a Continuing Veteran has ended, you are required to pay premiums for this coverage. To be eligible to extend coverage under the Standard Plan you must have elected COBRA coverage for yourself, or you must still be within your timeframe to make such an election. If you only elected COBRA coverage for your dependents, you are NOT eligible to extend coverage for yourself, and your dependents will not be able to extend coverage beyond the COBRA coverage period. However, if you die before your coverage as a Continuing Veteran ends, and before you can make a COBRA election, your dependents are permitted to elect to extend their coverage under this provision.

Lower Cost Plan

The Lower Cost Plan covers the same services as the Standard Plan, and has the same rules, requirements and legal obligations as the Standard Plan described throughout this SPD. The Lower Cost Plan, however, has different, and in most cases, greater out-of-pocket costs to you for these services. Because the Lower Cost Plan has greater out-of-pocket costs, you may elect to extend coverage under the Lower Cost Plan at lower monthly premiums than you could extend coverage under the Standard Plan.

To be eligible to extend coverage for you and your dependents under the Lower Cost Plan, you must have elected coverage for yourself under COBRA, or you must still be within the timeframe to make such an election. If you only elected COBRA coverage for your dependents, you are NOT eligible to elect coverage for yourself or your dependents under the Lower Cost Plan. However, if you die before your

coverage as a Continuing Veteran ends, and before you can make a COBRA election, your dependents are permitted to elect to extend their coverage under this provision and may elect to do so under the Lower Cost Plan.

Also, if you did elect COBRA coverage for yourself and your dependents, or are still within the timeframe to do so, you may elect coverage under the Lower Cost Plan in lieu of COBRA or you may change your election from the Standard Plan to the Lower Cost Plan. You do NOT have to wait until the COBRA coverage period ends to change your election to the Lower Plan. However, once you elect coverage under the Lower Cost Plan, you will NEVER have the option to again receive coverage under the Standard Plan.

If you elect to extend medical coverage for yourself under either the Standard Plan or the Lower Cost Plan, you may elect to extend dental and vision coverage for your dependents only. You may not extend medical,dental, or [vision coverage for your dependents unless you extend medical coverage for yourself.

Termination of Extended Coverage

You may continue your extended coverage under either the Standard Plan or the Lower Cost Plan, depending on your election, for the duration of the current collective bargaining agreement, unless the Plan is otherwise terminated, so long as you pay the required premiums. Premiums for extended coverage are due on the first day of each month, with a 30-day grace period. If premiums are not paid by the end of the grace period, coverage will be cancelled and you lose your right to coverage under the Plan.

Comparison of Standard Benefit Plan and Lower Cost Benefit Plan

The following chart lists some highlights of your medical benefits and provides a comparison of the out-of-pocket costs between the Standard Plan and the Lower Cost Plan. Note that in all cases, unless otherwise stated, you must pay the applicable Deductible, Coinsurance, and any cost that a non-Preferred Provider may charge that is greater than the Maximum Reimbursable Charge. You will find details about the medical program on the following pages and in the Plan Document.

BENEFIT COMPONENT	STANDARD PLAN	LOWER COST PLAN
Annual Deductible[1]	$850 Individual, $1,700 Family	$6,500 Individual, $13,000 Family
Annual Out-of-Pocket Maximum[1]	Medical: $2,000 per person, $5,000 family Prescription: $2,000 per person, $5,000 family	Combined Medical & Prescription $7,150 per person, $14,300 family
Maximum Lifetime Benefit	Unlimited	Unlimited
Maximum Lifetime Transplant	Unlimited	Unlimited
Preventive- including but not limited to mammograms and PSA screenings	100%, In Network, No Deductible 70%, Out-of-Network, After Deductible (mamograms 100%, no deductible)	100% In Network, No Deductible 70% Out-of-Network, After Deductible
Telehealth Appointments (other than behavioral health) [2]	You will see your current share of the costs for Telehealth services when you access MDLiveforCigna.	You will see your current share of the costs for Telehealth services when you access MDLiveforCigna.
Office Visits	80% In Network After Deductible 70% Out-of-Network After Deductible	100% In Network After Deductible 70% Out-of-Network After Deductible
Inpatient Semi-private Hospital Room & Board and Professional Services	80% In Network After Deductible 70% Out-of-Network After Deductible	100% In Network After Deductible 70% Out-of-Network After Deductible
Outpatient Pre-Admission Testing, Including Diagnostic X-rays, Lab, and Second/Third Opinions	100% No Deductible	100% No Deductible

BENEFIT COMPONENT	STANDARD PLAN	LOWER COST PLAN
Outpatient Facility, Surgical and Professional Services	100% After Deductible	100% After Deductible
Maternity, Including Pre- and Postnatal Care	80% In Network After Deductible 70% Out-of-Network After Deductible (Home Deliveries, Birthing Centers and Midwife Services covered at 100% after deductible)	100% In Network After Deductible 70% Out-of-Network After Deductible (Home Deliveries, Birthing Centers and Midwife Services covered at 100% after deductible)
Infertility Treatment	80% In Network After Deductible 70% Out-of-Network After Deductible	100% In Network After Deductible 70% Out-of-Network After Deductible
Well Child/ Immunization (to age 19)	100% In Network No Deductible 70% Out-of-Network After Deductible	100% In Network No Deductible 70% Out-of-Network After Deductible
Physical Therapy	80% In Network After Deductible 70% Out-of-Network After Deductible	100% In Network After Deductible 70% Out-of-Network After Deductible
Chiropractic	35 Visits Without Medical Necessity 80% In Network, After Deductible 70% Out-of-Network After Deductible	35 Visits Without Medical Necessity 100% In Network, After Deductible 70% Out-of-Network After Deductible
X-ray and Labs	80% In Network After Deductible 70% Out-of-Network After Deductible	100% In Network After Deductible 70% Out-of-Network After Deductible

BENEFIT COMPONENT	STANDARD PLAN	LOWER COST PLAN
Home Health Care[3]	100%, No Deductible Up to 100 Visits (4 hours equals 1 visit) Maxium of 16 hours per day	100% No Deductible Up to 100 Visits (4 hours equals 1 visit)
Emergency and Urgent Care Services	80% After Deductible	100% After Deductible
Transportation To Medical Facility (including professional ambulance)	80% In Network After Deductible 80% Out-of-Network After Deductible	100% In Network After Deductible 100% Out-of-Network After Deductible
Autism[4]	80% In Network After Deductible 70% Out-of-Network After Deductible	100% In Network After Deductible 70% Out-of-Network After Deductible
Prescription Drugs (Retail)	**Three Tier Retail Benefit:** No Deductible, Copays of: $15 Generic Drugs $25 Preferred Brand Name Drugs $50 Non-preferred Brand Name Drugs 90 Day Supply Available for Maintenance Prescriptions: 2x Retail Copay, No Deductible	100% In Network After Deductible 70% Out-of-Network After Deductible
Prescription Drugs (Mail Order)	Generic Preventive Maintenance[4] and Diabetic Testing Strips: 100% No Deductible Other Maintenance: 2x Retail Copay for 90 Day Supply	Generic Preventive Maintenance[4] and Diabetic Testing Strips: 100% No Deductible Other Maintenance: 100% No Deductible

BENEFIT COMPONENT	STANDARD PLAN	LOWER COST PLAN
Durable Medical	80% In Network After Deductible 70% Out-of-Network After Deductible	100% In Network After Deductible 70% Out-of-Network After Deductible
Mental Health Inpatient	No Deductible 80% In Network, 70% Out-of-Network	No Deductible 100% In Network, 70% Out-of-Network
• **Outpatient Office Visits**	In Network: 100% Visits 1-8, 80% Additional Visits Out-of-Network: 100% Visits 1-8, 70% Additional Visits	In Network: 100% Out-of-Network: 100% Visits 1-8, 70% Additional Visits
• **Outpatient Facility**	100% No Deductible	100% No Deductible
Substances of Abuse[5] Inpatient	NoDeductible 80% In Network, 70% Out-of-Network	NoDeductible 100% In Network, 70% Out-of-Network
• **Outpatient Office Visits**	In Network: 100% Visits 1-30, 80% Additional Visits Out-of-Network: 100% Visits 1-30, 70% Additional Visits	In Network: 100% Out-of-Network: 100% Visits 1-30, 70% Additional Visits
• **Outpatient Facility**	100% No Deductible	100% No Deductible

(1) Deductible and Out-of-Pocket Maximum are shared between in network and out-of-network services.

(2) The per appointment Telehealth fee is subject to change each January 1st.

(3) No limit on visits for certain forms of home health care to treat autism, mental health or substance of abuse disorder issues.

(4) Generic prescription medications used to prevent any of the following medical conditions: hypertension, high cholesterol, diabetes, asthma, osteoporosis, blood thinner, prenatal vitamins, birth control and FDA-approved Generic drugs to treat ADHD (attention deficit/hyper activity).

(5) These copays/coinsurance factors do not apply to Players who are in the NFL's Substances of Abuse Program or receiving the Behavioral Management Benefit.

Premiums for Extended Coverage

The following charts list the premiums for extended coverage for the 2020-2021 plan year under the Standard Plan and the Lower Cost Plan. As illustrated in the chart, there is only one option for extending the dental benefit.

Medical Plans

Monthly Plan Rates – September 1, 2020 – August 31, 2021

LEVEL OF COVERAGE	STANDARD PLAN*	LOWER COST PLAN
1 Adult Only	$655.39	$496.17
1 Child Only* **	$524.42	$396.93
2 Children* **	$1,048.86	$793.88
3 or More Children* **	$1,573.28	$1,1190.81
2 Adults (Player and Spouse)	$1,311.07	$992.34
1 Adult & 1 Child* **	$1,179.96	$893.10
1 Adult & 2 Children* **	$1,704.39	$1,290.05
1 Adult & 3 or More Children* **	$2,228.81	$1,686.98
2 Adults & 1 Child	$1,835.49	$1,389.27
2 Adults & 2 Children	$2,359.92	$1,786.21
2 Adults & 3 or More Children	$2,884.35	$2,183.65

Dental Plans

Monthly Plan Rates – September 1, 2019 – August 31, 2020

LEVEL OF COVERAGE	COST
1 Adult Only	$35.82
1 Child Only* **	$28.66
2 Children* **	$57.31
3 or More Children* **	$85.98
2 Adults (Player and Spouse)	$71.64
1 Adult & 1 Child* **	$64.48
1 Adult & 2 Children* **	$93.14
1 Adult & 3 or More Children* **	$121.80
2 Adults & 1 Child	$100.31
2 Adults & 2 Children	$128.96
2 Adults & 3 or More Children	$157.62

* If you elect coverage under the Standard Plan, you can move to the Lower Cost Plan at any time, but you may not move back to the Standard Plan.

** Once coverage is elected under the Lower Cost Plan, you **may not** elect coverage under the Standard Plan in the future.

*** Only available for the 18 month COBRA period, coverage for dependents only not allowed after expiration of COBRA (in certain situations dependents are eligible for COBRA for 36 months. Except during COBRA period, Player must have medical coverage under the Standard or Lower Cost Plan in order for dependents to have medical, dental or vision coverage.

Coordination with Medicare

If a Vested Player who elects Extended Coverage is or becomes eligible for Medicare coverage, he is still eligible for Extended Coverage. However, if such Vested Player also obtains Medicare, he must notify the Customer Service Center at 800-635-9671 within thirty (30) days of the effective date of his coverage under Medicare. If a Vested Player does not inform Customer Service of his coverage under Medicare, the Plan may recover from the Vested Player any and all claims paid by the Plan on the Vested Player's behalf to the extent, if any, such claims should have been paid by Medicare under the Plan's Coordination of Benefits provisions explained on page 74-75.

Benefits Administration

Additional Information

If, after reading this SPD, you have additional questions about your benefits, you may contact the Customer Service Center at 800-635-9671. You also may contact the companies below for information on the applicable benefits program.

BENEFIT NAME	INFORMATION
Life insurance and AD&D	Prudential Insurance Company of America Group Life Recordkeeping P.O. Box 13676 Philadelphia, PA 19176
Prescription drug benefits	Cigna Pharmacy Service Center P.O. Box 3598 Scanton, PA 18505-0598 800-622-5579
Medical coverage	Cigna Healthcare Service Center P.O. Box 182223 Chattanooga, TN 37422-7223 800-244-6224
Substances of abuse benefits (all Participants who are not required to contact SWS)	Cigna Healthcare Service Center P.O. Box 182223 Chattanooga, TN 37422 800-244-6224
Substances of abuse benefits (Players in the Substances of Abuse Program)	Cigna 2425 Porter Street, Suite 1 Soquel, CA 95073 800-880-2376

BENEFIT NAME	INFORMATION
Work/Life Resources Benefit	Cigna P.O. Box 188022 Chattanooga, TN 37422 866-421-8628
Dental coverage	Cigna P.O. Box 188037 Chattanooga, TN 37422-8037 800-244-6224
Vision coverage	MetLife P.O. Box 385018 Birmingham, AL 35238-5018 855-638-3931

Filing Claims for Benefits

Life and AD&D Claims

See pages 15-16 for the procedures for filing life and AD&D claims.

Medical, Dental and Prescription Drug Claims

In order to receive medical, dental or prescription drug benefits, **you must file claim forms within 1 year from the date of service.** You should submit all claims directly to Cigna at the address on your ID card. Make sure your claim includes the following information on your bill or on the form:

- name of patient
- diagnosis code and itemization of charges
- date of service
- provider tax identification number

Unless you specify otherwise, benefits will be paid directly to you.

Vision Claims

For In-Network claims, you do not need to file a claim. For reimbursement for Out-of-Network services, you must file claim forms within 12 months from the date of service. You should sumit all claims directly to MetLife at the address on your MetLife ID Card. You may obtain a claim form at metlife.com/mybenefits.

Substances of Abuse Services Claims

Depending on your status, file your claims with Cigna as described on page 28. Benefits will be paid directly to your Provider.

Processing of Medical and Dental Claims

The Plan will respond to your claim as soon as possible. The Plan's deadline for responding to your claim depends on the type of claim, as follows:

A **pre-service claim** is a claim for a benefit that requires approval before the benefit is available. For pre-service claims, the Plan will provide a written notice no later than 15 days after receipt of your claim, provided you have furnished all of the required information. If special circumstances require more time, you will be informed before the end of the 15 day period of the reason for the delay. If an extension is needed, the Plan will provide a determination no later than 30 days after receipt of your claim.

A **post-service claim** is a claim filed following your receipt of medical care. For post-service claims, the Plan will provide a written notice no later than 30 days after the receipt of your claim, provided you have furnished all of the required information. If special circumstances require more time, you will be informed before the end of the 30 day period of the reason for the delay. If an extension is needed, you will get a determination of your claim no later than 45 days after receipt of your claim.

An **urgent care claim** is any claim with respect to which the time periods for making non-urgent care determinations could seriously jeopardize your life or health or subject you to severe pain that cannot otherwise be adequately managed. If you demonstrate that your claim qualifies as an urgent care claim, the Plan will provide a response no later than 72 hours following the receipt of your claim by the Plan, unless you fail to provide required information. If more information is needed to process your claim, the Plan will notify you of such no later than 24 hours after receipt of your claim and give you adequate time to supply the necessary information before rendering a decision on your claim.

If you do not receive a response to your claim for benefits within the time period described for your type of claim, and you have not received a notice regarding the need for an extension or additional information, you should immediately contact the Customer Service Center at 800-635-9671 for an explanation. You may also treat the failure as a deemed denial and file an appeal, following the procedures described below.

Claims You Are Eligible for Coverage

You may have a claim that you are eligible to participate in the Plan, including, but not limited to, a claim that you are eligible pursuant to COBRA, as opposed to a claim to be reimbursed for a specific service or supply. In this case, you should contact the Customer Service Center, which will provide the initial determination based on the records available to it. The deadline for responding to your claim of eligibility is the same as summarized on the previous page for a post-service claim for benefits. If you are dissatisfied with the decision, you may appeal it to the Trustees, who will respond as soon as practicable. Contact the Customer Service Center for more information.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) a description of the Plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment that a medical item or service is not Medically Necessary, the treatment is experimental, or other similar exclusion or limit; (7) information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and (8) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Appealing Claim Denials

If your claim for benefits, which includes a request that an approved course of treatment be extended, is denied, in whole or in part, or if a previously approved course of treatment is curtailed or terminated, you or your Beneficiary will receive a written notice of the denial.

You may ask Cigna to review the denied claim. Contact the Customer Service Center at 800-635-9671 if you need help. Your request must be in writing, and it must be received by the appropriate Cigna entity within 180 days of receipt of the denial notice. Please refer to pages 68-69 for the proper address. The request should state the reasons why you believe your claim should be approved and provide any additional information (medical or dental records, etc.) which you believe supports your claim. You may have someone represent you during the appeal process, and you may ask questions and review relevant documents. In reaching its decision, Cigna has sole and absolute discretion to interpret the Plan's terms and to make any and all determinations, including determinations of disputed factual questions.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving a determination of Medically Necessary or clinical appropriateness will be considered by a health care professional. Cigna will respond in writing with a decision within 15 calendar days after it receives an appeal for a required pre-service or concurrent care coverage determination, and within 30 calendar days after Cigna received an appeal for a post-service coverage determination. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (1) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your physician would cause you severe pain which cannot be managed without the requested services; or (2) your appeal involves non-authorization of an admission or continuing inpatient hospital stay. If you request that your appeal be expedited based on (1) above, you may also ask for an expedited external independent review at the same time, if the time to complete an expedited appeal would be detrimental to your medical condition. Cigna's physician reviewer or your treating physician may decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

Cigna will provide you, free of charge, any new or additional evidence considered, relied upon or generated by Cigna in connection with your claim, or any additional rationale upon which Cigna based any adverse determination with respect to your claim, and will provide you this information as soon as possible and sufficiently in advance of any final notification on your claim to give you a reasonable opportunity to respond prior to any such notification.

If the Plan or Cigna does not adhere to these claim and appeals processes, you are deemed to have exhausted the process and may proceed to external review, including, but not limited, filing suit in federal district court.

Independent Review Procedure

If you are not fully satisfied with the decision and the appeal involves medical judgment, you may request that your appeal be referred to an Independent Review Organization ("IRO"). The IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to request an appeal to an IRO will not affect the claimant's rights to any other benefits under the Plan. There is no charge for you to initiate this Independent Review Process. The decision of the IRO will be binding on Cigna. To request a review, you must notify Cigna or the Customer Service Center at 800-635-9671 within 180 days of your receipt of Cigna's appeal review denial. Cigna will then be required to forward the file to the IRO. The IRO will render an opinion within 45 days.

When requested, and if (1) a delay would be detrimental to your medical condition, as determined by Cigna's physician reviewer, or if (2) your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the review shall be completed within 72 hours.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan provisions on which the determination is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information; (5) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment that a medical item or service is not Medically Necessary, the treatment is experimental, or other similar exclusion or limit; and (7) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review, but only if you file your claim in federal district court within 3 years of the date of the initial denial. You may have other voluntary alternative dispute resolution options. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Voluntary Appeal of a Denied Claim

If you are not satisfied with the decision on appeal by Cigna, or where applicable the IRO, you or your duly authorized representative may request review by the Trustees. You are not required to request review by the Trustees to exhaust your administrative rights, and you may file suit in federal district court without requesting review by the Trustees. If you do elect voluntary review by the Trustees, the time taken for this review will not count against your time to file a lawsuit. For claims involving medical judgment, you may seek review by the Trustees whether or not you sought review by an IRO. You may also seek review by the Trustees concurrently with your request for review by the IRO, or subsequent review by the IRO, but your request for voluntary review by the Trustees must be filed within the timeframe described below. Any determination by the IRO approving all or part of your claim will be binding on the Trustees even if you concurrently requested voluntary review by the Trustees.

You may request voluntary review by the Trustees by filing a written request to the Plan Administrator within 180 days of the date on the appeal denial letter from Cigna. The Trustees shall conduct a full review of such determination and mail to the claimant a written decision on the matter within sixty 60 days after the receipt of the request for review (unless special circumstances require an extension of up to sixty 60 additional days, in which case written notice of such extension shall be given to the claimant prior to the commencement of such extension). The right to voluntarily request review by the Trustees is solely the right of the Eligible Player or his Dependent, and you may not assign this right to any third party.

Processing of Vision Claims

For In-Network Claims, you do not need to file a claim for a Vision benefit. Claims for reimbursement for Out-of-Network services must be submitted to MetLife. Your vision claims shall be processed under MetLife's claims procedures, which shall be consistent with the procedures on page 70 for Medical and Dental Claims. Vision claims are not subject to the Plan's Voluntary Appeal process. Any questions regarding MetLife's claims process shall be directed to MetLife at the address and phone number on page 69.

Coordination of Benefits

When you or an Eligible Dependent is covered under two or more plans, one is the primary plan and all other plans are secondary plans. The primary plan pays your medical or dental benefits first. The secondary plan pays after the primary plan has paid.

How to Determine Which Plan Is Primary

The following rules apply when determining which is primary:

- A plan without a coordination provision is always the primary plan.
- If all plans have a coordination provision, the following apply:
  - The plan covering the patient directly, rather than as a Dependent, is the primary plan.
  - If the parents are not divorced and a Child is covered under both parents' plans, the plan of the parent whose birthday comes first in the year will be primary.
  - The plan covering the person as an active employee or Dependent of an active employee is primary over a plan covering him or her as a retired, laid-off or terminated employee or Dependent of such person.
  - In the case of divorce, the plan of the parent decreed by the court to have responsibility for health care expenses is the primary plan. In the absence of a court decree, the plan of the parent with custody is primary.
  - If you are a step-parent married to the parent with custody, your coverage will be primary.
  - When a determination cannot be made, the plan that has covered the patient longer is primary.

When the Plan Is Primary

If this Plan is primary, benefits will be paid as summarized in this SPD.

When the Plan Is Secondary

If there is other coverage and this Plan is secondary, your benefit from both plans will be no more than the total of your covered charges.

This means that if the benefits payable from this Plan and the benefits payable from the primary plan would be more than the total covered charges, your Plan benefits will be lowered until your total benefit is equal to or lower than your covered charges.

Statement of ERISA Rights

As a person covered under the Plan, you are entitled to certain rights and protections under ERISA, which provides that all persons covered by the Plan are entitled to:

- Examine, without charge at the Plan Administrator's office and other specified locations, copies of all Plan documents, including insurance policies, collective bargaining agreements and copies of all documents filed by the Plan with the US Department of Labor, such as detailed annual reports, and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information, including the CBA and a complete list of the Clubs sponsoring the Plan, including addresses, by writing to the Plan Administrator and asking for them. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person covered under the Plan with a copy of the summary financial report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for persons covered by the Plan, ERISA imposes duties upon the people who are responsible for the operation of the benefit portion of the Plan. The people who operate the Plan, called fiduciaries, have a duty to do so prudently and in your interest and in the interest of the other covered Beneficiaries.

The law provides that 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 getting a benefit or exercising your rights under ERISA. The law provides that if your claim for a benefit is denied in whole or in part, you have the right to receive a written notice explaining why your claim was denied, to obtain copies of documents related to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request copies of documents from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the documents and pay up to $110 a day until you receive them, unless they were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, and you have exhausted the remedies available under the Plan, you may file suit in federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that the people who operate the Plan misuse the Plan's money or if you are discriminated against for asserting your rights, you may ask the US Department of Labor for help, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If your suit is successful, the court may order the person you have sued to pay costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

If you have 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, US Department of Labor, listed in your telephone directory. Or you may write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave. NW
Washington, DC 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.

Common Benefits Administration Questions & Answers

Q. How do I file medical or dental claim?

A. You should submit your claims directly to Cigna at the address on your ID card. You will receive your reimbursement at your address of record.

Q. How do I file a vision claim?

A. For an In-Network Provider, you do not need to file claim. For an Out-of-Network Provider, you should submit your claims directly to MetLife at the address on your ID card. You will receive your reimbursement at your address of record. You may obtain a claim form at metlife.com/mybenefits.

Q. When should I submit my claims?

A. All claims must be filed within 1 year of service to be covered by the Plan. However, you should submit your claim as soon as you receive the bill to ensure timely payment.

Q. What if I disagree with how my claim has been paid?

A. You should first call the Customer Service Center at 800-635-9671 for a complete explanation. If you decide to appeal the denial, you must file a written request for review to Cigna. If a Vision claim, you must file a written request for review to MetLife. Please refer to pages 68-69 for the address of the appropriate Cigna or MetLife entity. The written request must be received by Cigna or MetLife [confirm with MetLife] within 180 days of receipt of your denial. Your request should state the reasons why your claim should be approved and provide any information that supports your request.

Q. How long do I have to file my claims?

A. You must file all claims for Self-Funded Benefits within 1 year of the date you received the service. You must file any Vision reimbursement claim within year of the date you received the service.

General Information

Plan Name

The name of the Plan is the NFL Player Insurance Plan.

Type of Plan

The Plan is an ERISA covered welfare plan that provides group health, life and AD&D, dental, vision and work/life resources benefits.

Plan Year

The financial records of the Plan are kept on a Plan Year basis. The Plan Year is a 12-month period beginning each September 1.

Plan Number

The number assigned to the Plan is 501.

Employer Identification Number

The Employer Identification Number is 13-3077470 and is used on any correspondence with the IRS or US Department of Labor.

Plan Administrator

The Plan is administered by the Management Council, which has delegated certain responsibilities to both Cigna and Alight Solutions. The Management Council has full discretionary authority to interpret the Plan and resolve all questions that arise under the Plan, including questions of fact. The Management Council has delegated the discretionary authority to apply the terms of the Plan and to make factual determinations to (1) Cigna in connection with all claims for Self-Funded Benefits, (2) MetLife in connection with all claims for Vision Benefits; and (3) Prudential in connection with all claims for Insured Benefits, except for Vision Benefits. Please address inquiries to:

Alight Solutions
Attn: NFL Player Insurance Plan
1025 Boulders Parkway, Suite 405
Richmond, VA 23225
800-635-9671

Type of Administration

The Self-Funded Benefits are administered under an administrative service only ("ASO") contract with Cigna. The Insured Benefits are administered and funded under an insurance contract with MetLife for Vision Benefits and with Prudential for Life and AD&D Benefits.

Plan Trustees

The Trustees advise the Management Council. The Trustees have the authority to approve minor Plan amendments and to decide certain appeals by players and their dependents. The Management Council and NFLPA each appoint two Trustees. Please address all correspondence to the Trustees as follows:

Alight Solutions
Attn: Trustees of the NFL Player Insurance Plan
1025 Boulders Parkway, Suite 405
Richmond, VA 23225
800-635-9671

Agent for Service of Legal Process

The Agent for Service of Legal Process is:

Belinda Lerner
National Football League
345 Park Ave.
New York, NY 10154

Service of Legal Process may also be made upon the Trustees.

Glossary

Using This Glossary

This glossary includes definitions of important terms you need to know in order to understand the Plan. Refer to this section whenever you have questions about the meanings of specific words, phrases or names. The terms are listed alphabetically.

AD&D

Accidental Death and Dismemberment Insurance.

Allowable Vision Expense

The amount under the Vision Plan that the Plan pays toward the cost of an eye exam, frames, corrective lenses, and corrective lenses enhancements.

ASO

A contract for administrative service only.

Behavior Management Benefit

The benefit provided under the Plan for individuals who have been identified as having engaged in high risk behavior, as described on page 29.

Beneficiary

The person or persons named by the Player to receive life or AD&D benefits in the event of the Player's death. The term also applies to a person eligible to receive medical,dental, and vision benefits under the Plan by virtue of the individual's relationship to a Player.

CBA

Has the meaning provided in the cover letter to the SPD.

Child

Has the meaning provided on page 6.

Club

A member club of the NFL.

COBRA

The Consolidated Omnibus Budget and Reconciliation Act of 1985, as amended.

Coinsurance

The percentage you must pay of the covered charge for services. The Plan pays the remaining percentage up to the Maximum Reimbursable Charges.

Continuing Veteran Coverage

Employer-paid coverage provided to Covered Veterans under Section 2.2 of the Plan.

Covid Amendments

Side Letters dated August 3, 2020, to the March 15, 2020 Collective Bargaining Agreement between the NFL and NFLPA establishing certain benefit and other changes to the CBA as a result of the COVID pandemic.

Coverage Ending Date

The last day of the applicable Plan Year, August 31.

Covered Veteran

A former Qualified Player who is covered under the Plan on the basis of the extended coverage provided to terminated Vested Players.

Credited Season

A season for which a Player is awarded a Credited Season under the Pension Plan.

Customer Service Center

Has the meaning provided in the cover letter to this document.

Deductible

The amount of the allowable charges you must pay before your Plan will begin to pay any benefit.

Deductible Carryover

Amounts you pay toward your Deductible during the last 3 months of the Plan Year will be applied toward the next year's Deductible.

Eligible Dependent

Has the meaning provided on page 6.

EOB

An explanation of benefits provided under the Plan.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

Experimental

Medical, dental, vision, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Cigna to be: (1) not demonstrated, through existing peer reviewed, evidence based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; (2) not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; (3) the subject of review or approval by an Institutional Review Board for the proposed use except as provided in an approved clinical trial; or (4) the subject of an ongoing phase I, II or III clinical trial, except as provided in an approved clinical trial.

FMLA

The Family and Medical Leave Act of 1993.

Game Day Roster

A Club's roster of Players on the day of any game during the regular or postseason (other than the Pro Bowl).

Higher-Risk Opt-Out Player

Means any Opt-Out Player who is at higher risk to the COVID virus as defined in the COVID Amendments.

Household Member

A person who legally resides with a Player who is eligible for the work/life resources benefit.

Injury

An accidental bodily wound or damage that is sustained by external force.

Injury Grievance

A claim or complaint that, at the time a player's NFL Player Contract or Practice Squad Player Contract was terminated by a Club, the player was physically unable to perform the services required of him by that contract because of an injury incurred in the performance of his services under that contract.

In-Network Provider

A provider of Vision services and supplies who is a participating Ophthalmologist, Optometrist or Optician in the Insurance Company's network of providers.

Insurance Policy

The policy, contract, or contracts issued by the Insurance Company which describes an Insured Benefit provided under the Plan, as the same may be amended and restated from time to time. Such Insurance Policy shall be deemed to include the insurance contract, the booklet-certificate, and any certificate of coverage provided by the Insurance Company to Players, Dependents, or both.

Insured Benefit

The Plan's life insurance and AD&D benefits and Vision Benefit.

Management Council

The NFL Management Council.

Maximum Reimbursable Charge

A charge for a Covered Medical, Dental, or Vision Expense that is determined based on the lesser of the Provider's normal charge for a similar service or supply; or a percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database selected by Cigna. The excess, if any, of a Provider's charges over the Maximum Reimbursable Charge is not applied to applicable Deductibles, co-payments and coinsurance.

Medically Necessary

The Plan covers only services and supplies that are considered Medically Necessary as determined by Cigna. Medically Necessary means that the services and/or supplies provided to you are needed for the diagnosis and treatment of an Injury, illness or pregnancy and are given at the appropriate level of care. To be considered needed, the service or supply must be:

- ordered by a physician, except that a psychologist may authorize Mental Health benefits and a chiropractor may authorize chiropractic benefits
- recognized throughout the Provider's profession as safe and effective
- required for the diagnosis or treatment of the particular illness or Injury and
- employed appropriately in a manner and setting that is appropriate for delivery of the services or supplies, taking into account the cost-effectiveness of alternative services, settings, or supplies

Mental Health

Services related to the treatment of a Mental Illness.

Mental Illness

Any disorder, other than a disorder caused by substances of abuse, that impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological symptoms related to one's mental health will not be considered to be charges made for treatment of a disorder affecting one's mental health.

NFL

The National Football League.

NFL COBRA Administrator

Has the meaning provided on page 54.

NFLPA

The National Football League Players Association.

Normal Retirement Date

The first day of the calendar month coincident with or next following a Player's 55th birthday.

Opt-Out Player

A Player, other than a Higher-Risk Opt-Out Player, who notified his Club on or before 4:00 pm New York time, on August 6, 2020, of his decision not to play football in the NFL during the 2020 Season.

Out-Of-Network Provider

A provider of Vision services and supplies who is not a participating Ophthalmologist, Optometrist or Optician in the Insurance Company's network of providers.

Out-of-Pocket Limit

The most you must pay out of your pocket for covered medical expenses in any Plan Year. After you reach the Out-of-Pocket Limit, the Plan will reimburse 100% of additional covered charges for the rest of the year. The Out-of-Pocket Limit takes into account amounts you paid towards the Deductible, but not amounts paid above Maximum Reimbursable Charges, or the amount of any penalties, such as the penalty imposed on a failure to pre-certify (see page 26).

Participant

A person entitled to benefits under the Plan.

Plan

The NFL Player Insurance Plan.

Plan Year

The 12-month period beginning on each September 1st.

Player

An individual who is or was under contract to play football with a Club.

PPO

A Preferred Provider Organization.

Preferred Provider

A Provider who has entered into a contract with a PPO to provide medical services at predetermined fees or costs as negotiated by Cigna and that Provider. The Providers qualifying as Preferred Providers may change. A Directory of Preferred Providers listing Preferred Providers in your area is available from the Customer Service Center or myCigna.com.

Provider
A licensed health care practitioner who is practicing within the scope of his or her license, or an institution, facility or agency authorized to provide medical services.

QMCSO
Qualified Medical Child Support Order.

Qualifying Benefit Status
The designation on a Game Day Roster of Active, Inactive, Reserve/Injured, Reserve/Physically Unable to Perform, or Practice Squad.

Qualifying Event
Has the meaning provided on page 54.

Qualified Player
A Player who has a Qualifying Benefit Status on a Game Day Roster in the Plan Year with respect to which benefits are claimed.

Relevant Information
Any document, record or other information which: (1) was relied upon in making a benefit determination; (2) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (3) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Pension Plan
The Bert Bell/ Pete Rozelle NFL Player Retirement Plan.

Preferred Provider
Preferred Provider means a Provider that has entered into a contract with a Preferred Provider Organization (a "PPO") to provide services at a predetermined cost in accordance with the agreement between the PPO and the Administrator or Claims Administrator.

Self-Funded Benefits
The Plan's vision, dental and medical benefits, including the prescription drug benefit.

SPD
Summary Plan Description.

Subrogation
The rights the Plan has to enforce its right to recover expenses that are the obligation of a third party.

Substances of Abuse Program
The NFL Policy and Program for Substances of Abuse.

Therapeutic Use Exemption Benefit
The benefit under the Plan covering the costs of the evaluation for a Therapeutic Use Exemption, as described on page 28.

Total Disability

A disability that qualifies a Player for Total and Permanent Disability Benefits under the Pension Plan, as determined under the Pension Plan. A Player with a Total Disability is Totally Disabled. An Eligible Dependent is Totally Disabled if, because of an Injury or illness, he or she cannot perform the normal activities of a person of the same age, gender and ability or is not able to perform any work for wage or profit (if the Eligible Dependent would normally work).

Trust

NFL Player Insurance Trust.

Trustees

Those individuals named as Trustees of the Plan and any successors thereto.

USERRA

Uniformed Services Employment and Re-employment Rights Act.

Vested Player

Any Player who qualifies as a Vested Player under the Pension Plan based solely on his Credited Seasons.

NFL PLAYER BENEFITS

NFL Player Insurance Plan
1025 Boulders Parkway, Suite 405
Richmond, VA 23225

Questions? 800.635.9671
www.nflplayerbenefits.com