NFL PLAYER INSURANCE PLAN

INSURANCE PLAYBOOK

SUMMARY PLAN DESCRIPTION

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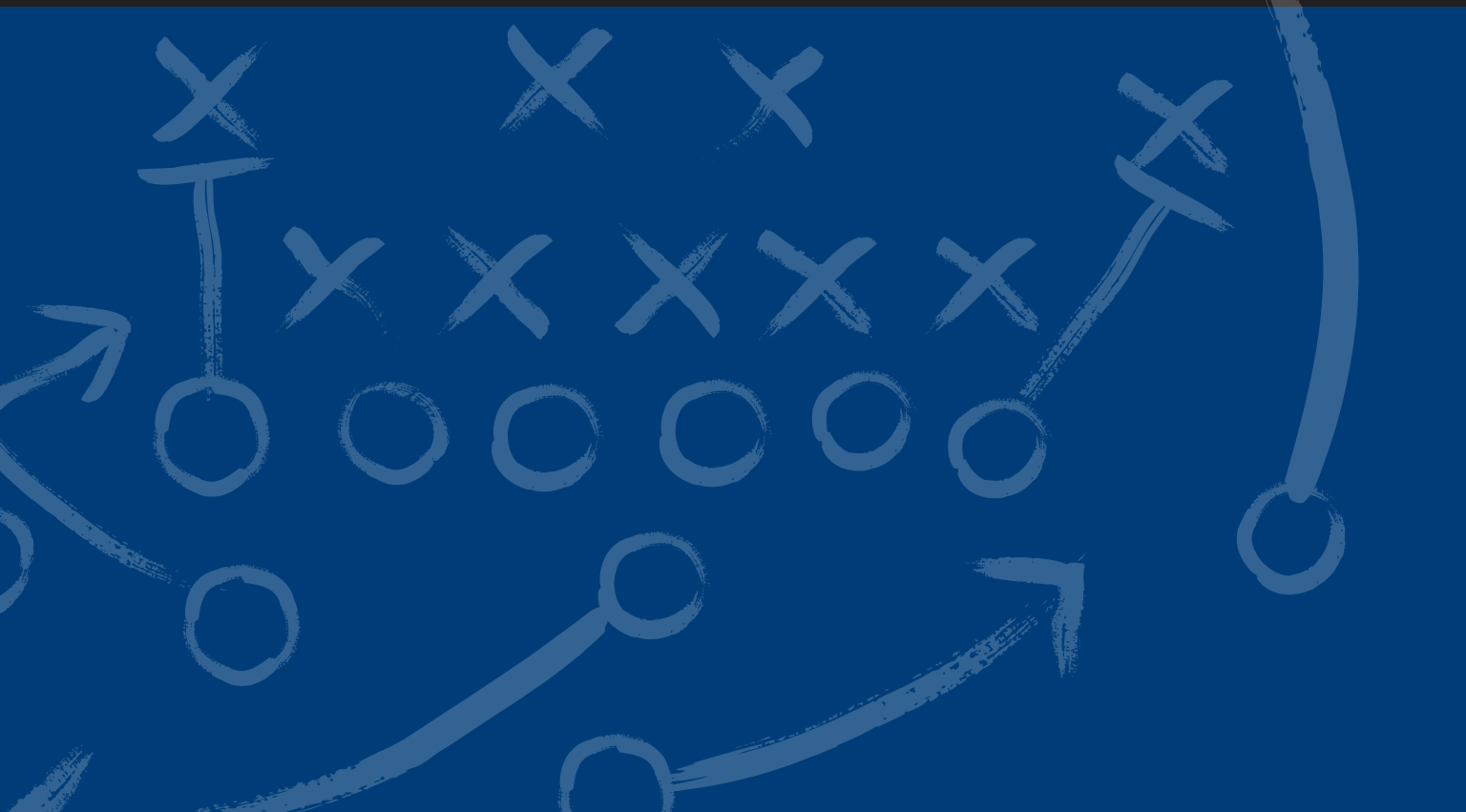
the game plan for your future



NFL Player Insurance Plan
Aon Hewitt
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800-635-9671

September 2014

Dear Participant:

The NFL Player Insurance Plan ("Plan") provides health and welfare benefits to eligible Players and their Eligible Dependents in accordance with the 2011 Collective Bargaining Agreement ("CBA") between the NFL Management Council ("Management Council") and the NFL Players Association ("NFLPA"). The member clubs ("Clubs") of the National Football League ("NFL") pay for the benefits through contributions to the NFL Player Insurance Trust ("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, 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 ***www.myCigna.com*** for help in locating a network Provider.

Your Plan provides special features to deal with your unique needs. For example:

Healthy Babies

Early prenatal care is very important to the good health of expectant mothers and babies. Enrolling in this program early in pregnancy enhances your chances for a successful birth. If you enroll, the Plan will reimburse up to $600 (the actual amount depends on when you enroll) of your otherwise unreimbursed maternity expenses. See page 30 for details.

Confidential Claims

Players and their families have special needs for confidentiality. The submission of claims for Mental Health, including the Supplemental Counseling Benefit, the Wellness Benefit and substances of abuse benefits will not be made known to your Club, the NFL or the NFLPA.

Your benefits are described in full in a separate, much longer 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.

This SPD describes the Plan in effect beginning on September 1, 2014. We know these benefits will provide an important measure of security for you and your family.

Dennis Curran
General Counsel, NFL Management Council

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Overview of the Plan

Benefits in Brief

The NFL provides the following benefits under the Plan:

- Life insurance
- Accidental death and dismemberment insurance ("AD&D")
- Medical coverage
- Dental coverage
- Wellness

Highlights of Your Benefits

The Plan's life and AD&D benefits are insured by Minnesota Life Insurance Company ("Minnesota Life"). Dental and medical benefits (including prescription drugs) and the wellness benefits are funded by the Clubs and administered in part by Cigna in its capacity as a third party 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, 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

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Benefit	Description	More information
Medical coverage	Your medical program provides coverage 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 22
Dental coverage	Your dental program, after payment of the Deductible, covers 100% of your preventive and diagnostic services and a part of your basic, major restorative and orthodontic expenses.	Beginning on page 43
Wellness Benefit	Your Wellness Benefit provides counseling and assistance to you, your Dependent or Household Member.	Beginning on page 50

Paying for Your Benefits

The Clubs fund on a per-capita basis the Trust that pays for the benefits provided under the Plan. Eligible Players pay the applicable medical and dental Deductibles, Coinsurance, any costs greater than Maximum Reimbursable Charges that a non-Preferred Provider may charge, and any penalties, such as the penalties imposed for a failure to pre-certify (see pages 26 and 27). The Management Council appoints the trustees of the Trust.

Future of the Plan

The NFL and the 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

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done at any time and without prior notice pursuant to the CBA. 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.

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, 2014. 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 eventually be described in an updated SPD or a Summary of Material Modification ("SMM"). However, there likely will be a delay between the date a change to the Plan becomes effective and the date that change is described in an SPD or an SMM. 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.

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Eligibility and Coverage

Eligibility

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

- Active
- Inactive
- Reserve/Injured
- Reserve/Injured/Designated for Return
- Reserve/Physically Unable to Perform
- Practice Squad

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

When Coverage Begins

Your life, AD&D, medical, dental and wellness 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 wellness coverages are effective on the first day you report to preseason training camp.
Had coverage under this Plan in the immediately prior Plan Year	Life, AD&D, medical, dental and wellness 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.

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If you	Then
Had coverage in any Plan Year other than the immediately prior Plan Year and it ended	Life, AD&D, medical, dental and wellness coverages are effective on the ***earlier*** of: • the day you report to preseason training camp or • the first day you are on a Game Day Roster in a Qualifying Benefit Status
Are a Dependent	Your medical, dental and wellness 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 wellness coverage is 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

Coverage for you and your Eligible Dependents begins when you have:

- met the eligibility requirements as stated above; and
- completed the enrollment process

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 Games as the result of an Injury Grievance or settlement of a potential Injury Grievance.

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Covering Your Eligible Dependents

Your dependents also may be covered by the medical, dental and wellness 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 Cigna has determined the Child was mentally or physically incapacitated before age 19. 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 or DNA evidence establishing you as the father. The documentation requirements apply even if a qualified medical child support order ("QMCSO") requires you to cover the Child. (Contact the Customer Service Center at 800-635-9671 for a free copy of the Plan's procedures for administering a QMCSO.)

Adding and Removing Dependents from 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:

- your marriage
- the birth or adoption of a Child
- your Dependent loses other medical insurance coverage

Your Dependents 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
- the death of your spouse
- the death of a Child
- your child ceases to satisfy the eligibility conditions set out above

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If you fail to provide proper notice, ***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 contributions for you cease
- the Coverage Ending Date that applies to you and your Dependents, plus any extensions shown on the charts 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 wellness benefits coverage end on the later of (1) the date your contract terminates, or (2) August 31.

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If you are in the Substances of Abuse Program or are receiving High-Risk 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.

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. However, your coverage may be extended to August 31 of a subsequent Plan Year, depending on your status as described on this page.

Non-vested Players 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 and wellness 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

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Vested Players

Medical, dental and wellness coverage provided to every terminated Vested Player 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 who earns a Credited Season for a season beginning in 2011 or thereafter will be offered the right to continue that coverage pursuant to COBRA, as discussed on pages 53–58, or to waive COBRA and elect instead a lower cost alternative. A Vested Player who elects either alternative will be able to continue the coverage for the duration of the current CBA, provided there is no break in coverage and the Vested Player satisfies the applicable requirements to maintain COBRA coverage.

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.

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.

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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 be a Qualified Player 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.

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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

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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	$1,600,000
5	$1,400,000
4	$1,200,000
3	$1,000,000
2	$800,000
1	$600,000
0	$600,000

Changes in the Amount of Your Life Insurance

The amount of your life insurance is based on the number of your Credited Seasons. Any change in the amount of your life insurance will be effective on the date you earn an additional Credited Season.

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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	Full amount
Seat belt benefit for loss of life	10% of full amount
A hand	50% of full amount
A foot	50% of full amount
An arm	75% of full amount
A leg	75% of full amount
Sight of an eye	50% 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	25% of full amount
Speech and hearing in both ears	100% of full amount
Speech	50% of full amount
Hearing in both ears	50% of full amount
Paralysis of both arms and legs (quadriplegia)	100% of full amount
Paralysis of both legs (paraplegia)	50% 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

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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 and a coma 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 Minnesota Life, and occur within 365 days of the accident.
- The loss cannot be due to mental or physical illness, infection, commission of a felony, or intentionally self-inflicted.
- The loss cannot be due to war or service in the armed forces of any country.
- The loss cannot be due to use of a substance of abuse.

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

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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 ***www.myCigna.com*** to access the eligibility site 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, 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 www.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.

When You Have No Beneficiary

Unless you 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. Under that rule, your beneficiary will be your spouse or, if you have no surviving spouse, the first surviving class of the following: child(ren), parents, siblings. If there are no such surviving relatives, your benefit will be paid to your estate.

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 the premium on life insurance over $50,000 that it pays. 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 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 Minnesota Life, 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.

Minnesota Life will respond to the claim within 90 days (45 days for a dismemberment or accelerated benefit claim), although Minnesota Life 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 Minnesota Life's determination with Minnesota Life, provided you do so within 60 days of the date Minnesota Life's initial determination is received (180 days for a dismemberment or accelerated benefit claim). Minnesota Life will respond to your appeal within 60 days (45 days for a dismemberment or accelerated benefit claim), although Minnesota Life may extend this deadline to 120 days upon timely notification (no extension for a dismemberment or accelerated benefit claim). Minnesota Life'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.

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When Benefits Will Not Be Paid

Life insurance and AD&D benefits will not be paid for a loss caused by a declared or undeclared war, or an act of war.

In addition, AD&D benefits will not be paid for a loss caused by drug or alcohol abuse or a loss caused by sickness, disease, bodily infirmity, or bacterial or viral infection, even if contracted by accident (this exclusion does not apply to bacterial infection that is the natural and foreseeable result of an accidental cut or wound).

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 Retirement Plan

Converting Your Life Insurance

If you have a right to convert to an individual policy, Minnesota Life 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 Minnesota Life 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.

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What You Need to Do

In order to make sure your life and AD&D coverage works 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 Minnesota Life
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 Minnesota Life.
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.

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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 14 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, 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 Minnesota Life, 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 or travelling on a common carrier.

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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 Retirement Plan.

Q. How do I convert my life insurance coverage?

A. If you have a conversion right when your group life insurance ends, Minnesota Life 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	$600 per person, $1200 per family
Plan Year Out of Pocket maximum	$2,000 per person, $5,000 per family for Medical $2,000 per person, $5,000 per family for Prescription
Maximum lifetime benefit	Unlimited
Maximum lifetime transplant benefit	Unlimited
Semiprivate hospital room and board	The Plan pays 80% in network; 70% otherwise
Infertility treatment	The Plan pays 80% in network; 70% otherwise, up to a lifetime maximum of $25,000*
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
Hospice services and supplies	The Plan pays 80% in network; 70% otherwise

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Features and Covered Charges	Benefit
Transportation to and from medical facility (including professional ambulance)	The Plan pays 80% in network; 70% otherwise
X-ray exams and therapy, lab tests	The Plan pays 80% in network; 70% otherwise
Emergency and Urgent Care Services	The Plan pays 80% except if not true emergency, then Plan pays 80% in network; 70% otherwise
Prescription drugs: retail	At participating pharmacies the Plan pays all but: • $15 for generic drugs • $25 for preferred brand name drugs • $50 for nonpreferred 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

Certain capitalized terms used throughout this SPD are defined in this SPD or in the Glossary of Terms.

Features and covered charges	Benefit
Outpatient preadmission testing, including diagnostic x-rays, lab exams and second/third surgical opinions	The Plan pays 100% with no Deductible
Home health care	The Plan pays 100% with no Deductible up to 100 visits per Plan Year***
Mammograms	The Plan pays 100% with no Deductible
PSA testing	The Plan pays 100% in network; 70% otherwise
Well Child/Immunization (to age 19)	The Plan pays 100% 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 4, 80% for additional visits in network; 70% otherwise
• ***Outpatient facility***	The Plan pays 100% with no Deductible

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Features and covered charges	Benefit
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

** Cost of related prescription drugs does not count against lifetime maximum*
*** Generic prescription medications used to prevent any of the following medical conditions are not subject to the copay: 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 copays/coinsurance factors do not apply to Players who are in the NFL's Substances of Abuse Program or receiving the High-Risk 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 22–25.

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 Carryover).

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 $781.10 LESS than John paid.***

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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	$600	$600
g. Covered amount*	$1,161	$1,711
h. Percentage covered by Plan (your Coinsurance)	80%	70% of Maximum Reimbursable Charge
i. Plan payment* (g.x h.)	$928.80	$1,197.70
j. Player's Payment (after deductible)	$232.20 (g-i)	$1,013.30 (g.-i.+e.)

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

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

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

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 and help you and your Eligible Dependents take better care of yourselves. The utilization review services include:

Preadmission 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 preadmission 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 preadmission 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 precertify, 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 precertify) 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.***

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. This Plan feature is available to an unmarried companion who you certify is carrying your unborn child. However, only the first of the four benefits described below is available in this case.

In order to receive benefits, you or your spouse must contact the Customer Service Center at 800-635-9671. A nurse will complete the preadmission 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 Benefits

The Plan provides the substances of abuse benefits listed on page 25. 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 ERM Associates, 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.

Supplemental Counseling Benefit

The Supplemental Counseling Benefit is intended to encourage Participants to seek professional assistance in dealing with personal issues. The submission of claims for the Supplemental Counseling Benefit and all other Mental Health benefits are private and confidential and will not be made known to your Club, the NFL or the NFLPA.

This benefit entitles a Participant to meet four times with a licensed and/or certified professional counselor. The cost of each session is covered at 100% of Preferred Provider contracted rates or the Maximum Reimbursable Charges of a non-Preferred Provider.

Special Counseling Benefits

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.

High-Risk 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. 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.

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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. Benefit 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

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- 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 (up to $500 annually)
  - 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.

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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 that occurred while the person is covered by this Plan
  - 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

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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 remains 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 53 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.

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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 www.myCigna.com for a Directory of Preferred Providers. You may also call the Customer Service Center at 800-635-9671, which can send you a copy.

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 preadmission 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 preadmission 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/Prescription Drug ID Card number. You then ask for a "preadmission 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, including the Supplemental Counseling Benefit, are confidential when they are made through ERM or Cigna as described on pages 30 and 31.

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

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

- Players under contract with a Club and Players in the Substances of Abuse Program must file their claims for substances of abuse benefits with ERM Associates.

- Dependents and Players not under contract with a Club (and 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 preadmission certification is required for any hospital admission other than an admission to a Preferred Provider for the normal delivery of a Child. The preadmission 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.

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

A. Log onto www.myCigna.com to access the eligibility site or contact the Customer Service Center at 800-635-9671 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 www.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 the SPD, 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 59. 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. 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. How are my football Injuries covered?

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 $600 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).

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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.

Certain capitalized terms used throughout this SPD are defined in this SPD or in the Glossary of Terms.

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 ***www.myCigna.com*** for a Directory of Preferred Providers. You may also call the Customer Service Center at 800-635-9671, which can send you a copy.

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

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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.

Predetermination of Benefits

If you and your dentist are planning extensive dental work, you should get a predetermination of benefits. A predetermination 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 predetermination 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.

Predetermination 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

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- 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 semiprecision 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 37 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 53 of this SPD.

Certain capitalized terms used throughout this SPD are defined in this SPD or in the Glossary of Terms.

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 60 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.

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.

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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.

Wellness Benefit

Eligibility

You, your Eligible Dependents and your Household Members are eligible for the Wellness 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 Wellness Benefit include:

- **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 Supplemental and Special Counseling Benefits described on pages 21 and 22.

- **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.

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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.

Web-Based Programs

Provides on-line access to information or other assistance in a large number of subject areas related to the purposes of the EAP.

Accessing the Wellness Benefit

You, your Eligible Dependents and your Household Members may access the Wellness Benefit by contacting the EAP Program Provider at (866) 421-8628. You may also access the Wellness Benefit at www.cignabehavioral.com and entering nflpe 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 8 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 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 Aon Hewitt, 7325 Beaufont Springs Drive, Suite 300, Richmond, VA 23225-5554 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

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Qualifying Event	Maximum Length of Coverage
• **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.

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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 Wellness 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

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.

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.

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	MINNESOTA LIFE GROUP LIFE CLAIMS 400 ROBERT ST NORTH ST. PAUL MN 55101 888-658-0193
Prescription drug benefits	CIGNA PHARMACY SERVICE CTR PO BOX 3598 SCRANTON PA 18505-0598 800-622-5579
Medical coverage	CIGNA HEALTHCARE SERVICE CTR PO BOX 182223 CHATTANOOGA TN 37422-7223 800-244-6224
Substances of abuse benefits (all Participants who are not required to contact ERM)	CIGNA HEALTHCARE SERVICE CTR PO BOX 182223 CHATTANOOGA TN 37422 800-244-6224
Substances of abuse benefits (Qualified Players (Actives) and Players in the Substances of Abuse Program)	ERM ASSOCIATES 221 MT. HERMON ROAD, STE C SCOTTS VALLEY CA 95066 800-880-2376

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Benefit name	Information
Dental coverage	CIGNA PO BOX 188037 CHATTANOOGA TN 37422-8037 800-244-6224

Filing Claims for Benefits

Life and AD&D Claims

See page 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.

Substances of Abuse Claims

Depending on your status, file your claims with Cigna or ERM Associates as described on page 31. Benefits will be paid directly to your Provider.

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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 ***preservice claim*** is a claim for a benefit that requires approval before the benefit is available. For preservice 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 ***postservice claim*** is a claim filed following your receipt of medical care. For postservice 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 should 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 59 and 60 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.

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.

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 stepparent 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
US DEPARTMENT OF LABOR
200 CONSTITUTION AVENUE 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.

Certain capitalized terms used throughout this SPD are defined in this SPD or in the Glossary of Terms.

Common Benefits Administration Questions & Answers

Q. How do I file medical or 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. 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. Please refer to pages 59 and 60 for the address of the appropriate Cigna entity. 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 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.

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 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 Aon Hewitt. 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, and (2) Minnesota Life in connection with all claims for Insured Benefits. Please address inquiries to:

AON HEWITT
ATTN NFL PLAYER INSURANCE PLAN
7325 BEAUFONT SPGS DR STE 300
RICHMOND VA 23225-5554
800-635-9671

Certain capitalized terms used throughout this SPD are defined in this SPD or in the Glossary of Terms.

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 Minnesota Life.

Plan Trustees

The Trustees advise the Management Council. The Trustees have the authority to approve minor Plan amendments and to decide appeals by players and their dependents who claim they have been denied the right to participate in the Plan (under COBRA or otherwise). The Management Council and NFLPA each appoint two Trustees. The current Trustees are: Ed McGuire, Bryan Wiedmeier, Tim Johnson, and Miki Yaras-Davis. Please address all correspondence to the Trustees as follows:

AON HEWITT
ATTN TRUSTEES OF THE NFL PLAYER INSURANCE PLAN
7325 BEAUFONT SPGS DR STE 300
RICHMOND VA 23225-5554
800-635-9671

Agent for Service of Legal Process

The Agent for Service of Legal Process is:

DENNIS CURRAN
NATIONAL FOOTBALL LEAGUE
345 PARK AVENUE
NEW YORK NY 10154

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

Glossary of Terms

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.

Aon Hewitt: Has the meaning provided on page 70.

ASO: A contract for administrative service only.

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 and dental 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.

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 Retirement Plan.

Certain capitalized terms used throughout this SPD are defined in this SPD or in the Glossary of Terms.

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, 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).

High-Risk 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 32.

Household Member: A person who legally resides with a Player who is eligible for the Wellness Benefit.

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

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

Management Council: The NFL Management Council.

Maximum Reimbursable Charge: A charge for a Covered Medical or Dental 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, copayments 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.

Certain capitalized terms used throughout this SPD are defined in this SPD or in the Glossary of Terms.

NFL: The National Football League.

NFL COBRA Administrator: Has the meaning provided on page 53.

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.

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 precertify (see pages 22–25).

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 www.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/Injured/Designated for Return, Reserve/Physically Unable to Perform, or Practice Squad.

Qualifying Event: Has the meaning provided on page 53.

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.

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

Self-Funded Benefits: The Plan's 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.

Supplemental Counseling Benefit: The benefit under the Plan providing additional counseling benefits, as described on page 31.

Certain capitalized terms used throughout this SPD are defined in this SPD or in the Glossary of Terms.

Total Disability: A disability that qualifies a Player for Total and Permanent Disability Benefits under the Retirement Plan, as determined under the Retirement 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 Reemployment Rights Act.

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

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