COLLECTIVE BARGAINING AGREEMENT
between
NBA SERVICES CORP.
and the
NATIONAL BASKETBALL REFEREES ASSOCIATION
(September 12, 2022)

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Exhibit M **Section 35A of the NBA Constitution**
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AGREEMENT made as of this 12th day of September, 2022, by and between NBA Services Corp. and the National Basketball Referees Association ("NBRA"):

Article I

Definitions

As used in this Agreement, the following terms shall have the following meanings:

1. "Game" means any game played by an NBA team during any Pre-Season, Regular Season, or Playoffs.

2. "NBA" means NBA Services Corp. or the National Basketball Association, as the context shall imply.

3. "Off-Season" means any period during the term of this Agreement beginning the day after the last Playoff Game of any Season and ending the day before the first day of Referee Training Camp in the next Season, except following the 2028-29 Season, when such period will end on the day this Agreement expires.

4. "Playoffs" means, with respect to any Season during the term of this Agreement, the period beginning on the first day of any Play-In Tournament Games played after the conclusion of the Regular Season and ending on the last day of playoff (as opposed to pre-season or regular season) competition among or between NBA teams.

5. "Pre-Season" means, with respect to any Season during the term of this Agreement, the period beginning on the first day of Referee Training Camp and ending on the day preceding the first day of the Regular Season.

6. "Referees" means all persons employed by the NBA as active game officials in the United States and Canada under the terms of this Agreement.

7. "Regular Season" means, with respect to any Season during the term of this Agreement, the period beginning on the first day and ending on the last day of regular season (as opposed to pre-season or playoff) competition among or between NBA teams.

8. "Season" means any NBA season during the term of this Agreement beginning on the first day of Referee Training Camp and ending on the day of the last Playoff Game.

9. "Travel Day" means a day on which a Referee (i) is required by the NBA to stay in a hotel, and (ii) actually stays in a hotel booked through the NBA's designated travel agency (as evidenced by the submission of valid hotel receipts to the NBA).

10. "Year" means any period during the term of this Agreement beginning on October 1 and ending on the following September 30, except in 2029, when such period will end on the day this Agreement expires.

11. "Years of Service" means the number of years of NBA service credited to a Referee under the terms of this Agreement. Under no circumstances shall the definition of Years of Service herein be used for purposes of determining a Referee's "Years of Referee Service" under the Restated National Basketball Association Referees' Pension Plan or the NBA Retirement Plan for Referees.

Article II

Union Recognition; Union Security; Dues Check Off; Years of Service; Non-Discrimination

Section 1. Union Recognition.

(a) The NBA recognizes the NBRA as the exclusive collective bargaining representative of all Referees, and the NBRA warrants that it is duly empowered to enter into this Agreement for and on behalf of such Referees.

(b) Notwithstanding Article II, Section 1(a) above, the NBA does not recognize the NBRA as the collective bargaining representative of any Referees, or any other persons, outside of the United States and Canada. Neither any term of this Agreement, nor the application of any term of this Agreement to games or events outside of the United States and Canada (including, without limitation, pursuant to Article III, Sections 7 or 8), shall be construed to constitute such recognition of the NBRA by the NBA.

Section 2. Union Security and Dues Check-Off.

(a) Except where prohibited by law, within the later of forty-five (45) days after the execution date of this Agreement, or forty-five (45) days following the date of employment, a Referee must, as a condition of employment, (i) become and remain a member of the NBRA in good standing, or (ii) begin and subsequently continue to pay financial core obligations to the NBRA related to collective bargaining and the administration of collective bargaining agreements.

(b) During the period covered by this Agreement, and except where prohibited by law, the NBA agrees to check off, from the salary of each Referee who is a member of the NBRA and who has so authorized the NBA in writing, the regular dues, charges and initiation fees as assessed against such Referee by the NBRA, and to remit such dues,

charges, and/or initiation fees to the NBRA at the times and in the manner specified in the Referee's written authorization.

(c) The NBRA indemnifies, saves and holds harmless the NBA against any and all claims, demands, suits, or other forms of liability that may arise, directly or indirectly, in connection with the enforcement or application of any term or provision of this Section 2, including, without limitation, claims relating to any action taken by the NBA in reliance upon any written authorization provided hereunder.

Section 3. Years of Service.

Annexed hereto as Exhibit A is a list of Referees and their respective Years of Service as of the conclusion of the 2021-22 NBA Season. Beginning with the 2022-23 Season, each Season during the term of this Agreement shall count as one (1) Year of Service for a Referee if, during the applicable Season, such Referee (i) is assigned to work in the NBA and (ii) officiated at least one (1) Pre-Season or Regular Season Game. A Year of Service will be credited to a Referee on the June 30th following the Season for which it is being credited.

Section 4. Non-Discrimination.

Neither the NBA nor NBRA shall discriminate against any employee covered by this Agreement by reason of race, color, national origin, religion, gender, age, disability, alienage or citizenship status, ancestry, marital status, creed, genetic predisposition or carrier status, sexual orientation, veteran status, familial status, union membership, or any characteristic protected by law. At the election of the grievant, any claims of such discrimination, including, but not limited to, a claim made pursuant to Title VII of the Civil Rights Act, the Americans with Disabilities Act, the Age Discrimination in Employment Act, 42 U.S.C. § 1981, the Family and Medical Leave Act, or any other similar law, rule, or regulation pertaining to discrimination in employment, may be subject to the grievance and arbitration procedures set forth in Article XV

of this Agreement; provided, however, that if the grievant elects to pursue his/her claim (a) through the grievance and arbitration procedure, when the grievance is referred to arbitration in accordance with Article XV, Section 2(d), the grievant will be deemed to have waived his/her right to pursue all discrimination claims arising out of the same transaction or facts underlying the grievance in any forum other than in arbitration (and will so confirm such waiver by signing the form annexed hereto as Exhibit B and providing such form to the NBA's General Counsel within five (5) days of the waiver), or (b) by commencing a proceeding in federal or state court or any forum other than arbitration, the grievant will be deemed to have waived his/her right to pursue all discrimination claims arising out of the same transaction or facts underlying the grievance in arbitration. In rendering a decision, the arbitrator shall apply the law as set forth in the statute under which the claim is brought, including, but not limited to, the applicable statute of limitations and remedy. Nothing herein shall prevent an employee from filing a charge with the Equal Employment Opportunity Commission or any other administrative agency.

Article III

Work Assignments and Scheduling

Section 1. Management Rights with Respect to Assignment and Scheduling.

(a) Except as may be set forth below in this Article III, all matters relating to the assignment and scheduling of work for Referees shall be in the sole and absolute discretion of the NBA. The foregoing shall not, however, detract from the rights accorded Referees to submit vacation requests in accordance with Article VII, Section 1 below.

(b) Except as may be set forth below in this Article III, a Referee assigned to officiate any Game, or to perform any other work pursuant to the terms of this Agreement, shall be required to accept and perform such assignment unless, upon request by the Referee, the head of the NBA Referee Operations Department (or his designee), in his sole and absolute discretion, decides to relieve the Referee of such assignment, provided that a Referee may reject an assignment if (i) the assignment is a Pre-Season Game to be played outside of the United States or Canada, or (ii) the Referee qualifies for leave of absence in accordance with the NBA's Family and Medical Leave of Absence Policy ("FMLA Policy").

(c) Referees are eligible for unpaid leave of absence pursuant to the NBA's FMLA Policy and applicable laws and regulations. A Referee will have met the requirement under the NBA's FMLA Policy to "have worked at least 1,000 hours during the previous 12-month period before the date the leave is to begin" only if the Referee was assigned to work and officiated at least thirty-one (31) Games during the previous 12-month period before the date the leave is to begin.

Section 2. Number of Referees Per Game.

The NBA shall assign three (3) Referees to officiate each NBA Pre-Season, Regular Season and Playoff Game played in the United States or Canada. Notwithstanding the foregoing, the NBRA acknowledges that, due to missed assignments, sudden injury, unforeseen events, or other similar circumstances, less than three (3) Referees may be present to officiate any particular Game. In such an event, the Referees present at such Game shall discharge their duties to the best of their abilities, without any further obligation on the part of the NBA.

Section 3. Number of Game Assignments.

(a) During each Season, a Referee may be assigned to work up to a maximum of eighty-two (82) Pre-Season and Regular Season Games. Notwithstanding the foregoing, during each Season, the NBA shall have the right to require a Referee to officiate more than eighty-two (82) such Games. For each such Pre-Season and Regular Season Game officiated in excess of eighty-two (82), and subject to Article III, Section 3(b) below, such Referee shall receive 1/82nd of the Referee's annual salary for that Season (as set forth in Article IV, Section 1), plus an additional amount (an "Additional Amount") of $500.

(b) For the sole purpose of determining whether any Additional Amount is payable to a Referee in accordance with Article III, Section 3(a) above, the calculation of the total number of Pre-Season and Regular Season Games officiated by a Referee during any Season shall include (i) the NBA's assignment of such Referee to any such Game which is necessitated by an unforeseen circumstance affecting another Referee, including, but not limited to, illness, injury, family emergency or travel difficulty, and (ii) any Pre-Season and Regular Season Game that is cancelled, provided that prior to the cancellation of such Game the Referee has departed for the city in which the cancelled Game was to be played.

(c) The NBA shall provide Referees with their Pre-Season schedule of assignments on or before September 15th. For Regular Season Games played in October or November, the NBA shall provide Referees with their schedule of assignments on or before October 5th. For Regular Season Games played in December, January, or February, the NBA shall provide Referees with their schedule of assignments on or before the fifth (5th) day of the month prior to the month in which the assigned Regular Season Games are to be played. For Regular Season Games played in March or April, the NBA shall provide Referees with their schedule of assignments twenty-one (21) days in advance of the first such assigned Game. If any deadline set forth in this paragraph falls on a weekend or national holiday, the NBA shall provide the schedule on the next business day.

(d) The schedule for the month of December shall include assignments through January 3rd.

Section 4. Playoffs.

(a) No Referee with less than two (2) Years of Service at the commencement of any Season shall be eligible to officiate any Playoff Games played during that Season. In the event, however, that the NBA does not have a sufficient number of Referees to staff Playoff Games adequately, Referees with less than two (2) Years of Service shall be eligible to officiate such Playoff Games.

(b) The NBA may assign Referees to serve as alternate officials at Playoff Games ("Alternate Playoff Officials"). Without limiting the NBA's exclusive right to determine the duties and responsibilities of a Referee assigned to serve as an Alternate Playoff Official at a Playoff Game, and in addition to complying with all other terms of this Agreement, a Referee assigned as an Alternate Playoff Official will be required to:

(i) Attend and participate in all pre-game, halftime, and post-game activities required of Referees assigned to officiate the Game;

(ii) Be dressed in the NBA-mandated game uniform for the duration of the Game;

(iii) Remain stationed in the Referees' dressing room for the duration of the Game;

(iv) Watch the Game on the television monitor in the Referees' dressing room;

(v) Be prepared to work as a Referee in the Game; and

(vi) Work as a Referee in the Game at the direction of the NBA.

(c) (i) The list of Referees selected for the first round of the Playoffs will be provided to the NBRA and the Referees selected for the first round one (1) week in advance of the first Game of the first round;

(ii) The NBA will make reasonable efforts to provide the list of Referees selected for the second, third and fourth rounds of the Playoffs to the NBRA and the Referees selected no later than forty-eight (48) hours prior to the first Game of the respective round.

(d) Immediately following the NBA's notification to Referees selected to officiate a Game 5, Game 6, or Game 7 of a Playoff round, the NBA shall provide an email notification to all Referees selected to work in that Playoff round that Playoff Game assignments for Game 5, Game 6, or Game 7, as applicable, have been made.

Section 5. Assignments to Non-Referees.

Notwithstanding anything to the contrary that may be set forth in any other provision of this Agreement:

(a) The NBA may assign persons other than Referees to officiate Pre-Season Games, provided that the number of such Pre-Season Game assignments does not exceed twenty-four (24) per Season. In the event the NBA makes such assignments, all Referees with ten (10) or more Years of Service shall be offered the opportunity to officiate no less than four (4) Pre-Season Games during that Season. The maximum and minimum assignment limits in the foregoing two sentences are based on a Pre-Season schedule in which each NBA team is permitted to play up to eight (8) Pre-Season Games (the "Pre-Season Game Maximum"); if the NBA reduces the Pre-Season Game Maximum during the term of this Agreement, such maximum and minimum assignment limits shall be reduced in proportion to the reduction in the Pre-Season Game Maximum.

(b) The NBA may assign persons other than Referees to officiate Regular Season Games played through January 31st of each Regular Season, provided that the number of such Regular Season Game assignments does not exceed fifty (50) per Season. In assigning persons other than Referees to officiate Regular Season Games in accordance with the preceding sentence, the NBA will use its best efforts to ensure that Referees with less than ten (10) Years of Service do not lose Regular Season Game assignments through January 31st of a Regular Season.

(c) (i) In addition to the assignments to persons other than Referees that may be made pursuant to Section 5(b) above, the NBA may assign persons other than Referees to officiate Regular Season Games played from February 1st of each Season through the end of such Regular Season, for primary purposes other than professional development and assessment of such persons (i.e., to fill a gap in the schedule due to Referee unavailability), provided that the number of Regular Season Game assignments under this Section 5(c)(i) does not exceed forty-

eight (48) per Season. In assigning persons other than Referees to officiate Regular Season Games in accordance with the preceding sentence, the NBA will use its best efforts to ensure that Referees do not lose Regular Season Game assignments from February 1st through the end of the Regular Season.

(ii) For every group of four (4) assignments to persons other than Referees made pursuant to this Section 5(c), each Referee shall be credited with one (1) Game officiated (i.e., if there are between 1 and 4 such assignments, each Referee shall be credited with 1 Game; if there are between 5 and 8 such assignments, each Referee shall be credited with a second Game, etc.) for purposes of determining whether the Referee has met the VAC Minimum pursuant to Article IV, Section 8(a) and is considered to be on the Referee's Roster for the Retirement Plan pursuant to Article VIII, Section 3(b)(iv).

(d) The number of non-Referees officiating any Pre-Season or Regular Season Game will be limited to one (1) for any particular Game, provided that the foregoing limitation will not apply in the event of unforeseen circumstances affecting another Referee, including, but not limited to, illness, injury, family emergency or travel difficulty.

Section 6. All-Star Game and Related Events.

Referees will be assigned by the NBA to officiate (i) the NBA's annual All-Star Game, and (ii) other contests or exhibitions presented in connection with such All-Star Game, including, for example and without limitation, the Rising Stars Challenge, the Skills Challenge event, the Three-Point Shooting Contest, and the Dunk Contest (such contests or exhibitions, collectively referred to herein as "All-Star Events"). Referees assigned to work the All-Star Game and/or All-Star Events shall be notified of their assignments upon the release of the January 5th schedule.

Section 7. Games Outside of the United States and Canada.

To the extent the NBA controls the assignment of officials for Games played by NBA teams outside the United States and Canada, the NBA (to the extent permitted by law) shall assign Referees. In the event of such assignment, the NBA shall notify the General Counsel of the NBRA, and the terms and conditions of this Agreement, as appropriate in the circumstances, shall apply.

Section 8. Developmental League.

Notwithstanding the provisions of Article III, Section 3 above, during any Season the NBA may assign one or more Referees with less than four (4) Years of Service to officiate games in any developmental basketball league then affiliated with the NBA, including, e.g., the NBA G League (a "Developmental League"). The decision to assign any, some, or all such Referees to a Developmental League, and the number of Developmental League games to which any such Referees are to be assigned, shall be in the NBA's sole and absolute discretion; provided, however, that during each Season in which a Referee is assigned to a Developmental League, such Referee will officiate no less than thirty-one (31) Pre-Season and Regular Season Games in the NBA; and provided further that the NBA shall notify the General Counsel of the NBRA of any such assignment. In the event of any such assignment to a Developmental League located outside of the United States and Canada, the terms and conditions of this Agreement, as appropriate in the circumstances, shall apply. Solely for purposes of compensation, satisfaction of the VAC Minimum, Years of Service, and benefits under this Agreement, all Developmental League games assigned to and officiated by a Referee shall count as NBA games.

Section 9. Pre-Season Training Camp.

Prior to the commencement of each Season, the NBA may require Referees to report to a training camp at a place and time designated by the NBA ("Training Camp").

Section 10. Instructional Camp.

(a) For training purposes, and in addition to Training Camp, the NBA may require Referees, who, following the conclusion of any Season, are placed in Group III (in accordance with Article X, Section 2), to attend for a period of up to ten (10) days an instructional camp during the immediately following Off-Season at a place and time designated by the NBA ("Instructional Camp"). Any Referee not required to attend such Instructional Camp may request permission to attend, and permission to attend will not be unreasonably denied by the NBA. Nothing herein shall require the NBA to conduct an Instructional Camp at any time.

(b) The NBA may offer any number of Referees the opportunity to serve as instructors at an Instructional Camp. No Referee shall be required to accept such offer or otherwise serve as an instructor at an Instructional Camp. Nothing herein shall limit the NBA in any way from hiring or employing persons other than Referees as instructors at any Instructional Camp.

Section 11. Meetings with NBA Players and Team Personnel.

The NBA may require any number of Referees to attend meetings and make presentations (at places and times designated by the NBA) regarding game rules or other officiating matters, including, but not limited to, a Coaches and Referees Summit with NBA coaches and/or other NBA team personnel, the Rookie Transition Program, and Pre-Season meetings with NBA teams (including players and/or team personnel).

Section 12. Replay Center.

(a) The NBA may require any number of Referees to work in the NBA Replay Center (the "Replay Center") during the Season.

(b) A Referee working in the Replay Center will perform replay-related duties as designated by NBA Referee Operations management, including, but not limited to, final decision making during Games with respect to Game events (e.g., calls, non-calls, violations) following video review from the Replay Center. The NBA may exercise its management rights pursuant to Article XIV, Section 1(b) and through Referee Operations management personnel make any final decisions about Game events following video review from the Replay Center. With the exception of assigned Referees or NBA Referee Operations management personnel, no other person shall participate in final decision making about Game events following video review from the Replay Center, other than to provide technical assistance.

(c) Replay Center shifts shall generally be limited to seven (7) hours or less, beginning thirty (30) minutes before the scheduled start time of the first Game played during the shift, provided that no shift will end until the conclusion of any and all Games that are scheduled to start within five (5) hours after the beginning of the Referee's shift.

(d) The NBA shall provide Referees with notice that they are required to work in the Replay Center at the same time that the NBA provides Referees with their schedules of Game assignments pursuant to Section 3(c) above. The types of Game events (e.g., calls, non-calls, violations) subject to video review from the Replay Center shall be defined in the Work Rules for NBA Officials at the commencement of each Season. The NBA will meet with NBRA representatives for the purpose of discussing any substantive changes to these work rules. Notwithstanding the foregoing, nothing herein shall limit the NBA's right to determine in its sole discretion the types of Game events that are subject to video review from the Replay Center and all playing rules and procedures related thereto.

(e) Replay Center assignments will not be considered as an alternative to performing the work of an active Referee through a schedule of Game assignments because the essential function of a Referee's job is to officiate NBA Games on the playing courts where NBA teams are playing.

(f) Assignments to work in the Replay Center are not Game assignments and, accordingly, any terms and conditions of this Agreement applicable to Game assignments or to officiating Games shall not apply to Replay Center assignments; provided, however, that assignments to work in the Replay Center shall count as Game assignments or as officiating Games solely for the purposes of determining the following: (i) Years of Service pursuant to Article I, Section 11 and Article II, Section 3; (ii) FMLA eligibility pursuant to Article III, Section 1(c); (iii) the number of Pre-Season Games offered to Referees with ten (10) or more Years of Service pursuant to Article III, Section 5(a); (iv) Game schedules pursuant to Article III, Sections 13(a) and 15; (v) satisfaction of the of the VAC Minimum pursuant to Article IV, Section 8(a); (vi) ground transportation within cities of Game assignments pursuant to Article V, Section 11; (vii) mode of travel to and from Game assignments pursuant to Article VI, Section 1; (viii) submission of an Itinerary pursuant to Article VI, Sections 3(a) and (b); (ix) inclusion on the Referees' Roster pursuant to Article VIII, Section 3(b)(iv); and (x) the beginning of a Referee's Off-Season pursuant to Article XI, Section 1.

(g) For purposes of Section 15(a) below, up to four (4) Travel Days in connection with assignments to the Replay Center will be considered Non-Travel Days when they are immediately preceded by or followed by a Game assignment in Brooklyn, New York, Boston, Philadelphia or Washington, D.C.

Section 13. Back-To-Back & Holiday Games.

(a) Except when it determines (in its sole and absolute discretion) that there is a reasonable necessity for acting otherwise, the NBA shall not assign a Referee to officiate:

(i) Games on consecutive days where the two home cities for such Games are not in contiguous time zones;

(ii) Games on consecutive days when the first Game of such group of Games is scheduled to start at 8:30 p.m. or later; or

(iii) Consecutive Regular Season Games when the first such Game is played in a city in the Pacific time zone and the second such Game is played in a city in the Eastern time zone, unless at least forty-eight (48) hours have elapsed between the completion of the first Game and the start time of the second Game.

(b) On or before September 1 preceding each Season, the NBRA may submit three separate lists to the NBA – the first list identifying up to eighteen (18) Referees who have a preference not to be assigned to officiate Games on consecutive days during any Season, the second list identifying any Referees who have a preference to be assigned to officiate Games on consecutive days during any Season, and the third list identifying Referees volunteering to be assigned to officiate Games scheduled on the following days: Thanksgiving Day; December 24, 25, or 31; January 1; and Martin Luther King, Jr. Day. The NBA will use its best efforts to consider such lists when assigning Referees to officiate Games.

Section 14. Returning Home Between Assignments.

(a) Referees shall, during the periods between Game and/or Replay Center assignments, be permitted to return to their home cities in accordance with the following terms and conditions:

(i) When the schedule assigned to the Referee provides for one (1) day off between Game and/or Replay Center assignments, the Referee may return home if the scheduled duration of a direct flight from the city of the Referee's last assignment to the Referee's home city is one (1) hour or less.

(ii) When the schedule assigned to the Referee provides for two (2) days off between Game and/or Replay Center assignments, the Referee may return home if the scheduled duration of a direct flight from the city of the Referee's last assignment to the Referee's home city is four (4) hours and fifteen (15) minutes or less and the scheduled duration of a flight from the Referee's home city to the city of the Referee's next assignment is four (4) hours and fifteen (15) minutes or less.

(iii) When the schedule assigned to the Referee provides for the Referee to officiate a "Day Game" (i.e., a Game or Replay Center assignment starting at 3:30 p.m. local time or earlier) and the Referee's next Game or Replay Center assignment is scheduled to start in the evening of the second calendar day following that Day Game or Replay Center assignment, the Referee may return home if the scheduled duration of a direct flight from the city of the Day Game or Replay Center assignment to the Referee's home city is three (3) hours or less and the scheduled duration of a direct flight from the Referee's home city to the city of the Referee's next assignment is two (2) hours and thirty (30) minutes or less.

(iv) When the schedule assigned to the Referee provides for three (3) days off between Game and/or Replay Center assignments, the Referee shall return home without regard to the scheduled duration of any flights from or to the cities of the Game or Replay Center assignments.

(b) If a Referee does not return home when permitted pursuant to Section 14(a)(ii) or (iii) and instead elects to proceed directly from the city of the first Game and/or Replay Center assignment to the city of the second Game and/or Replay Center assignment without going home, the NBA will provide the Referee with a hotel room pursuant to Article VI, Section 2 on the day after the first Game or Replay Center assignment in the city of the second Game or Replay Center assignment and a meal stipend pursuant to Article V, Section 2(b) below for that day. The Referee must present valid receipts documenting his/her hotel stay under this Section 14(b) within ten (10) days of such stay and, if the Referee fails to present such receipts, then the Referee shall reimburse the NBA for the cost of the hotel stay and the Referee shall not be eligible for a meal stipend.

Section 15. Non-Travel Days.

The NBA will not assign a Referee to officiate:

(a) Games such that a Referee receives fewer than forty-five (45) Non-Travel Days during any Regular Season (a "Non-Travel Day" being defined as a day when a Referee is not required by the NBA to stay in a hotel and is not assigned to officiate a Game);

(b) A schedule of Regular Season Games that contains more than twelve (12) consecutive Travel Days; or

(c) A schedule of Regular Season Games that contains eleven (11) consecutive Travel Days without two (2) consecutive Non-Travel Days both immediately preceding and immediately following the eleven (11) consecutive Travel Days.

Article IV

Salary & Other Compensation

Section 1. Salary Scale.

During the period covered by this Agreement, and subject to such adjustments as may be required by Article III, Section 3 above, Referees (based on Years of Service) shall receive the following annual salaries in consideration for the performance of their services under this Agreement:

Years of Service Prior to Start of Season	2022-23 Salary	2023-24 Salary	2024-25 Salary	2025-26 Salary	2026-27 Salary	2027-28 Salary	2028-29 Salary
0	$ 221,656	$ 228,306	$ 236,296	$ 243,385	$ 250,687	$ 259,461	$ 267,245
1	$ 237,331	$ 244,451	$ 253,007	$ 260,597	$ 268,415	$ 277,809	$ 286,144
2	$ 248,352	$ 255,802	$ 264,756	$ 272,698	$ 280,879	$ 290,710	$ 299,431
3	$ 260,034	$ 267,835	$ 277,209	$ 285,525	$ 294,091	$ 304,384	$ 313,516
4	$ 272,417	$ 280,589	$ 290,410	$ 299,122	$ 308,096	$ 318,879	$ 328,446
5	$ 285,543	$ 294,109	$ 304,403	$ 313,535	$ 322,941	$ 334,244	$ 344,271
6	$ 299,457	$ 308,441	$ 319,237	$ 328,814	$ 338,678	$ 350,532	$ 361,048
7	$ 314,205	$ 323,631	$ 334,959	$ 345,007	$ 355,358	$ 367,795	$ 378,829
8	$ 329,839	$ 339,734	$ 351,625	$ 362,174	$ 373,039	$ 386,095	$ 397,678
9	$ 346,411	$ 356,804	$ 369,292	$ 380,370	$ 391,782	$ 405,494	$ 417,659
10	$ 363,977	$ 374,896	$ 388,017	$ 399,658	$ 411,648	$ 426,055	$ 438,837
11	$ 382,597	$ 394,075	$ 407,867	$ 420,103	$ 432,706	$ 447,851	$ 461,287
12	$ 402,334	$ 414,404	$ 428,908	$ 441,775	$ 455,028	$ 470,954	$ 485,083
13	$ 423,254	$ 435,952	$ 451,210	$ 464,747	$ 478,689	$ 495,443	$ 510,306
14	$ 445,432	$ 458,795	$ 474,852	$ 489,098	$ 503,771	$ 521,403	$ 537,045
15	$ 468,938	$ 483,006	$ 499,911	$ 514,908	$ 530,355	$ 548,918	$ 565,385
16	$ 476,558	$ 490,855	$ 508,034	$ 523,275	$ 538,974	$ 557,838	$ 574,573
17	$ 484,302	$ 498,831	$ 516,290	$ 531,779	$ 547,732	$ 566,903	$ 583,910
18	$ 492,172	$ 506,937	$ 524,680	$ 540,420	$ 556,633	$ 576,115	$ 593,398
19	$ 500,170	$ 515,175	$ 533,206	$ 549,202	$ 565,678	$ 585,477	$ 603,041
20	$ 522,177	$ 537,842	$ 556,667	$ 573,367	$ 590,568	$ 611,238	$ 629,575
21	$ 530,662	$ 546,582	$ 565,713	$ 582,684	$ 600,165	$ 621,170	$ 639,805
22	$ 539,286	$ 555,464	$ 574,905	$ 592,153	$ 609,917	$ 631,264	$ 650,202
23	$ 548,049	$ 564,491	$ 584,248	$ 601,775	$ 619,828	$ 641,522	$ 660,768
24	$ 556,955	$ 573,664	$ 593,742	$ 611,554	$ 629,901	$ 651,947	$ 671,506
25	$ 579,233	$ 596,610	$ 617,491	$ 636,016	$ 655,097	$ 678,025	$ 698,366
26	$ 588,646	$ 606,305	$ 627,526	$ 646,351	$ 665,742	$ 689,043	$ 709,714

Years of Service Prior to Start of Season	2022-23 Salary	2023-24 Salary	2024-25 Salary	2025-26 Salary	2026-27 Salary	2027-28 Salary	2028-29 Salary
27	$ 598,211	$ 616,157	$ 637,723	$ 656,855	$ 676,560	$ 700,240	$ 721,247
28	$ 607,932	$ 626,170	$ 648,086	$ 667,529	$ 687,554	$ 711,619	$ 732,967
29	$ 617,811	$ 636,345	$ 658,617	$ 678,376	$ 698,727	$ 723,183	$ 744,878
30+	$ 644,995	$ 664,344	$ 687,596	$ 708,224	$ 729,471	$ 755,003	$ 777,653

Section 2. Salary Payment Schedule.

Referees shall receive their annual salaries in fifteen (15) equal bi-weekly installments, commencing with the first week of October in each Season; provided, however, that any Referee may, by notice in writing received by the NBA on or before the September 1 preceding such Season, elect to have such salary paid in twenty-six (26) equal bi-weekly installments, commencing with the first week of October in each Season.

Section 3. Playoff Pool.

(a) The NBA's aggregate liability for Referee compensation for all Playoff Games officiated in each Season shall be the dollar amounts set forth below (the "Playoff Pool"):

2022-23: $3,700,000

2023-24: $3,811,000

2024-25: $3,944,385

2025-26: $4,062,717

2026-27: $4,184,598

2027-28: $4,331,059

2028-29: $4,460,991

(b) The Playoff Pool will be allocated on a per Playoff round basis, as follows: (i) thirty percent (30%) of the Playoff Pool will be allocated to the first round of the

Playoffs; (ii) twenty-seven percent (27%) of the Playoff Pool will be allocated to the second round of the Playoffs; (iii) twenty-five percent (25%) of the Playoff Pool will be allocated to the third round of the Playoffs; and (iv) eighteen percent (18%) of the Playoff Pool will be allocated to the fourth round of the Playoffs.

(c) Within each round of the Playoffs, the applicable percentage of the Playoff Pool will be allocated on a pro-rata basis equally among all Referees selected for that round.

(d) (i) A Referee who has suffered an injury that would qualify for salary continuation pursuant to Article VII, Section 2 below and who worked as a Game official in the prior two consecutive Seasons' Playoffs will be paid an amount equal to fifty percent (50%) of the amount paid to that Referee in the prior Season for working in that prior Season's Playoffs.

(ii) In no event shall the NBA's obligation to pay all Referees qualifying for payments under this Section 3(d), in the aggregate for a Season, exceed the following amounts (the "Playoff Injury Protection Maximum"):

2022-23	$200,000
2023-24	$206,000
2024-25	$213,210
2025-26	$219,606
2026-27	$226,194
2027-28	$234,111
2028-29	$241,134

(iii) In the event the amount that would be paid exceeds the Playoff Injury Protection Maximum for that Season, each Referee qualifying for payments under this Section 3(d) will receive a pro rata share of the Playoff Injury Protection Maximum amount.

Any payment made pursuant to this Section 3(d) is in addition to, and shall not limit, the Playoff Pool for a Season.

(e) All Playoff Pool compensation and payments pursuant to Section 3(d) above for the immediately concluded Season shall be paid to Referees by no later than the conclusion of the Off-Season following such Season.

Section 4. All-Star Game.

(a) A Referee who officiates the NBA All-Star Game in any Season will (i) be compensated at the rate of $4,500 for such game, and (ii) receive an All-Star ring, the design of which shall be in the sole and absolute discretion of the NBA.

(b) A Referee who officiates the NBA All-Star Events in any Season will be compensated at the rate of $3,500.

Section 5. Instructional Camps & Meetings.

When working at the direction of the NBA, a Referee will be compensated at the rate of $1,100 for:

(a) Each day served as an instructor at any Instructional Camp;

(b) Attendance at a Rookie Transition Program;

(c) Attendance at a Coaches and Referee Summit; or

(d) Conducting a meeting with an NBA team (including players and/or team personnel) regarding game rules or other officiating matters, excluding any meetings with NBA teams that take place immediately before or after any scheduled Game.

Time spent preparing or traveling for any such work will not be compensable.

Section 6. Alternate Playoff Officials.

A Referee who performs the services of an Alternate Playoff Official during a Playoff Game will be compensated at the following rates:

(a) For the 2022-23, 2023-24, and 2024-25 Seasons: $2,000

(b) For the 2025-26, 2026-27, 2027-28, and 2028-29 Seasons: $2,150

Section 7. Crew Chief Stipend.

A Referee serving as a Crew Chief for a Regular Season or Playoff Game shall receive a Crew Chief stipend at the following rates for such Game (the "Crew Chief Stipend"):

(a) For the 2022-23, 2023-24, and 2024-25 Seasons: $425

(b) For the 2025-26, 2026-27, 2027-28, and 2028-29 Seasons: $475

The Crew Chief Stipend will be paid in arrears in the second payroll period after the month in which the Crew Chief Stipend was earned.

Section 8. Variable Assignment Compensation.

(a) A Referee will receive a Variable Assignment Compensation ("VAC") payment for each Season that the Referee works a minimum of twenty (20) Pre-Season and/or Regular Season Games and Replay Center assignments (the "VAC Minimum"). VAC payments will be in the following amounts for each Season:

(i) 2022-23: $35,000

(ii) 2023-24: $35,000

(iii) 2024-25: $36,000

(iv) 2025-26: $36,000

(v) 2026-27: $37,500

(vi) 2027-28: $37,500

(vii) 2028-29 $37,500

(b) A Referee with greater than zero (0) but less than ten (10) Years of Service during a Season in which the Referee satisfies the VAC Minimum shall receive, in

addition to the VAC amount set forth in Section 8(a), $5,000 for that Season in accordance with Section 8(d) below.

(c) A Referee on an approved leave of absence due to the Referee's own pregnancy or in connection with the Referee giving birth to a child will be deemed to have satisfied the VAC Minimum.

(d) The VAC payment will be made in the second pay period following the date that the Referee satisfies the VAC Minimum.

Article V

Expenses

Section 1. Game Allowance.

(a) For the 2022-23 Season only, a Referee who receives an annual contribution to the Retirement Plan pursuant to Article VIII, Section 2(c)(i) for the 2022-23 Season will receive a Game Allowance of $150 for each Pre-Season or Regular Season Game to which such Referee is assigned and works.

(b) For the 2023-24 Season only, a Referee who receives an annual contribution to the Retirement Plan pursuant to Article VIII, Section 2(c)(i) for the 2023-24 Season will receive a Game Allowance of $100 for each Pre-Season or Regular Season Game to which such Referee is assigned and works.

(c) A Referee will not receive a Game Allowance for any assignment to officiate a Game outside of the United States and Canada.

(d) Payments of Game Allowances will be made on a monthly basis, in the second regular pay period following the month in which the Game Allowances were earned.

Section 2. Meal Stipend.

(a) Unless the NBA pays directly for a Referee's meals, the NBA shall provide a Referee with a meal stipend for each Travel Day assigned by the NBA in connection with the Referee's:

(i) assignment to officiate any Pre-Season, Regular Season, or Playoff Game or any All-Star Game or Event;

(ii) attendance at Training Camp;

(iii) attendance at an Instructional Camp as a participant or an instructor;

(iv) assignment to conduct a meeting with an NBA team (including players and/or team personnel); or

(v) working in the Replay Center.

(b) During each Season set forth below, the meal stipend for each assigned Travel Day shall be as follows:

(i) 2022-23: $115.50

(ii) 2023-24: $119

(iii) 2024-25: $123

(iv) 2025-26: $127

(v) 2026-27: $131

(vi) 2027-28: $135

(vii) 2028-29: $139

Section 3. Meal Stipend Payment: Pre-Season & Regular Season.

(a) For each month (or assignment scheduling period, if schedules are not provided monthly), the NBA shall pay each Referee, upon submission of valid hotel receipts to the NBA by the Referee, an amount equal to the meal stipend set forth in Article V, Section 2(b) above, multiplied by the number of the Referee's actual Travel Days during such month (or scheduling period) applicable to the Referee's (including, when applicable, assignments for the NBA All-Star Game and Events) during each such month (or scheduling period).

(b) Payments of meal stipends will be made on a monthly basis, in the second regular pay period following the month in which the meal stipends were earned.

Section 4. Meal Stipend Payment: Playoffs.

Upon submission of valid hotel receipts to the NBA by a Referee assigned to officiate any Playoff Game (including as an Alternate Official), the NBA shall pay to such Referee an amount equal to the meal stipend set forth in Article V, Section 2(b) above multiplied by the number of Travel Days applicable to such Playoff Game.

Section 5. Meal Stipend Payment: Camps, Meetings & Replay Center.

Upon submission of valid hotel receipts to the NBA, following any Training Camp, Instructional Camp, assignments worked in the Replay Center, or qualifying meeting with an NBA team under Article IV, Section 5(d), the NBA shall pay to each Referee who was required to attend, and actually attended such event or worked such assignment, an amount equal to the meal stipend set forth in Article V, Section 2(b) above multiplied by the number of Travel Days applicable to such event or assignment (as applicable).

Section 6. Meal Stipend Regulations.

All meal stipend payments made by the NBA under this Agreement shall be subject to all applicable regulations (including but not limited to Internal Revenue Service regulations) regarding expense payments made to employees. It is the intention of the parties that, for so long as permitted by the IRS, the NBA will continue to use the IRS "high low" substantiation method with respect to meal stipend payments.

Section 7. Other Expenses.

Upon the submission of valid receipts, the NBA will separately reimburse Referees for the reasonable cost of hotel Internet access and parking.

Section 8. Locker Room Attendants.

Referees are prohibited from paying tips or compensation of any kind to team or arena personnel, other than to locker room attendants (subject to a maximum tip of $20 per Referee), for personal services performed for Referees by such personnel during Games.

Section 9. International Officiating License.

The NBA shall reimburse a Referee for the ordinary and reasonable expenses (other than those expenses for which a Referee is reimbursed by the Federation Internationale de Basketball or USA Basketball) actually incurred in connection with the training or other activities required for such Referee to obtain or maintain his or her international basketball officiating license, but only if the Referee's participation in such activities is approved in advance by the head of the NBA Referee Operations Department.

Section 10. Relocation.

If, during the period covered by this Agreement, a Referee, at the request of the NBA, relocates to a geographic vicinity designated by the NBA, the NBA shall reimburse the Referee for the actual expenses incurred (provided they are ordinary and reasonable) in connection with such move including, but not limited to, amounts paid to moving companies for the transfer of the Referee's and his or her immediate family's personal effects and the cost of temporary lodging in the new geographic area for up to 30 days following the move. Reimbursable moving expenses shall not include costs associated with the sale and purchase of residences incurred in connection with a move.

Section 11. Ground Transportation Within Cities of Game Assignments.

For Referees who travel outside their home cities for a Game assignment, the NBA will pay the cost of rental cars for necessary transportation within the immediate geographic locale where the Game will be played, in accordance with the following:

(a) When a crew of Referees is assigned to officiate home Games played by Denver, Detroit, Golden State, Memphis, and Oklahoma City, the crew may rent three (3) cars.

(b) When a crew of Referees is assigned to officiate a home Game played by Milwaukee, and at least one (1) crew member stays in Chicago and at least one (1) crew member stays in Milwaukee, the crew may rent two (2) cars.

(c) When a crew of Referees is assigned to officiate a home Game played by any team other than a team listed in Article V, Sections 11(a) and (b) above (with the exception of any team based in New York), the crew may rent one (1) car, provided, however, that if an Alternate Official is assigned to work a Playoff Game, the assigned crew for such Playoff Game (including the Alternate Official) shall be permitted to rent two (2) cars.

(d) Referees may not rent cars in connection with home Games played by any team based in New York, but shall use ground transportation providers as designated by the NBA.

(e) When a crew of Referees is assigned to officiate a home Game in Los Angeles and at least one member of the crew has a scheduled "off day" for the day prior to the day of the Game, the crew may rent one (1) car for such "off day."

(f) When renting a car in accordance with this Article V, Section 11, a Referee shall (at the NBA's option) either (i) charge the rental to a national car rental company credit card provided by the NBA, or (ii), upon the submission of valid written receipts to the NBA, be reimbursed for the actual expense incurred to rent the car from a national rental company approved by the NBA in advance of rental.

(g) The charging of, or reimbursement for, the rental of a car as provided under this Article V, Section 11 shall apply only to the extent that (i) such car is rented for a

reasonable period of time in connection with transportation in and around the home city of a Game assignment, (ii) the rental cost is ordinary and reasonable and does not exceed the cost for a premium size sedan or standard size SUV category of car (the size between these two options to be determined at the discretion of the NBA), provided, however, that only a full size category car may be rented when the crew rents three (3) cars pursuant to Article V, Section 11(a) above, and (iii) such car is rented from, and returned to, a location in, or within the immediate geographic locale of, the home city of such Game assignment. Absent unusual circumstances, and subject to Article V, Section 11(e) above, the period of rental time for which a car may be rented shall be no more than forty-eight (48) hours per Game assignment.

(h) The Crew Chief for each Game shall be responsible for coordinating all car rental and travel arrangements.

Article VI

Travel

Section 1. Mode of Travel To and From Game and Replay Center Assignments.

(a) Referees are required to travel by airplane when traveling to and from Game and Replay Center assignments outside of their cities of residence.

(b) Notwithstanding Article VI, Section 1(a) above, and subject to Article VI, Section 3(c) below, Referees may use ground transportation (i.e., train, car, or bus) for travel:

(i) to and from Game assignments between the following pairs of home team locations or the Replay Center, as applicable:

(A) New York City and New Jersey;

(B) New York City and Philadelphia;

(C) New York City and Washington, D.C.;

(D) New York City and Boston;

(E) New Jersey and Philadelphia;

(F) New Jersey and Washington, D.C.;

(G) New Jersey and Boston;

(H) Philadelphia and Washington, D.C.;

(I) Chicago and Milwaukee;

(J) Golden State and Sacramento;

(K) Houston and San Antonio;

(L) Chicago and Indianapolis;

(M) Cleveland and Detroit;

(N) Miami and Orlando;

(O) Charlotte and Atlanta; and

(P) Dallas and Oklahoma City;

(ii) to and from Game or Replay Center assignments between a Referee's home residence and the arena at which the assigned Game is to be played or the Replay Center (as applicable), when such arena or the Replay Center (as applicable) is less than three (3) hours by car from such residence;

(iii) to alternate airports in the event of a flight cancellation or flight delay in excess of two (2) hours; and

(iv) in unusual situations, when approved in advance by the NBA Referee Operations Department.

Section 2. Travel Arrangements, Hotels, and Payment.

(a) Referees shall book all air and rail travel to or from Game and Replay Center assignments and to or from any Training Camp, Instructional Camp, or other meetings or events they are required to attend, and book all hotel stays for days when the NBA requires Referees to stay in a hotel, through a travel agency designated by the NBA at the NBA's sole discretion (the "Designated Travel Agency").

(b) All costs for air and rail travel and hotel stays under this Section 2, including booking fees, service fees, change fees, cancellation fees, ticket and reservation fees, and one checked piece of luggage, shall be charged to an NBA Business Travel Account ("BTA") with the Designated Travel Agency, or such other NBA account as designated by the NBA. Referees may book their own travel arrangements with the Designated Travel Agency, or may delegate such responsibility to the NBRA's travel agent (who shall book with the Designated Travel Agency), but in all circumstances bookings must be made in in accordance with all terms of this Section 2.

(c) Referees shall book non-refundable business class airfare for all flights on the airline of their choice.

(d) Referees shall book hotel rooms from a list of hotels designated by the NBA at the NBA's sole discretion (following consultation with the NBRA) and at the standard rates negotiated by the NBA.

(e) A Referee may use upgrade vouchers, miles, and loyalty and reward points issued in the Referee's own name from airlines, hotels and credit cards in connection with travel and hotel bookings; provided, however, that the NBA will not reimburse or allocate any value to the upgrade vouchers, miles or points used.

(f) Referees shall book their air or rail travel and hotel stays within seven (7) days of their receipt of the schedule of Game and Replay Center assignments to which the air or rail travel and hotel stays pertain, unless the Referee receives an assignment less than fourteen (14) days prior to the date of the assignment, in which case the Referee shall book his or her air or rail travel and hotel within twenty-four (24) hours of receipt of the assignment.

(g) In the event that a Referee (or the NBRA's designated travel agent acting on behalf of such Referee) books his or her air or rail travel or hotel arrangements, including all changes and cancellations for such arrangements, with any person or entity other than the Designated Travel Agency, the Referee will be solely responsible for all costs associated with such travel and, without limiting any disciplinary action the Referee may be subject to for failing to comply with the requirements of this Section 2, the Referee will not receive a Game Allowance (to the extent otherwise eligible to receive such allowance) for the Game for which such travel was taken.

(h) In the event that the Designated Travel Agency is unable to confirm, or does not have documentation of, the fact that a Referee's booked air travel was taken and/or taken on the ticket purchased, then upon the NBA's request, a Referee must submit to NBA Referee Operations documentation evidencing the costs of the travel arrangements and the fact that such travel was taken. If any such documentation is requested under these circumstances and no such documentation is submitted, a Referee may be subject to discipline pursuant to Article XI, Section 4 below and a Referee will not receive a Game Allowance (to the extent otherwise eligible to receive such allowance) for the Game.

(i) In the event that a Referee, due to the Referee's own illness or injury, is unable to work a scheduled assignment(s), the Referee shall, through the Designated Travel Agency, cancel all travel arrangements (air, rail, hotel (as applicable)) for such assignment(s) that the Referee is unable to work. In all other instances, a Referee must obtain prior written approval from the NBA to change or cancel travel arrangements. The Referee shall direct all reimbursements, credits and/or vouchers for all such cancelled or changed travel arrangements to be credited to the NBA's BTA account and/or to the benefit of the NBA. The Referee shall not retain any reimbursements, credits or vouchers for any such cancelled or changed travel arrangements. The NBA shall pay for all booking fees, service fees, and cancellation fees assessed by the Designated Travel Agency and/or a transportation carrier or hotel for each such affected assignment.

(j) Other than as expressly set forth in this Agreement, the NBA shall have no financial obligation for such travel, whether by way of direct payment, reimbursement to Referees, or otherwise.

Section 3. Travel Requirements.

(a) Prior to the first day of every month (or other applicable scheduling period) during the Season, each Referee shall submit to the NBA Referee Operations Department a detailed written itinerary via the Referee Engagement and Performance System ("REPS") or other form satisfactory to the NBA, showing the Referee's travel schedule for such month (or scheduling period) (the "Itinerary"). The Itinerary must include the following information: dates of travel; mode of transport; time of departure and arrival; name of airline and flight number (if traveling by air); name of train, rental car, or bus company (if traveling commercially by ground); and name, address, and contact information of hotel(s) or other lodging.

(b) Referees are required to travel in accordance with their Itineraries. Unless otherwise provided in this Article VI, any deviation from a Referee's Itinerary must be submitted via REPS or email to, and approved in advance of the applicable travel date by, the NBA Referee Operations Department.

(c) Referees who must travel to an assigned Game must be physically present in the city where the Game is to be played, as follows:

(i) For a Day Game (i.e., a Game scheduled to start on or before 3:30 p.m. (local time)), no later than 7:00 p.m. (local time) on the day before such Game.

(ii) For a Night Game (i.e., a Game scheduled to start after 3:30 p.m. (local time)), no later than 11:59 p.m. (local time) on the day before such Game.

(iii) Notwithstanding Article VI, Section 3(c)(i) and (ii) above, a Referee who has received Game assignments on consecutive days is required, if possible, to travel by airplane immediately after the conclusion of the prior Game to the city where the subsequent Game is to be played. If such travel is not possible, the Referee is required

to travel on the morning immediately following the prior Game by taking the first scheduled direct airplane flight to the city where the subsequent Game is to be played.

(iv) Notwithstanding Article VI, Section 3(c)(ii) and (iii) above, if the city in which a Night Game is to be played is less than three (3) hours by train, car, or bus from a Referee's point of departure to such city, the Referee must be physically present in such city no later than 11:00 a.m. (local time) on the day of such Game.

(d) Referees who must travel to a Replay Center assignment must arrive in the city where the Replay Center is located on the day of the Replay Center assignment, but no less than seven (7) hours prior to the commencement of the Replay Center assignment, unless impracticable based on the Referee's point of departure.

(e) Referees are required to comply with all applicable rules and regulations of the airlines, rental car companies, trains, and other common carriers that they use for travel, including, but not limited to, rules and regulations relating to ticketing, passenger conduct, and payment.

(f) A Referee's failure to adhere to any of the provisions of this Section 3 will subject such Referee to discipline by the NBA, including fines, suspensions without pay, and/or termination of employment. Any fine or suspension imposed pursuant to this subsection shall be governed by the rights, duties, and procedures set forth in Article XI, Section 4 hereof. Any referee terminated pursuant to this subsection shall be afforded the right of review set forth in Article X, Section 4(d).

Section 4. Ground Transportation To and From Airports.

Referees shall travel to and from airports in connection with Game or Replay Center assignments via a ground transportation provider designated by the NBA, using a corporate account provided by the NBA. If the ground transportation provider is Uber, then the

class of car shall be Uber Black (if the NBA designates any other provider, then a similar class of car shall be used).

Article VII

Employment Benefits

Section 1. Vacation.

(a) Except as set forth below, the NBA shall schedule assignments so as to provide Referees with nine (9) or more Years of Service with consecutive days without an assignment ("Vacation Days"), once prior to March 1 of each Season covered by this Agreement, in accordance with the following schedule:

Years of Service Prior To Start of Season	Vacation Days
9 years	3
10 years	4
11 years	5
12 years	6
13 years	7
14 or more years	8

(b) For purposes of this Section, a Vacation Day shall not include any day during which a Referee must travel to officiate a Game or any day during which a Referee travels home after officiating a Game.

(c) The vacation period during any Season for qualifying Referees shall be based upon the scheduling needs of the NBA, taking into consideration the requests of all such Referees based upon their relative seniority. The NBA shall use its best efforts to provide each qualifying Referee with a vacation at the time requested.

(d) The NBA shall use its best efforts to reduce proportionally the number of Games a Referee officiates during the month in which such Referee takes vacation.

(e) If a Referee during any Season is not assigned to officiate any Pre-Season or Regular Season Games for a period of thirty (30) or more days by reason of such Referee's injury, illness, or other medical condition (the "Missed Assignment Period"), and upon a determination that such Referee is cleared to return to work under Article IX, Section 2(c), such Referee's Vacation Days for such Season shall be reduced proportionally, in accordance with the following calculation: (i) multiply the Referee's Vacation Days for such Season by a fraction, the numerator of which is the number of days in the Missed Assignment Period and the denominator of which is the number of days in the period commencing on the first day of such Season and ending on the day prior to March 1 of such Season, (ii) round the result up or down to the nearest whole number, and (iii) subtract the result in Step (ii) from the Referee's remaining Vacation Days as of the date he or she is cleared to return to work under Article IX, Section 2(c), provided that the result of this Step (iii) can never be less than zero (0).

Section 2. Salary Continuation for Injuries.

(a) If, during the term of this Agreement, a Referee suffers an injury that results in such Referee being unfit to officiate any scheduled assignment, then, so long as such unfitness continues, but in no event beyond the term of one (1) year from the date of such injury, the Referee shall continue to be entitled to receive his or her annual salary as provided for by this Agreement, at the rate applicable at the time of such injury.

(b) A Referee's entitlement to payments under this Section shall be subject to the following:

(i) The Referee must provide written notice of the injury to the NBA Referee Operations Department, stating the time, place, cause, and nature of such injury. Such written notice must be received by the NBA within seventy-two (72) hours of the

time when the Referee knew (or should have known) that the injury could result in such Referee being unfit to officiate any scheduled assignment.

(ii) The NBA shall be entitled to require the Referee to submit to one or more examinations by a physician designated or approved by the NBA, who shall determine, in such physician's sole and absolute discretion, whether such Referee is (or continues to be) unfit, as a result of an injury, to officiate his or her scheduled assignments. Such examination(s) shall occur at a time and a place reasonably designated by the NBA.

(iii) The Referee must comply, during the period of his or her unfitness, with any fitness, rehabilitation and/or conditioning programs (as prescribed by the NBA or its designee) that are reasonably related to the duties and tasks of a Referee and are intended to restore the Referee to active officiating status.

(c) No Referee shall be entitled to payments pursuant to this Section resulting in more than one (1) year's annual salary (at the rate(s) applicable) for the same injury (including recurrences) in any five (5) year period.

(d) The NBA's obligations hereunder shall be reduced by any workers' compensation benefits and insurance provided for by the NBA and paid or payable to the Referee. As a condition of an injured Referee's receiving salary pursuant to this provision, such Referee shall agree, in writing, (i) to assign to the NBA workers' compensation benefits and insurance proceeds relating to the injury suffered, and (ii) if necessary to effectuate such assignment, to receive the applicable salary for such one (1) year period at the rate of twenty-six (26) equal bi-weekly installments instead of at the rate of fifteen (15) equal bi-weekly installments.

(e) If a Referee receiving salary continuation payments under this Article VII, Section 2 (other than for pregnancy or birth of a child) does not meet the VAC Minimum for a Season while receiving salary continuation, the Referee shall be paid fifty percent (50%) of the VAC payment the Referee would have received had they met the VAC Minimum, with such payment to be made in the second pay period following the conclusion of the Regular Season.

(f) As used in this Article VII, Section 2, "injury" shall mean (i) a physical illness, condition or injury that is directly suffered or sustained by a Referee in the course, and within the scope, of Referee's employment and affects all or a portion of Referee's body such that the Referee is unfit to officiate and shall include any recurring problem(s) which may result in the aggravation, continuation and/or repetition of the same illness, condition or injury, without regard to the number of occurrences that may cause such illness, condition or injury, or (ii) a Referee's pregnancy or a Referee giving birth to a child either during the Season or during the immediately preceding Off-Season, such that the Referee is unfit to officiate.

Section 3. Medical Insurance.

(a) During the term of this Agreement, the NBA shall provide Referees and qualifying former Referees (pursuant to Article VIII below) with medical insurance coverage under the policy identified and described in Exhibit C hereto (the "Group Medical Insurance Policy"), provided that (i) a Referee has elected to be covered by such policy, (ii) the NBA is able to obtain and maintain such policy, and (iii) the annual premiums paid or payable by the NBA for such policy (including, but not limited to, any payments attributable to any excise tax paid or payable by the NBA pursuant to the Affordable Care Act) do not exceed the following amounts for the respective Years covered by this Agreement:

2022-23	$3,790,398
2023-24	$4,169,437

2024-25	$4,586,381
2025-26	$5,045,019
2026-27	$5,549,521
2027-28	$6,104,473
2028-29	$6,155,344 (pro-rated for 11 months)

(b) Referees shall contribute twenty-five percent (25%) of the cost of annual premiums paid or payable by the NBA for the Group Medical Insurance Policy. Such contributions shall be made, first, through appropriate salary deductions from each active Referee; and, second, through a reduction in either the marketing payment to the NBRA (Article XIII, Section 1(c)) and/or the Playoff Pool (Article IV, Section 3).

Section 4. Disability Insurance.

During the term of this Agreement, the NBA shall provide Referees with disability insurance coverage under the policies identified and described in Exhibit D hereto (the "Group Disability Insurance Policies"), provided that (a) the NBA is able to obtain and maintain such policies, and (b) the annual premiums paid or payable by the NBA for such policies do not exceed the following amounts for the respective Years covered by this Agreement:

2022-23	$528,618
2023-24	$549,763
2024-25	$571,754
2025-26	$594,624
2026-27	$618,409
2027-28	$643,145
2028-29	$613,132 (pro-rated for 11 months)

Section 5. Dental Insurance.

During the term of this Agreement, the NBA shall provide Referees and qualifying former Referees (pursuant to Article VIII below) with dental insurance coverage under the policy identified and described in Exhibit E hereto (the "Group Dental Insurance Policy"), provided that (a) the NBA is able to obtain and maintain such policy, and (b) the annual premiums paid or payable by the NBA for such policy do not exceed the following amounts for the respective Years covered by this Agreement:

2022-23	$125,505
2023-24	$130,525
2024-25	$135,746
2025-26	$141,176
2026-27	$146,823
2027-28	$152,696
2028-29	$145,570 (pro-rated for 11 months)

Section 6. Life and AD&D Insurance.

During the term of this Agreement, the NBA shall provide Referees and qualifying former Referees (pursuant to Article VIII below) with life insurance coverage under the policies identified and described in Exhibit F hereto (the "Group Life Insurance Policy"), provided that (a) the NBA is able to obtain and maintain such policies, and (b) the annual premiums paid or payable by the NBA for such policies do not exceed the following amounts for the respective Years covered by this Agreement:

2022-23	$135,136
2023-24	$140,541

2024-25	$146,163
2025-26	$152,009
2026-27	$158,089
2027-28	$164,413
2028-29	$156,740 (pro-rated for 11 months)

Section 7. Vision Insurance.

During the term of this Agreement, the NBA shall provide Referees and qualifying former Referees (pursuant to Article VIII below) with vision insurance coverage under the policy identified and described in Exhibit G hereto (the "Group Vision Insurance Policy"), provided that (a) the NBA is able to obtain and maintain such policy, and (b) the annual premiums paid or payable by the NBA for such policy do not exceed the following amounts for the respective Years covered by this Agreement:

2022-23	$13,380
2023-24	$13,915
2024-25	$14,471
2025-26	$15,050
2026-27	$15,652
2027-28	$16,278
2028-29	$15,519 (pro-rated for 11 months)

Section 8. Cost Limitations Relating to Health & Welfare Benefits.

With respect to the Group Medical, Disability, Dental, Life and AD&D, and Vision Insurance Policies provided under Article VII, Sections 3-7 above, if, in any Year, the annual premium paid or payable by the NBA for any such policy will exceed the applicable dollar amount set forth in Article VII, Sections 3(a)(iii), 4(b), 5(b), 6(b), or 7(b) above (the

difference between the annual premium and such dollar amount hereinafter defined as the "Excess Premium"), the NBA, after consultation with the NBRA, shall either:

(i) maintain the existing insurance benefit, pay the required premium, and reduce the marketing payment to the NBRA (Article XIII, Section 1(c)) and/or the Playoff Pool (Article IV, Section 3) by the amount of the Excess Premium; or

(ii) reduce or adjust the benefit levels under such policy, or obtain coverage under another mutually acceptable policy, so as to eliminate any Excess Premium for the applicable policy.

Section 9. Adjustment for Additional Referees.

The dollar amounts set forth in Article VII, Sections 3(a)(iii), 4(b), 5(b), 6(b), and 7(b) above shall be adjusted (upward or downward), on a pro rata basis, to reflect any change in the number of Referees (but not former Referees (or eligible dependents should the Referee no longer participate in the applicable insurance program) eligible for coverage under Article VIII, Section 4(c)(ii)) to be included in the applicable insurance program for its annual term, as measured against the number of Referees and former referees included in such insurance program for the year commencing October 1, 2021 and ending September 30, 2022.

Article VIII

Post-Employment Benefits

Section 1. Pension Plan.

(a) The Restated National Basketball Association Referees' Pension Plan (restated and amended effective June 1, 2012), as amended by the First through Eighth Amendments thereto (a defined benefit plan attached as Exhibit H, which is hereinafter referred to as the "Pension Plan"), shall remain in effect as a frozen plan through the term of this Agreement; provided, however, that the provisions of the Pension Plan shall be subject to any limitations or restrictions that may be imposed under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and/or the Internal Revenue Code of 1986, as amended (the "Code") (including, but not limited to, any restrictions that may be imposed under Code Section 436) and shall be further subject to the terms and conditions of this Article as set forth below.

(b) Pursuant to the Pension Plan:

(i) The Normal Retirement Benefit of each Referee under the Pension Plan shall continue to be frozen as of June 1, 2010 and no Referee shall accrue any additional benefits under the Pension Plan for service as a Referee on or after June 1, 2010, or be credited with any Years of Referee Service under the Pension Plan for the 2010-11 Regular Season or any Regular Season thereafter; provided, however, that a Referee who is a participant in the Pension Plan and had less than three (3) Years of Referee Service as of the conclusion of the 2009-10 Regular Season shall continue to be credited with any Years of Referee Service on account of any Regular Season thereafter until such Referee has three (3) Years of Referee Service for the sole purpose of determining the Referee's vested percentage in his or her Accrued Benefit under the Pension Plan.

(ii) Any individual who first became a Referee (or any individual who previously was, and is then rehired, as a Referee) on or after June 1, 2010 shall not be eligible to become a participant in the Pension Plan.

Section 2. Retirement Plan.

(a) The NBA Retirement Plan for Referees (restated and amended effective October 1, 2012), as amended by the First through Fifth Amendments thereto (a defined contribution plan attached as Exhibit I, which is hereinafter referred to as the "Retirement Plan"), shall, subject to the approval of the Internal Revenue Service (the "IRS"), remain in effect through the term of this Agreement; provided, however, that the provisions of the Retirement Plan shall be subject to any limitations or restrictions that may be imposed under ERISA and/or the Code and shall be further subject to the terms and conditions of this Article VIII as set forth below.

(b) The annual contribution formula under the Retirement Plan for any Referee who was credited with a Year of Referee Service for the 2010-11 Regular Season (or any Referee who received salary continuation for the entire 2010-11 Regular Season) shall continue to be equal to two percent (2%) times the Referee's total Years of Referee Service (up to a maximum of 10) times the Referee's base salary, subject to the limitations imposed under the Code as described in Section 3 of this Article VIII.

(c) (i) For the 2022-23 and 2023-24 Seasons, the annual contribution formula under the Retirement Plan for any individual who first becomes a Referee, or any individual who previously was, and is then rehired as, a Referee, for the 2011-12 Regular Season or any Regular Season thereafter shall be equal to one and three-quarters percent (1.75%) times the Referee's total Years of Referee Service (up to a maximum of 10) times the Referee's base

salary, subject to the limitations imposed under the Code as described in Section 3 of this Article VIII.

(ii) Beginning with the 2024-25 Season, the annual contribution formula under the Retirement Plan for any individual who first becomes a Referee, or any individual who previously was, and is then rehired as, a Referee for the 2011-12 Regular Season or any Regular Season thereafter, shall be equal to two percent (2%) times the Referee's total Years of Referee Service (up to a maximum of 10) times the Referee's base salary, subject to the limitations imposed under the Code as described in Section 3 of this Article VIII.

(d) Within thirty (30) days of the conclusion of each Regular Season, the NBA shall make the annual contribution to the Retirement Plan earned by a Referee under the Retirement Plan for that Regular Season.

Section 3. Provisions Applicable to Pension Plan and Retirement Plan.

(a) The provisions contained in this Section 3 shall apply to both the Pension Plan and the Retirement Plan. Accordingly, any and all references to "Plans" in this Section 3 shall be read and interpreted as including reference both to the Pension Plan and/or the Retirement Plan, each where applicable.

(b) Notwithstanding any of the foregoing provisions of this Article VIII:

(i) All actuarially determined contributions to be made to the Pension Plan, and all contributions to be made to the Retirement Plan, will, when paid, be fully deductible under the Code. If, for any reason, all or any portion of such contributions will not, when paid to the Plans, be fully deductible under the Code, the parties agree that the contributions shall be reduced to result in all of such contributions being fully deductible when paid. The parties agree that the foregoing determinations, including but not limited to, any

actuarial assumptions and projections related thereto and the application of the deduction limitations under the Code to contributions to be made to the Plans, shall be made by the current actuaries of the applicable Plan and any such determinations shall be binding and conclusive.

(ii) The benefits accrued and payable under the Pension Plan shall at all times be subject to all applicable limitations under the Code, including but not limited to, the limitation on benefits under Code Section 415. For purposes of the preceding sentence, the limitations on benefits under the Code shall be the limitations in effect for the 2022 calendar year, as such limitations may be adjusted for increases in the cost of living in the manner provided under Section 415(d)(2) of the Code. In no event, however, shall the benefit payable to any Referee under the Pension Plan exceed the applicable limitation on benefits under the Code as in effect for the year in which the benefit is paid to such Referee.

(iii) All contributions to be made to the Retirement Plan shall at all times be subject to all applicable limitations under the Code, including but not limited to, the limitation on contributions under Code Section 415, the maximum limitation on compensation under Code Section 401(a)(17), and the maximum limitations on 401(k) deferrals under Code Section 402(g). For purposes of this Section 3(b)(iii), the limitation on contributions under Code Section 415 and the maximum limitation on compensation under Code Section 401(a)(17) shall be the limitations in effect for the 2022 calendar year, as such limitations may be adjusted for increases in the cost of living in the manner provided under Code Section 415(d)(2) and Code Section 401(a)(17)(B). In no event, however, shall the contribution to be made on behalf of a Referee or the compensation taken into account in determining the contribution exceed the applicable limitations on contributions and compensation under the Code as in effect for the year in which such contribution is made.

(iv) A Referee shall be considered to be on the Referees' Roster for a Regular Season if such Referee performs officiating services in thirty (30) or more of a combination of Championship Games and Exhibition Games played, and Replay Center assignments worked, during such Regular Season. Pursuant to Article III, Section 8, all Developmental League games (as defined in Article III, Section 8) assigned to and officiated by a Referee shall count as Championship Games for purposes of this Section 3(b)(iv).

(v) For purposes of this Article VIII: (A) the terms "Accrued Benefit," "Normal Retirement Benefit," "Referee," "Year of Referee Service," and "Regular Season" referred to in Section 1 shall have the meanings defined in the Pension Plan; and (B) the terms "Referee," "Referees' Roster," "Regular Season," "Championship Games," "Exhibition Games," and "Year of Referee Service" referred to in Sections 2 and 3(b)(iv) shall have the meanings defined in the Retirement Plan.

Section 4. Post-Employment Severance and Insurance Benefits.

Upon termination, retirement, or resignation of employment as a Referee during the term of this Agreement, and subject to the additional terms of eligibility set forth in Article VIII, Section 5 below, a Referee will be eligible for post-employment severance and/or insurance benefits only in accordance with the following provisions:

(a) Termination for Good Cause Based on Ratings.

(i) A Referee who was employed as a Referee by the NBA during the 2008-09 Season, has ten (10) or more Years of Service at the time of his or her termination, and whose employment is terminated for good cause pursuant to Article X, Section 4(b), will be eligible to receive severance pay in the amount of $14,000 for each such Year of Service, provided that in no event shall the amount of such severance pay exceed $300,000.

(ii) A Referee who was first employed as a Referee by the NBA during the 2009-10 or any later Season, has ten (10) or more Years of Service at the time of his or her termination, and whose employment is terminated for good cause pursuant to Article X, Section 4(b), will be eligible to receive severance pay in the amount of $7,000 for each such Year of Service, provided that in no event shall the amount of such severance pay exceed $200,000.

(b) Termination Without Good Cause.

(i) A Referee who was employed as a Referee by the NBA during the 2008-09 Season and whose employment is terminated without good cause pursuant to Article X, Section 5, will be eligible to receive severance pay in the amount of $21,000 for each such Year of Service, provided that in no event shall the amount of such severance pay exceed $450,000.

(ii) A Referee who was first employed as a Referee by the NBA during the 2009-10 or any later Season and whose employment is terminated without good cause pursuant to Article X, Section 5, will be eligible to receive severance pay in the amount of $10,500 for each such Year of Service, provided that in no event shall the amount of such severance pay exceed $300,000.

(c) Resignation or Retirement. A Referee who voluntarily resigns or retires as a Referee with fifteen (15) or more Years of Service will be eligible to receive:

(i) severance pay, calculated as follows:

(A) for a Referee with at least fifteen (15) but less than twenty (20) Years of Service as of the date that the Referee resigns or retires, $15,000 for each Year of Service;

(B) for a Referee with at least twenty (20) but less than twenty-five (25) Years of Service as of the date that the Referee resigns or retires, $17,500 for each Year of Service;

(C) for a Referee with twenty-five (25) or more Years of Service as of the date that the Referee resigns or retires, $20,000 for each Year of Service;

provided, however, that in no event shall the amount of such severance pay under this Section 4(c)(i) exceed the amount of annual salary (or, for a Referee with twenty-five (25) or more Years of Service, the amount of annual salary plus VAC payment) that such Referee received for the Season immediately preceding the Off-Season in which the Referee resigns or retires;

(ii) continued coverage under the Group Medical, Dental and Vision Insurance Policies until the former Referee's 65th birthday (or, if the former Referee has reached their 65th birthday, coverage shall be offered to the former Referee's eligible dependents until the earlier of ten (10) years following the Referee's date of retirement or the former Referee's spouse's 65th birthday), provided that (A) such former Referee, on a monthly basis, reimburses the NBA for premiums on the same terms as active Referees are required to pay (i.e., twenty-five percent (25%) of the annual premium for such Group Medical coverage), and (B) any former Referee hired by the NBA to work in a non-Referee role and who is eligible for insurance benefits coverage offered to non-Referee employees of the NBA shall not be eligible for coverage under this Section 4(c)(ii) at any time while employed by the NBA or thereafter;

(iii) continued group term life insurance coverage under the Group Life Insurance Policy (but in no event beyond the former Referee's 65th birthday) in the amount of $500,000, provided that such former Referee, on a monthly basis, reimburses the NBA for one hundred percent (100%) of the premiums paid for such coverage.

Section 5. Additional Terms Concerning Post-Employment Severance Pay and/or Insurance Benefits.

(a) Under no circumstances shall any Referee be entitled to post-employment severance and/or insurance benefits under more than one of the provisions of Section 4 above.

(b) To be eligible to receive post-employment severance and/or insurance benefits under Article VIII, Section 4(c), an otherwise qualifying Referee must notify the NBA in writing of his or her decision to resign or retire during the Off-Season (but no later than the July 15) immediately preceding the first Season in which such Referee will no longer be employed as a Referee. After providing such notice, such former Referee may not subsequently request reinstatement.

(c) No post-employment severance or insurance benefits shall be paid or provided by the NBA under any provision of this Agreement, unless

(i) an otherwise qualifying Referee and the NBRA sign an Agreement and Release in the form annexed hereto as Exhibit J, which shall include, without limitation, the release of any and all rights of such Referee to apply for and/or receive benefits under the Group Disability Insurance Policy; and

(ii) such signed Agreement and Release is received by the NBA, and becomes effective, on or before the October 1 immediately following the termination, retirement, or resignation of such Referee's employment as a Referee.

(d) Any Referee who has at any time received disability benefit payments under the Group Disability Insurance Policy (provided pursuant to Article VII, Section 4) will not be eligible to receive any post-employment severance and/or insurance benefits under this Agreement, unless, subsequent to the date on which such Referee receives the last disability benefit payment under such Policy, such Referee is credited with at least two (2) "Years of Referee Service" as such term is defined under Section 1.34 of the Pension Plan.

(e) Any severance provided pursuant to Article VIII, Section 4, shall be paid in fifty-two (52) equal bi-weekly installments, commencing with the first regular pay period in the month of October immediately following the termination, retirement, or resignation of such Referee's employment as a Referee.

Article IX

Fitness; Medical Examinations

Section 1. Fitness Generally.

Referees shall maintain the physical fitness required to perform the duties of an active game official and all other job responsibilities of a Referee. Except as provided for in this Article IX, a Referee shall not be subject to any physical fitness standards.

Section 2. Injury, Illness or Medical Condition.

(a) During any Season and/or Off-Season, a Referee must immediately provide notice to the NBA of any injury, illness, or medical condition that may impact the Referee's ability to work or provide any services under this Agreement, and such notice must include the time, place, cause, and nature of such injury, illness, or condition.

(b) A Referee who consults a physician for any such injury, illness, or medical condition shall authorize and direct such physician to provide the NBA, its insurers, or any of its appointed physicians, health care providers, therapists, or trainers with all information that any or all of them may request regarding any such injury, illness or condition. To facilitate the disclosure of information required under this Article, Referees must sign individual authorizations as may be requested by the NBA.

(c) A Referee missing more than four (4) consecutive scheduled Game assignments due to any injury, illness, or medical condition shall be permitted to resume officiating Games only upon the written certification of a physician designated or approved by the NBA, stating that the Referee has been cleared to return to work and officiate Games. Any disputes concerning the determination made by such physician shall be resolved in accordance with the dispute resolution procedure in Article IX, Section 3(b) below. If such Referee is not

assigned or available to officiate any Games for a period of thirty (30) or more days, then the NBA may assign such Referee to officiate up to three (3) games in a Developmental League prior to assigning the Referee to work any further NBA Games, and any such games officiated in a Developmental League shall be included in determining whether a Referee shall be listed on the "Referees' Roster" for purposes of the Pension Plan and Retirement Plan.

(d) The NBA may require a Referee who (i) does not officiate any Games during the last two (2) weeks of the Regular Season due to any injury, illness, or medical condition and (ii) does not officiate any Playoff Games, to attend an Instructional Camp for a period not to exceed five (5) days, provided that a Referee may decline such an assignment if a physician designated or approved by the NBA determines that such Referee is not medically able to participate in such Instructional Camp. Any disputes concerning the determination made by such physician shall be resolved in accordance with the dispute resolution procedure in Article IX, Section 3(b) below, except that the NBA and the NBRA shall agree upon a neutral physician within five (5) days following the NBRA's request, and such physician shall determine whether the Referee is medically able to participate in an Instructional Camp.

Section 3. Examinations and Fitness Determinations.

(a) During each of the Seasons covered by this Agreement (and in addition to any physical examination that may be required prior to or in conjunction with any Training Camp), the NBA shall have the right, at any time and without advance notice, to require that any Referee submit to up to two (2) examinations at a time and place, and by a physician, designated by the NBA. The costs of such examination(s) shall be borne by the NBA.

(b) With respect to an examination of a Referee that is conducted pursuant to Article IX, Section 3(a) above, if, based on the totality of circumstances, the NBA's designated physician determines that such Referee is unfit to perform the duties of a Referee, the Referee:

(i) shall be suspended without pay (unless the Referee is entitled to salary continuation pursuant to Article VII, Section 2), until such time as the NBA's physician certifies in writing that the Referee is fit to perform such duties; and

(ii) may be required to participate in fitness, rehabilitation and/or conditioning programs (as prescribed by the NBA or its designee) that are reasonably related to the duties and tasks of a Referee, are intended to restore the Referee to active officiating status, and that continue until such time as the NBA's physician certifies in writing that the Referee is fit to perform such duties.

In the event of any dispute concerning the determination made by the physician designated by the NBA in accordance with this Article IX, Section 3, the Referee involved shall, upon the request of the NBRA, be examined by a physician mutually selected by the NBA and the NBRA. The NBA and the NBRA shall agree upon the physician to be selected within ten (10) days following the NBRA's request, and such physician shall determine whether the Referee is fit to perform the duties of a Referee. The written determination of such mutually selected physician shall be final and binding upon the NBRA, the NBA, and the Referee involved, who, if determined to be fit to perform the duties of a Referee, shall be entitled to be made whole. The costs of any such examination shall be borne equally by the NBA and the NBRA. During any period of suspension under this Article IX, Section 3(b), a Referee, if otherwise eligible and qualified, shall be entitled to such benefits under the Group Disability Insurance Policy as may be provided to Referees.

(c) With respect to an examination of a Referee that is conducted pursuant to Article IX, Section 3(a) above, if, based on the totality of circumstances, the NBA's designated physician determines that the Referee is at risk of (i) becoming unfit to perform the duties of a

Referee, or (ii) failing to meet any of the standards referenced in Section 4 of this Article IX for measuring whether a Referee is fit to perform the duties of a Referee, the Referee may be required, for so long as such risk persists, to participate in fitness, rehabilitation and/or conditioning programs (as prescribed by the NBA or its designee) that are reasonably related to the duties and tasks of a Referee and are intended to eliminate the health risk(s) described above.

Section 4. Weight Checks.

At the beginning of each Season covered by this Agreement, a duly licensed physician selected by the NBA shall designate for each Referee a weight in accordance with the United States Army's weight tables then in effect, taking into consideration a Referee's height, age and gender, provided that an additional two (2) pounds will be permitted for Referees over age 50 and an additional four (4) pounds will be permitted for Referees over age 60. For a Referee employed as a Referee by the NBA during the 2021-22 Season, the height utilized for purposes of such weight designation will be as set forth on the annexed Exhibit K. For a Referee first employed as a Referee by the NBA during the 2022-23 Season or any later Season, the height utilized for purposes of such weight designation will be the Referee's measured height taken during Training Camp for his or her first Season as a Referee. Each Referee shall maintain the Referee's designated weight at all times during each such Season. The NBA, if requested in writing by the Referee within five (5) days following such designation, will consult with the personal physician of such Referee with respect to the appropriate weight for that Referee. Such designation shall, however, remain in the absolute and sole discretion of the physician designated by the NBA. Each Referee shall submit to up to three (3) weight checks per Season to be held at such places and times as may be designated by the NBA. Weight checks hereunder may be conducted by an NBA team doctor or other licensed physician or trainer designated by the NBA, and shall be conducted utilizing a uniform scale. A Referee whose weight exceeds the

designated weight shall submit to a body fat percentage measurement conducted by an NBA team doctor or other licensed physician or trainer designated by the NBA. The body fat measurement will be assessed against the United States Army's maximum allowable body fat percentages then in effect for an individual of the same age and gender as the Referee. Any Referee who exceeds both the designated weight and the maximum allowable body fat percentage shall, upon written notice from the NBA, be given thirty (30) days to reduce that weight or body fat percentage to the designated weight or maximum allowable body fat percentage. If upon the expiration of such thirty (30) day period the Referee's weight and body fat percentage exceed the designated weight and maximum allowable body fat percentage, such Referee shall be subject to disciplinary action, up to and including, reasonable fines, suspension, and/or termination of employment.

Section 5. Release.

Each Referee, now or hereafter employed, and the NBRA hereby release and waive every claim, demand, or cause of action the Referee or the NBRA may now or in the future have against the NBA, its affiliates, and teams (and all owners, directors, officers and employees of the NBA, its affiliates, and teams), whether for damages or otherwise, arising out of or in connection with any injury (including permanent disability and death) suffered by a Referee in the normal course of his or her employment, whether caused by or arising from negligence or otherwise.

Article X

Evaluation and Termination

Section 1. Definitions.

Referees with three (3) or fewer Years of Service shall be regarded as "Probationary" Referees, and Referees with more than three (3) Years of Service shall be regarded as "Veteran" Referees.

Section 2. Evaluations.

(a) During each Season, the NBA will provide Referees with a mid-season performance evaluation.

(b) Each Referee who worked in excess of twenty-five (25) Regular Season Games in any Season will be evaluated following the conclusion of such Season. The evaluation shall be based on the Referee's Regular Season performance, and shall consist of a composite rating based upon evaluations made by NBA coaches (which shall count for 25% of the composite rating), general managers (15%), and the NBA (60%) (which shall be comprised of an evaluation made by the head of the NBA Referee Operations Department) (35% of the composite rating) and an evaluation made by the Director of Officials (25% of the composite rating)). All ratings will be submitted to the head of the NBA Referee Operations Department. The composite ratings will be tabulated by a nationally recognized accounting firm designated by the NBA (after consultation with the General Counsel of the NBRA) and will be expressed for each Referee in one of the following five (5) rating categories: "Significantly Exceeds," "Exceeds," "Meets," "Below," or "Significantly Below." Following its tabulation of the composite ratings, the accounting firm will furnish an alphabetical listing of the Referees who fall within each rating category to the head of the NBA Referee Operations Department, who will, within five (5)

days of his receipt of the composite ratings, but no later than July 1, furnish them to the General Counsel of the NBRA.

(c) Following the conclusion of each Season, all Referees will be ranked by the accounting firm described in Article X, Section 2(b) on the basis of the composite ratings compiled for such season, with those Referees who rank in the bottom 25% of all rated Referees to be placed in a grouping designated as Group III. Following the completion of the rankings, the accounting firm shall furnish an alphabetical list of those Referees who rank in Group III to the head of the NBA Referee Operations Department, who will, within five (5) days of his receipt of the list, but no later than July 1, furnish it to the General Counsel of the NBRA.

(d) Upon request of the NBRA, the NBA will attend periodic meetings each Year to discuss issues relating to the NBA's performance development program.

(e) The NBA will continue to provide all information to the NBRA in accordance with the Confidentiality and Settlement Agreement between the parties dated April 1, 2014, which is attached as Exhibit L and incorporated by reference herein, provided, however, that the parties agree that Paragraph 7 of Exhibit L hereby shall be amended to substitute the dates December 31, 2028 for December 31, 2015, and March 31, 2029 for March 31, 2016, respectively, where referenced in such Paragraph 7.

Section 3. Termination of Probationary Referees.

(a) If, following the conclusion of any Season covered by this Agreement, a Probationary Referee, based upon the composite ratings referred to in Article X, Section 2 above, ranks in Group III, such Referee may, in the NBA's absolute and sole discretion, be terminated from employment with the NBA; and such termination shall be deemed to be for good cause under this Agreement and any applicable statute, regulation or rule of law. In such event, the Referee shall have the right to an informal review of the termination by the Commissioner or his

designee. The determination made by the Commissioner or his designee shall be final and binding and neither the NBRA nor such Referee shall have any right to a review of such termination, or any right to advance any claim of any kind whatsoever in connection therewith, before any person or body (including, but not limited to, any court, administrative agency, or arbitrator of any kind).

(b) In addition, the employment of a Probationary Referee may be terminated at any time for good cause (other than such Referee's ranking in Group III) or, following the conclusion of any Season, without cause, and in either of such events the Referee shall (except as provided for by Article X, Section 5 and/or by Article XI, Section 3) have the right to an informal review of the termination by the Commissioner or his designee. The determination by the Commissioner or his designee shall be final and binding, and neither the NBRA nor the Referee involved shall have any right to a review of such determination, or any right to advance any claim of any kind whatsoever in connection therewith, before any person or body (including, but not limited to, any court, administrative agency, or arbitrator of any kind).

Section 4. Termination of Veteran Referees.

(a) If, following the conclusion of any Season, a Veteran Referee with less than ten (10) Years of Service ranks in Group III based upon the composite rating referred to in Article X, Section 2 above, such Referee may, in the NBA's absolute and sole discretion, be terminated from employment by the NBA; and such termination shall be deemed to be for good cause under this Agreement and any applicable statute, regulation or rule of law.

(b) If, following the conclusion of any Season, a Veteran Referee with ten (10) Years of Service or more ranks in Group III based upon the composite rating referred to in Article X, Section 2 above, twice during any three successive NBA seasons in which he or she is assigned to officiate NBA games (which may include NBA seasons preceding the term of this

Agreement), such Referee may, in the NBA's absolute and sole discretion, be terminated from employment by the NBA; and such termination shall be deemed to be for good cause under this Agreement and any applicable statute, regulation or rule of law.

(c) In the event a Veteran Referee is terminated from employment pursuant to Article X, Sections 4(a) or 4(b) above, the Referee shall have the right to an informal review of the termination by the Commissioner or his designee. The determination by the Commissioner or his designee shall be final and binding, and neither the NBRA nor the Referees involved shall have any right to a review of such determination, or any right to advance any claim of any kind whatsoever in connection therewith, before any person or body (including, but not limited to, any court, administrative agency, or arbitrator of any kind).

(d) In addition, the employment of a Veteran Referee may be terminated at any time for good cause (other than such Referee's ranking in Group III) and in such event the Referee shall (except as provided for by Article XI, Section 3) have the right to a review (on the basis set forth below) of that determination by an arbitrator selected by the parties from an American Arbitration Association list of prominent professional arbitrators, with each party alternately striking names from such list until only one remains. Any arbitration proceeding shall be conducted in New York City and in accordance with the Voluntary Labor Arbitration Rules of the American Arbitration Association. All costs of arbitration, including the fees and expenses of the arbitrator, shall be borne equally by the NBA and the NBRA; but each party shall bear the cost of its own counsel and the like. In the event that the arbitrator concludes that good cause did not exist for the termination of the Referee, the arbitrator shall award the Referee post-employment severance pay pursuant to Article VIII, Section 4(b).

(e) The NBA shall be entitled to terminate a Veteran Referee at any time for good cause; provided, however, if the NBA, following the conclusion of any Season, decides to terminate a Referee based on such Referee's performance for the preceding NBA season(s) (which may include seasons immediately preceding the term of this Agreement), it shall notify the Referee in writing within 30 days after the last game of the Playoffs for that Season; and provided further that such notification shall be deemed given once it is sent via certified or overnight mail to the Referee, with a copy to the General Counsel of the NBRA.

Section 5. Termination Without Good Cause.

(a) In addition to and notwithstanding the foregoing provisions of this Article X, the NBA shall have the right at any time to terminate the employment of any Referee without good cause, whether or not the specific provisions regarding termination as set forth above in this Article X may be applicable to such Referee. In such event, the Referee shall have the right to an informal review of the termination by the Commissioner or his designee. The determination by the Commissioner or his designee shall be final and binding, and neither the NBRA nor the Referee involved shall have any right to a review of such determination, or any right to advance any claim of any kind whatsoever in connection therewith, before any person or body (including, but not limited to, any court, administrative agency, or arbitrator of any kind).

(b) In the event of a termination pursuant to Article X, Section 5(a) above, the Referee shall receive post-employment severance pay in accordance with Article VIII, Section 4(b); and such payment shall be in lieu of any other payment to which the Referee may be entitled on account of such termination under this Agreement and any applicable statute, regulation or rule of law. Such payment shall commence upon either (i) the NBA's receipt of written notice from the Referee that he or she will not seek review of the termination, or (ii) a final determination by the Commissioner or his designee upholding the termination. In the event

the Referee is reinstated, such Referee shall continue to receive the applicable salary under Article IV, Section 1, and will receive no additional payments under this provision.

Section 6. Employment Ending Due To Disability.

A Referee's employment will terminate for good cause if such Referee is continuously disabled for a period of twelve (12) months and the NBA (in its sole and absolute discretion) concludes there is no reasonable expectation that such Referee will return to work in any reasonable period of time. In this event, the NBA shall provide the Referee with written notice confirming termination of employment.

Section 7. NBRA Representation.

In any review provided for under this Article X, the Referee may be represented by the NBRA.

Article XI

Conduct of Referees

Section 1. Other Employment and Business Activities.

During the term of this Agreement, no Referee shall be employed by or provide services to any entity or person other than the NBA, or own or operate a business (including, without limitation, any corporation, partnership, or sole proprietorship) without first providing written disclosure of such activity and then receiving the NBA's express written consent, which shall not be unreasonably withheld, provided that (i) any Regular Season employment or business activity shall be considered per se unreasonable if it, standing alone or when combined with other outside employment and business activities, exceeds five (5) hours per week; (ii) any Off-Season employment or business activity shall be considered per se reasonable in the absence of a conflict with a legitimate business interest of the NBA (such as, as reasonably determined, an actual or perceived conflict of interest, activity that raises integrity concerns, or activity of a disreputable nature) or a scheduling conflict with an Instructional Camp or meetings with NBA Players or Team Personnel; and (iii) no Referee may be employed in a management position (as opposed to as a consultant or advisor) by any basketball organization (e.g., league, team, or college conference) other than summer instructional camps and tournaments. For the purposes of this Article XI, Section 1 only, a Referee's Off-Season shall begin with the day following his/her last assigned Game of the Season, provided that a Referee who has not initially been assigned to a round of the Playoffs may be required, in an unforeseen circumstance affecting another Referee, including, but not limited to, illness, family emergency, or travel difficulty, to officiate in a Playoff game in that round, and he/she may not assert his/her involvement in Off-Season employment or business activity as a reason to decline such assignment.

Section 2. Gambling.

No Referee shall violate the NBA's anti-gambling rules, as set forth in the rules provided to Referees in accordance with Article XI, Section 4, below.

Section 3. NBA Constitution.

(a) Section 35A of the NBA Constitution (a copy of which, as in effect on the date of this Agreement, is annexed hereto as Exhibit M, but which may be amended from time to time by the NBA) is an integral part of this Agreement, and all Referees shall be bound by and subject to the provisions of such Section.

(b) Any dismissal, disqualification, suspension or fine imposed upon a Referee by the Commissioner or his designee pursuant to Section 35A of the NBA Constitution, including for conduct on the playing court or for the preservation of the integrity of, or the maintenance of public confidence in, the game of basketball, shall be final and binding upon the Referee involved and upon the parties to this Agreement, and neither the Referee nor the NBRA shall have any right to a review of such action by the Commissioner or his designee, or any right to advance any claim of any kind whatsoever in connection therewith, before any person or body (including, but not limited to, any court, administrative agency, or arbitrator of any kind). Each Referee, now or hereafter employed, and the NBRA hereby release the Commissioner, his designee and/or the NBA, and waive every claim against the Commissioner, his designee and/or the NBA for damages and for all claims and demands whatsoever arising out of or in connection with any such action by the Commissioner or his designee.

Section 4. Other Conduct.

(a) Work Rules.

(i) In addition to the foregoing, each Referee shall observe and comply with all requirements of the NBA respecting conduct of its Referees, at all times,

whether on or off the playing floor. The NBA may, from time to time during the period covered by this Agreement, establish and amend written rules for the governance of Referees ("Work Rules"), and the Work Rules shall be part of this Agreement as fully as if herein written and shall be binding upon each Referee, provided, however, that (A) no such Work Rule may alter any express provisions of this Agreement, (B) absent exigent circumstances, the NBA will provide the NBRA with ten (10) days' notice before changing, suspending, or supplementing a Work Rule, and (C) if requested by the NBRA, the NBA will meet and confer with the NBRA over any change, suspension, or supplement to a Work Rule, and the NBA will consider any good-faith reasonable suggestions made by the NBRA.

(ii) For each Season during the term of this Agreement, no later than fifteen (15) days prior to the start of Training Camp, a copy of the Work Rules shall be provided to the General Counsel of the NBRA, who will be advised, in writing, of all changes to the Work Rules made during the Off-Season. Referees shall be provided with the Work Rules at the start of Training Camp.

(iii) For any violation of the Work Rules or for any conduct impairing the faithful and thorough discharge of the duties incumbent upon each Referee, the NBA may take disciplinary action against a Referee, including without limitation, suspension without pay, imposition of fines (which may be deducted from any money due or to become due to the Referee), and termination of employment under Article X, Section 3(b) or 4(d).

(b) (i) When a Referee is fined and/or suspended under this Section, the Referee shall be given notice in writing, stating the amount of the fine and/or the duration of the

suspension and the reason therefor. In addition, the Referee shall have the right to an informal review of such fine and/or suspension by the Commissioner or his designee. Except as provided specifically in Article XI, Sections 4(c) and (d) below, the determination of the Commissioner or his designee shall be final and binding, and neither the NBRA nor the Referee involved shall have any right to a review of such determination, or any right to advance any claim of any kind whatsoever in connection therewith, before any person or body (including, but not limited to, any court, administrative agency, or arbitrator of any kind).

(ii) A Referee shall have up to fourteen (14) days from receipt of written notice of a fine and/or suspension to notify the NBA in writing if the Referee seeks an informal review of such discipline. The NBA shall have up to fourteen (14) days from receipt of written notice that a Referee is seeking an informal review of a fine and/or suspension to hold such informal review; and up to fourteen (14) days from the date the informal review is held to issue a determination on such informal review. All fines shall be paid within thirty (30) days following the Referee's receipt of the written notice of the fine or, if an informal review is sought by the Referee, within thirty (30) days following the date the NBA issues its determination on an informal review.

(c) In the event that a Referee is fined in an amount in excess of $2,500, or suspended without pay in excess of three (3) Games, such Referee shall have the right to a formal hearing before the Commissioner or his designee (but only if such Referee has not previously had an informal review of such fine and/or suspension as provided for by Article XI, Section 4(b) above). A Referee shall have up to fourteen (14) days from receipt of written notice of such a fine and/or suspension to notify the NBA in writing if the Referee seeks a formal hearing of such discipline. Promptly upon receiving such notice, the NBA will meet and confer

with the NBRA to schedule the hearing, which shall be held at a reasonable date and time thereafter, taking into account the additional complexities of a formal hearing. At such formal hearing, the Referee may be represented by counsel, adduce evidence, and examine and cross examine witnesses, and a transcript shall be made. Following the conclusion of such hearing, the Commissioner or his designee shall determine whether there was good cause for the fine and/or suspension imposed. If the Commissioner or his designee determines that good cause did not exist, the amount of any fine paid by the Referee shall be remitted to such Referee, and/or the Referee shall be reimbursed for any salary withheld by the NBA as a result of the fine and/or suspension.

(d) In the event that the Commissioner or his designee determines that there was good cause for the fine and/or suspension imposed, the NBRA shall, on behalf of the Referee, have the right to a review (on the basis set forth below) of that determination by an arbitrator selected by the parties from an American Arbitration Association list of prominent professional arbitrators, with each party alternately striking names from such list until only one remains. Any arbitration proceeding shall be conducted in New York City and in accordance with the Voluntary Labor Arbitration Rules of the American Arbitration Association; provided, however, that the arbitrator's jurisdiction shall be limited solely to the specific question whether the determination of the Commissioner or his designee that good cause existed for the fine and/or suspension imposed was clearly erroneous; and provided, further, that the arbitrator's determination shall be based solely upon the record as made at the hearing before the Commissioner or his designee and upon such written argument as the NBA and the NBRA may submit. All costs of arbitration, including the fees and expenses of the arbitrator, shall be borne

equally by the NBA and the NBRA; but each party shall bear the cost of its own counsel and the like.

(e) In the event that the arbitrator concludes that the determination by the Commissioner or his designee was clearly erroneous, the amount of any fine paid by the Referee shall be remitted to such Referee, and/or the Referee shall be reimbursed for any salary withheld by the NBA as a result of the fine and/or suspension. No award of the arbitrator may require, and nothing herein contained shall be construed to require, the NBA to reinstate the suspended Referee, provided the NBA makes the remittance and/or reimbursement as required by the foregoing sentence.

(f) The NBA and NBRA may agree, in writing, to extend the deadlines set forth in Sections 4(b) and (c) above.

Section 5. NBA/NBRA Anti-Drug Program.

The NBRA, for itself and on behalf of all persons now or hereafter employed by the NBA as Referees, acknowledges and agrees to the terms of the NBA/NBRA Anti-Drug Agreement, a copy of which is attached as Exhibit N hereto, including all penalties applicable to violations thereof.

Article XII

No Strike Provision and Other Undertakings

Section 1. No Strike.

(a) Neither the NBRA nor any of its members will (i) call, sanction, or participate in any strike or other interference or disruption whatsoever with the operations of the NBA or with the conduct or presentation of any Pre-Season, Regular Season or Playoff Game, any All-Star Game or Event, or any other NBA event, (ii) call for, sanction, or participate in any concerted violation of any rule(s) prescribed by the NBA regarding the conduct of Referees at or during any Game, All-Star Game or Event, or any other NBA event, or (iii) observe or respect any picketing of any nature or engage in any sympathy strikes.

(b) It is specifically agreed and understood that, given the unique nature of the NBA's business and operations, the provisions of this Article XII shall be of full force and effect irrespective of whether any dispute that may arise between the NBRA and/or a Referee and the NBA constitutes a dispute that is arbitrable under this Agreement.

Section 2. Enforcement.

(a) It is specifically agreed and understood that, in the event of any alleged breach or threatened breach by the NBRA or a Referee of this Article XII, and in addition to any other remedies that may be available to it, the NBA shall have the right:

(i) To obtain from any court having jurisdiction such equitable relief as may be appropriate, including, but not limited to, an order enjoining the NBRA and/or any Referee from any further such breach or threatened breach; and/or

(ii) To submit a dispute concerning such breach or threatened breach for resolution pursuant to either the Voluntary Labor Arbitration Rules or the Expedited

Labor Arbitration Rules of the American Arbitration Association ("AAA"), with the arbitrator appointed by the AAA having the jurisdiction and authority to grant the NBA such equitable relief as may be appropriate, including, but not limited to, an order enjoining the NBRA and/or any Referee from any further such breach or threatened breach. Any such arbitration proceeding shall be conducted in New York City, and all costs of arbitration, including the fees and expenses of the arbitrator, shall be borne equally by the NBA and the NBRA, but each party shall bear the cost of its own counsel and the like.

(b) Nothing contained in Article XII, Section 2(a) shall deprive the NBRA of the right (if any) to assert, in a proceeding commenced pursuant to that Section, that the NBA is not entitled to injunctive relief on the ground that the alleged or threatened breach sought to be enjoined was caused by an unfair labor practice (within the meaning of the National Labor Relations Act) allegedly committed by the NBA.

(c) It is specifically agreed and understood that, in the event of any breach of this Article XII, and in addition to any other remedies that may be available to the NBA (including, but not limited to, action taken by the NBA under Article XI with respect to any individual Referee who participates in any breach of this Article XII), the marketing money (under Article XIII, Section 1) and/or Playoff Pool money (under Article IV, Section 3) otherwise payable to the NBRA or Referees under this Agreement may be reduced by an amount not exceeding $1,000,000 for each such breach, and by an additional $50,000 for each Referee who participates in such breach.

Article XIII

Miscellaneous

Section 1. Apparel and Marketing.

(a) Notwithstanding any prior practice or arrangement, the parties agree that during all Games and warm ups and between the locker room and the court, Referees shall only wear such uniforms and any other items of equipment, clothing and footwear as may be determined by the NBA and only in the manner prescribed by the NBA.

(b) The NBRA, for itself and on behalf of all Referees, agrees that neither it nor any Referee shall enter into any contract or arrangement pursuant to which, in exchange for any form of consideration paid to a Referee or the NBRA, one or more Referees wears, displays or endorses (or agrees to wear, display or endorse) any product (including but not limited to footwear). In addition, the NBA shall maintain and reserve the right to use, during the term of this Agreement and thereafter, each Referee's name, picture, or likeness for any commercial and promotional purposes, and the NBRA, for itself and on behalf of all Referees, agrees that neither it nor any such person shall assert any claim against the NBA, any NBA team, NBA Properties, Inc. ("NBAP"), or any affiliate thereof (an "NBA Entity") for the use by the NBA Entity (or by any licensee of such NBA Entity) of a Referee's name, picture or likeness for any such purposes.

(c) In consideration for the foregoing, the NBA shall pay to the NBRA, for distribution to active or retired Referees in a manner determined by the NBRA (with such determination subject to the NBA's approval, which approval shall not be unreasonably withheld), the following amounts:

For the 2022-23 Season:	$675,000
For the 2023-24 Season:	$695,250
For the 2024-25 Season:	$719,584

For the 2025-26 Season: $741,171

For the 2026-27 Season: $763,406

For the 2027-28 Season: $790,126

For the 2028-29 Season: $813,829

Section 2. Interviews or Public Statements.

A Referee shall not grant any interviews to the press or otherwise make any public statements (including, but not limited to, via radio, television, the Internet, or any other medium) without the approval of the head of the NBA Referee Operations Department. Notwithstanding the foregoing, a crew chief shall be permitted to discuss a rule interpretation with a pool reporter immediately after a Game.

Section 3. Awards.

Any Referee who works his or her first Playoff Game shall receive an NBA Playoff Watch. Any Referee who works his or her first NBA Finals Game shall receive an NBA Finals Ring. The design of such watches and rings shall be in the absolute and sole discretion of the NBA.

Section 4. Tickets.

(a) The NBA will provide to the NBRA and its authorized representatives up to four (4) tickets to any Game at box office prices, provided that the NBA receives a request for such tickets at least forty-eight (48) hours before such Game, and provided that such tickets are available from the home team.

(b) A Referee assigned to officiate any Game will receive two (2) complimentary tickets for each such Game.

(c) No tickets provided under this Section 4 shall be sold by the NBRA or any Referee or by any person to whom the NBRA or a Referee distributes such tickets. If it is

determined that the NBRA has violated the foregoing prohibition, the NBRA will lose its rights to purchase Game tickets under this Agreement. If it is determined that a Referee has violated the foregoing prohibition, the Referee will, in addition to any other discipline imposed pursuant to Article XI, lose the entitlement to complimentary Game tickets under this Agreement.

Article XIV

Management Rights

Section 1. Management Rights.

(a) Subject only to the limitations as may be explicitly set forth in this Agreement, the NBA shall retain the exclusive right to manage its business, including, but not limited to, the right to hire new Referees, to direct the working force, to classify or reclassify Referees, to lay off Referees because of lack of work, to determine the qualifications of Referees, to observe and evaluate a Referee's performance, to discipline, suspend, or discharge Referees, and to require Referees to observe rules and regulations presently in effect and/or to be put into effect.

(b) The methods, procedures and mechanics of officiating, including, but not limited to, whether and the extent to which Referee Operations management may make final decisions with respect to Game events (e.g., calls, non-calls, violations) following video review from the NBA Replay Center, shall be determined solely by the NBA.

(c) The listing of the foregoing rights is not intended to and shall not be restrictive of or a waiver of any of the rights of management not listed, whether or not such rights have been exercised by the NBA in the past.

Article XV

Grievances

Section 1. Definitions.

Any dispute involving the interpretation or application of any provision of this Agreement shall hereinafter be referred to as a "grievance," and shall be resolved exclusively in accordance with the provisions of this Article XV. Notwithstanding the foregoing, (a) disputes involving the discipline of any Referee shall not be subject to resolution in accordance with the grievance procedure established by this Article XV, but rather shall be exclusively resolved in accordance with the provisions of Articles X and XI of this Agreement (provided, however, that disputes arising under Article II, Section 4 and Exhibit N, Section 2(e) of this Agreement shall be subject to this Article XV), and (b) disputes arising under Article XII shall be exclusively resolved in accordance with the provisions of Article XII of this Agreement.

Section 2. Procedures.

(a) Grievance by a Referee and/or the NBRA. A Referee having a grievance shall submit such grievance, in writing, signed by the grievant and an authorized representative of the NBRA on behalf of the grievant, to the NBA's General Counsel; and, in order to be effective, such grievance must be submitted within thirty (30) days from the date of the occurrence upon which the grievance is based, or within thirty (30) days from the date upon which the facts giving rise to the grievance became known or reasonably should have become known to the party initiating the grievance, whichever is later. The NBRA may file a grievance in its own name, or on behalf of some or all Referees (provided that such Referee(s) approve of the filing of such grievance), by submitting it to the NBA's General Counsel, in writing; and, in order to be effective, such grievance must be submitted within thirty (30) days from the date of

the occurrence upon which the grievance is based, or within thirty (30) days from the date upon which the facts giving rise to the grievance became known or reasonably should have become known to the party initiating the grievance, whichever is later.

(b) Grievance by the NBA. A grievance by the NBA shall be submitted to the NBRA's General Counsel, in writing, within thirty (30) days from the date of the occurrence upon which the grievance is based, or within thirty (30) days from the date upon which the facts giving rise to the grievance became known or reasonably should have become known to the NBA, whichever is later.

(c) Request for Meeting. Either the NBRA or the NBA may request a meeting with the other party to discuss the grievance, but such request or meeting shall not extend the time periods provided for in this grievance procedure. If no response to the grievance is delivered to the grieving party within thirty (30) days after submission of the grievance, the grievance shall be deemed denied by the opposing party.

(d) Arbitration. If a satisfactory settlement is not effected in the grievance procedure, either the NBRA or the NBA may refer the matter to arbitration by sending the other party a writing requesting arbitration. A grievance with respect to which arbitration is not requested within thirty (30) days from the date on which the grievance is denied or deemed denied shall be deemed waived and shall be dismissed with prejudice.

(e) Arbitrator. Disputes referred to arbitration shall be decided by a neutral arbitrator mutually agreed upon by the parties. In the event the parties are unable to mutually agree upon the appointment of an arbitrator within ten (10) days of either side requesting arbitration, the parties shall jointly request that the American Arbitration Association furnish the parties with a list of nine (9) prominent, professional arbitrators from its national panel (limited

to those from the Mid-Atlantic and Northeastern states), all of whom must be members in good standing of the National Academy of Arbitrators. The parties shall alternate in striking names from the list until only the name of one person remains, and that person shall be deemed appointed as arbitrator. Except as otherwise provided in this Section 2(e), arbitration proceedings before the arbitrator shall be conducted in New York City and in accordance with the Labor Arbitration Rules of the American Arbitration Association.

(f) Scope of Arbitration. An arbitrator selected pursuant to this Article XV shall have no jurisdiction or authority to add to, detract from, or alter in any way the provisions of this Agreement. Nor, in the absence of agreement by the NBA and the NBRA, shall the arbitrator have jurisdiction or authority to resolve questions of substantive, as opposed to procedural, arbitrability, including the question of whether the arbitrator, as opposed to the Commissioner (or his designee) has jurisdiction to hear or resolve a particular dispute. The arbitrator's award shall be in writing, shall constitute full, final and complete disposition of the grievance, and shall be binding upon the NBA, the NBRA, and any Referees involved.

(g) Costs of Arbitration. All costs of arbitration, including the fees and expenses of the impartial arbitrator, shall be borne equally by the parties, provided that each of the parties shall bear the cost of its own witnesses, counsel and the like.

Article XVI

Notices to the NBRA

Section 1. Notice of Rules.

The NBA shall provide the NBRA's General Counsel with copies of all rules and policy notices (including any statements of clarification of any previously issued rule or policy) issued to Referees as and when they are distributed to them, provided that any changes, suspensions, or supplements to the Work Rules shall be subject to the procedure set forth in Article XI, Section 4(a)(i).

Section 2. Notice of Discipline.

The NBA shall provide the NBRA's General Counsel with copies of all Referee discipline notices by email and hard copy delivery. The email copy will be sent when the notice is released or mailed to the affected Referee.

Article XVII

Integration; Governing Law; Miscellaneous

Section 1. Integration.

This Agreement constitutes the entire understanding between the parties, shall govern their entire relationship, and shall be the sole source of any and all rights or claims which may be asserted in arbitration hereunder or otherwise. All understandings, conversations and communications, as well as all prior agreements (except as specifically set forth herein), oral or written, expressed or implied, between the NBA and the NBRA and/or any representative of either, are merged into and superseded by this Agreement and shall be of no force or effect. This Agreement may not be modified, altered, or amended, except by a writing signed by both parties.

Section 2. Governing Law.

This Agreement is made under and shall be governed by the internal law of the State of New York, except where United States federal law may govern. No action with respect to this Agreement shall be brought or maintained in any court other than the United States District Court for the Southern District of New York or the Supreme Court of the State of New York, New York County.

Section 3. Miscellaneous.

(a) In the event that any provision of this Agreement is found to be inconsistent with the Internal Revenue Code (or the rules and regulations issued thereunder), the National Labor Relations Act, any other federal, state, provincial, or local statute or ordinance, or the rules and regulations of any other government agency, or is determined to have an adverse effect upon the right of the NBA (or any successor entity) to a tax exemption under Section 501(c) (6) of the Internal Revenue Code of 1954 (or any successor section of like

import), then the parties hereto agree to make such changes as are necessary to avoid such inconsistency or to obtain or maintain such exemption retaining, to the extent possible, the intention of such provision.

(b) In the event the NBA does not take an action otherwise required by this Agreement on the ground that such action would violate the law of any jurisdiction, it will notify the General Counsel of the NBRA in writing.

(c) The headings and organization of this Agreement are solely for the convenience of the parties, and shall not be deemed part of, or considered in construing or interpreting, this Agreement.

(d) All of the Exhibits hereto are an integral part of this Agreement and of the agreement of the parties thereto.

Article XVIII

Term of Agreement

This Agreement shall be effective from September 1, 2022, and shall continue in full force and effect until September 1, 2029.

NBA SERVICES CORP.

By: DocuSigned by: Byron Spruell 7A43E77E1F2C4EA...

Byron Spruell
President, League Operations

NATIONAL BASKETBALL REFEREES ASSOCIATION

By:

Lee Seham
Bargaining Representative

By:

James Capers
Member, Executive Board

By:

Marc Davis
Member, Executive Board

By:

John Goble
Member, Executive Board

By:

Rodney Mott
Member, Executive Board

By:

Zach Zarba
Member, Executive Board

EXHIBIT A

YEARS OF SERVICE SCHEDULE

Years of Service as of Conclusion of 2021-22 Season
(Credited as of June 30, 2022)

Referee	Years of Service
Conley, John	1
Schwab, Brandon	1
Scott, Danielle	1
Jelks, Simone	2
Mehta, Suyash	2
Nagy, Andy	2
Butler, John	3
Green, Nate	3
Schroeder, Jenna	3
Scott, Evan	3
Adair, Brandon	4
Dagher, Mousa	4
Moyer-Gleich, Ashley	4
Myers, Matt	4
Ransom, Phenizee	4
Sago, Natalie	4
Acosta, Ray	5
DeRosa, JB	5
Goldenberg, Jason	5
Sterling, Jonathan	5
Goble, Jacyn	6
Nansel, Brett	6
Smith, Aaron	6
Washington, CJ	6
Ervin, Mitchell	7
Ford, Tyler	7
Petraitis,Gediminas	7
Holtkamp, Lauren	8
Taylor, Dedric	8
Van Duyne, Justin	8
Taylor, Ben	9
Lane, Karl	11
Maddox, Tre	11

Orr, JT	11
Scott, Kevin	11
Twadorski, Scott	11
Barnaky, Brent	12
Buchert, Nick	12
Cutler, Kevin	12
Tiven, Josh	12
Williams, James	12
Fitzgerald, Kane	13
Kogut, Marat	13
Workman, Haywoode	13
Blair, Curtis	14
Dalen, Eric	14
Forte, Brian	15
Goble, John	15
Lindsay, Mark	15
Guthrie, David	17
Wright, Sean	17
Lewis, Eric	18
Boland, Matt	19
Zarba, Zach	19
Brown, Tony	20
Malloy, Ed	20
Collins, Derrick	21
Fraher, Pat	21
Kirkland, Courtney	22
Davis, Marc	24
Kennedy, Bill	24
Mott, Rodney	24
Richardson, Derek	25
Wood, Leon	26
Adams, Bennie	27
Capers, James	27
Corbin, Sean	27
Wall, Scott	27
Brothers, Tony	28
Foster, Scott	28
Smith, Michael	29
Washington, Tom	31

EXHIBIT B

ELECTION TO ARBITRATE

By signing below, you confirm that you have elected to have all discrimination claims arising out of the same transaction or facts underlying the attached grievance referred to arbitration in accordance with Article II, Section 4 and Article XV, Section 2(d) of the Collective Bargaining Agreement between NBA Services Corp. ("NBA") and the National Basketball Referees Association ("NBRA") made and entered into as of September 12, 2022 (the "CBA"). Your election means that your claims will be decided by final and binding arbitration under Article XV of the CBA, and you have given up the ability to file suit or seek any relief about any issue related to your claims in any court or other forum (except as set forth below). The award rendered by the arbitrator may be entered as a judgment by a court of competent jurisdiction.

All procedures and remedies that would be available in a court of law will be available in arbitration. Your election to arbitrate is completely voluntary, and nothing herein will preclude you from pursuing a claim with the Equal Employment Opportunity Commission or other administrative agency. You should consult with an NBRA representative and/or a private attorney before signing this Election To Arbitrate.

I have read and understand the foregoing and confirm my election to resolve all discrimination claims arising out of my employment through the arbitration procedure provided by the CBA. I understand that by signing below I agree that the arbitration shall be the final and binding remedy for my claims.

_____ _____

Signature Date

_____

Print Name

UnitedHealthcare Insurance Company

UnitedHealthcare Choice Plus

Certificate of Coverage, Riders, Amendments, and Notices

for

NBA SERVICES CORP.

Group Number: G/GA8N8038NM **Health Plan:** BS - RH **Prescription Code:** S5
Effective Date: October 1, 2021

Offered and Underwritten by
UnitedHealthcare Insurance Company

Riders, Amendments, and Notices

begin immediately following the last page

of the Certificate of Coverage

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Group. The *Certificate* describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's *Application* and payment of the required Policy Charges.

In addition to this *Certificate,* the Policy includes:

- The *Schedule of Benefits.*
- The Group's *Application.*
- Riders, including the *Outpatient Prescription Drug Rider*.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate.* When this happens we will send you a new *Certificate,* Rider or Amendment.

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends.*

We are delivering the Policy in New Jersey . The Policy is subject to the laws of the state of New Jersey and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, New Jersey law governs the Policy.

Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms.*

How Do You Use This Document?

Read your entire *Certificate* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *Certificate* at www.myuhc.com.

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations.* Read *Section 8: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this *Certificate* and any summaries provided to you by the Group, this *Certificate* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact Us?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins.* To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Policy issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms.*

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. If you have questions about this, contact your Group.

Be Aware the Policy Does Not Pay for All Health Care Services

The Policy does not pay for all health care services. Benefits are limited to Covered Health Care Services. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

We understand that there are many variables that influence the decisions you make regarding your care, including the coverage available under this plan. However, final care decisions are between you and your Physician. Your Physicians are solely responsible for all health services that you receive.

Choose Your Physician

It is your responsibility to select the providers who will deliver your care. We arrange for Physicians and other providers and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other providers who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. **If you do not obtain prior authorization as required, the amount you are required to pay will be increased, as described in the** *Schedule of Benefits.* For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits.*

Pay Your Share

You must meet any applicable deductible and pay a Co-payment or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits.* You must also pay any amount that exceeds the Allowed Amount.

Please note: For bundled payments discussed in *Do We Pay Incentives to Providers?* in *Section 8: General Legal Provisions,* your Co-payment and/or Co-insurance will be calculated based on the provider type that received the bundled payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment and/or Co-insurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment and/or Co-insurance as described in your *Schedule of Benefits.*

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions.

Show Your ID Card

You should show your ID card or have your provider verify your eligibility by calling us every time you request health care services. If you do not show your ID card or have your provider verify your eligibility, the provider may fail to bill the correct entity for the services delivered. If you have not received your ID card from us, or if you have lost your ID card, please contact us as soon as possible. If you need to seek services and do not have your ID card, please direct your provider to verify your eligibility by calling us to ensure proper payment of claims.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you have the right to make an assignment of Benefits, whereby your provider may request payment from us. You may also request payment on your own behalf at your option. Claims must be filed in a format that contains all of the information we require, as described in *Section 5: How to File a Claim.*

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health care services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under the Policy for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether the Policy will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

Subject to your appeal rights set forth under *Section 6: Questions, Complaints and Appeal,* we will do the following:

- Make an initial interpretation of Benefits and the other terms, limitations and exclusions set out in this *Certificate,* the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may assign this authority to other persons or entities that may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Care Services

We pay Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits,* unless the service is excluded in *Section 2: Exclusions and Limitations.* This means we only pay our portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, we pay Benefits after we receive your or your out-of-Network provider's request for payment that includes all required information. See *Section 5: How to File a Claim.*

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT),* a publication of the *American Medical Association,* and/or the *Centers for Medicare and Medicaid Services (CMS).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service

billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at www.myuhc.com or the telephone number on your ID card.

We may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, we will use a comparable methodology(ies). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group.* Refer to our website at www.myuhc.com for informatio n regarding the vendor that provides the applicable methodology.

Offer Health Education Services to You

We may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms.)*
- You receive Covered Health Care Services while the Policy is in effect or during any extension of benefits period.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Policy.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Health Condition, Substance Use Disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Policy.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Co-payment and/or Co-insurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.

- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

2. Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services.*

3. Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI).)*
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs,* the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards *(IRBs)* before you are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Policy.

4. Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.
- Tetralogy of fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services.*

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for *CHD* services.

5. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Medicine, "M.D.", Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.".
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

6. Dental Services - Other

Services including surgery, general anesthesia and associated Hospital or Alternate Facility charges when the dentist and Physician determine that the services are necessary for the safe and effective treatment of one of the following:

- A dental condition.
- A medical condition covered under the Policy which requires hospitalization or general anesthesia for dental services rendered by a Doctor of Medicine, "M.D.", Doctor of Dental Surgery, "D.D.S.", or Doctor of Medical Dentistry, "D.M.D." regardless of where the dental services are provided.

Services are limited to Covered Persons who are one of the following:

- A child under 5 years of age.
- A person who is severely disabled.

Services for the diagnosis or treatment of a dental disease are not Covered Health Care Services.

7. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services to ensure that a person with diabetes is educated regarding the proper self-management and treatment of their diabetic condition, including information on proper diet. Services must be ordered by a Physician and provided by appropriately licensed or registered providers.

Covered Health Care Services for self-management and diet education are limited to the following:

- Visits as Medically Necessary upon the diagnosis of diabetes.
- Visits as Medically Necessary upon diagnosis by a Physician or nurse practitioner/clinical nurse specialist of a significant change in the person's symptoms or conditions which necessitate changes in that person's self-management.
- Visits as Medically Necessary upon the determination of a Physician or nurse practitioner/ clinical nurse specialist that reeducation or refresher education is necessary.

Diabetes self-management education must be provided by one of the following:

- A dietitian who is registered by a nationally-recognized professional association of dietitians.
- A provider recognized as a certified diabetes educator by the *American Association of Diabetes Educators.*

A registered pharmacist qualified regarding management education for diabetes by any institution recognized by the *Board of Pharmacy* of the State of New Jersey.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment (DME) and Supplies.* Benefits for blood glucose meters including continuous glucose monitors and blood glucose monitors for the legally blind, insulin syringes with needles, test strips for blood glucose monitors and visual reading and urine test strips, ketone test strips and tablets, insulin, injection aids, oral agents for controlling blood sugar and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider.*

8. Durable Medical Equipment (DME) and Supplies

Benefits are provided for DME and certain supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Mobility Devices.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services.*
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate.*

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998.*

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits.*

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations,* under *Medical Supplies and Equipment.*

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate.*

9. Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits are not available for services to treat a condition that does not meet the definition of an Emergency. This exclusion does not apply to the medical screening exam required to determine whether an Emergency exists.

10. Enteral Nutrition

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies.
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

For the purpose of this Benefit, "enteral formulas" include:

- Amino acid-based elemental formulas.
- Extensively hydrolyzed protein formulas.
- Modified nutrient content formulas.

For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment;
- Chronic physical disability;
- Intellectual disability; or
- Loss of life.

Donated Human Breast Milk

Benefits are provided for donated human breast milk for Covered Persons under the age of six months subject to the following conditions:

- The Covered Person is medically or physically unable to receive maternal breast milk or participate in breast feeding, or the Covered Person's mother is medically or physically unable to produce breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; and
- The Covered Person's practitioner issued an order for the donated human breast milk.

We also cover pasteurized donated human breast milk as ordered by the Covered Person's practitioner for Covered Persons under the age of six months if the Covered Person meets any of the following conditions:

- A body weight below healthy levels determined by the Covered Person's practitioner;
- A congenital or acquired condition that places the Covered Person at a high risk for development of necrotizing enterocolitis; or
- A congenital or acquired condition that may benefit from the use of donor breast milk as determined by the New Jersey Department of Health.

As used in this provision, pasteurized donated human breast milk means milk obtained from a human milk bank that meets the quality guidelines established by the New Jersey Department of Health. If there is no supply of human breast milk that meets such guidelines there will be no coverage under this provision.

The pasteurized donated human breast milk may include human milk fortifiers if indicated by the Covered Person's practitioner.

11. Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause infertility such as chemotherapy, radiation treatment, and oophorectomy due to cancer. Services include the following procedures:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under your *Outpatient Prescription Drug Rider* or under *Pharmaceutical Products* in this section.

Benefits are not available future implantation.

Benefits are not available for long-term storage costs (greater than one year).

12. Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

13. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition to learn, improve or keep skills and functioning for daily living. We will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative Benefits under this section do not include physical therapy, occupational therapy or speech therapy for Autism Spectrum Disorder or other Developmental Disabilities. Benefits for these services are payable as described in *Mental Health Condition and Substance Use Disorder Services.*

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- Treatment is administered by any of the following:
  - Licensed speech-language pathologist.
  - Licensed audiologist.
  - Licensed occupational therapist.
  - Licensed physical therapist.
  - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential Treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided:

- Treatment plan.
- Medical records.
- Clinical notes.
- Other necessary data to allow us to prove that medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress that is capable of being demonstrated, we may request a treatment plan that includes:

- Diagnosis.
- Proposed treatment by type, frequency, and expected duration of treatment.
- Expected treatment goals.
- Frequency of treatment plan updates.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care.* Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME) and Supplies* and *Prosthetic Devices and Orthotics.*

14. Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear.

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing aid, associated accessories, and associated fitting charges, testing and repair of a hearing aid.

For Covered Persons age 16 and older, if more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, we will pay only the amount that we would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this Certificate. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

15. Hearing Loss Screening

Covered Health Care Services include screening for newborn hearing loss by appropriate electro physiologic screening measures and periodic monitoring of infants for delayed onset hearing loss. No Copayment amount or Annual Deductible applies to these Benefits.

16. Hemophilia Services

Covered Health Care Services include home treatment of routine bleeding episodes due to hemophilia. The treatment must be supervised by a state-approved hemophilia treatment center. Benefits are provided for blood products including, but not limited to Factor VIII, Factor IX and Cryoprecipitate as well as blood infusion equipment including, but not limited to, syringes and needles.

17. Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required or when continued hospitalization would otherwise be required.

Benefits are available for full-time nursing care and full-time care by an aide on a short-term basis if needed. Home Health Agency services include physical, occupational, or speech therapy, medical social work and nutritional services.

Benefits are available for the following items to the extent that they would have been available if the Covered Person were confined in a Hospital:

- Medical supplies.
- Drugs and medications ordered by a Physician.
- Laboratory services given or ordered in a Hospital.
- Special meals.
- Diagnostic, therapeutic or surgical services provided on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for

Physician-directed medical management.

18. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call us at the telephone number on your ID card for information about our guidelines for hospice care.

19. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours following a simple mastectomy.
- 72 hours following a modified radical mastectomy.

If you agree, the attending provider may discharge you earlier than these minimum time frames.

Your cost share for Covered Health Care Services rendered during a hospitalization in a Network Hospital will be limited to the Co-payment, deductible or Co-insurance applicable to Network services as long as all request for prior authorization requirements have been met. Please refer to your Schedule of Benefits for the Co-payment, deductible, Co-insurance and prior authorization requirements that apply to your plan. This applies to Covered Health Care Services received at a Network Hospital regardless of whether the admitting Physician is a Network or out-of-Network provider. However, although the inpatient services will be treated as Network services, the services of the out-of-Network admitting Physician will be treated as out-of-Network services.

20. Infertility Services

Benefits will be provided to the same extent as for any other medical condition under the Policy. Diagnosis and treatment of Infertility including but not limited to:

- Diagnosis and diagnostic tests.
- Medications.
- Surgery.
- Gamete intrafallopian transfer.
- Four completed egg retrievals per Covered Person while covered under this plan or any plan with the same employer.
- Medical costs of egg and sperm donors.
- Benefits for gamete intrafallopian transfer are limited to a Covered Person who meets all of the following conditions:
- The Covered Person has used all reasonable, less expensive and Medically Necessary treatments and is still unable to become pregnant or carry a pregnancy.
- The Covered Person has not reached the limit of four completed egg retrievals.
- The Covered Person is 45 years of age or younger.

Services must be performed at facilities that conform to standards established by the *American Society for Reproductive Medicine* or the *American College of Obstetrics and Gynecologists.*

For the purposes of this Benefit, "therapeutic donor insemination" means insemination with a donor sperm sample for the purpose of conceiving a child.

21. Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*
- Prostate cancer screening which includes an annual diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services.*

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient.*

22. Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services, including digital tomosynthesis, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

23. Mental Health Condition and Substance Use Disorder Services

Mental Health Condition and Substance Use Disorder Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office subject to the Same Terms and Conditions that apply to other medical or surgical benefits. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.

- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Mental Health Condition Services for Autism Spectrum Disorder include Behavioral Interventions Based on *Applied Behavioral Analysis (ABA)* and Related Structured Behavioral Programs as prescribed through a treatment plan.

Substance Use Disorder Services are provided at Network Facilities subject to the following:

- the prospective determination of medical necessity is made by the Covered Person's practitioner for the first 180 days of treatment during each year and for the balance of the year the determination of medical necessity is made by us;
- Prior Authorization is not required for the first 180 days of inpatient and/or outpatient treatment during each year but may be required for inpatient treatment for the balance of the year;
- concurrent and retrospective review are not required for the first 28 days of inpatient treatment during each year but concurrent and retrospective review may be required for the balance of the year;
- retrospective review is not required for the first 28 days of intensive outpatient and partial hospitalization services during each year but retrospective review may be required for the balance of the year;
- retrospective review is not required for the first 180 days of outpatient treatment including outpatient prescription drugs, during each year but retrospective review may be required for the balance of the year; and
- If no Network Facility is available to provide in-patient services, we shall approve an in-plan exception and provide benefits for in-patient services at an Out-of-Network Facility.
- The first 180 days per plan year assumes 180 inpatient days whether consecutive or intermittent. Extended outpatient services such as Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment are counted as inpatient days. Any unused inpatient days may be exchanged for two outpatient visits.

Please note: Benefits for days 29 and after of inpatient care will be subject to concurrent review. A request for approval of inpatient care beyond the first 28 days must be submitted for concurrent review before the expiration of the initial 28-day period. A request for approval of inpatient care beyond any period that is approved under concurrent review must be submitted within the period that was previously approved.

We will not initiate concurrent review more frequently than at two-week intervals. If we determine that continued inpatient care is no longer Medically Necessary, we will provide written notice within 24 hours to the Covered Person and the Covered Person's Physician of the decision and the right to file an appeal, as described in *Appeals for Inpatient Substance Use Disorder Services* in *Section 6: Questions, Complaints and Appeals.*

The Mental Health Condition/Substance Use Disorder Designee provides administrative services for all levels of care.

We encourage you, but do not require you, to contact the Mental Health Condition/Substance Use Disorder Designee for referrals to providers and coordination of care.

Autism Spectrum Disorder and Other Developmental Disabilities Habilitative Services:

For Covered Persons with a primary diagnosis of Autism Spectrum Disorder or another Developmental Disability, Benefits under this section include:

- Physical therapy provided by a licensed physical therapist.
- Speech and language pathology services provided by a licensed speech and language pathologist.
- Occupational therapy provided by a licensed occupational therapist.

Benefits for these therapies will be provided as prescribed through a treatment plan and will not be denied on the basis that the treatment is not restorative.

The treatment plan must include all elements necessary to appropriately provide Benefits, including, but not limited to:

- a diagnosis;
- proposed treatment by type, frequency, and duration;
- the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated;
- and the treating Physician's signature.

We may request an updated treatment plan once every six months from your Physician to review medical necessity, unless a more frequent review is agreed upon by us and your Physician, due to emerging clinical circumstances.

New Jersey Early Intervention System (NJEIS) Family Cost Share Expense:

The *New Jersey Early Intervention System (NJEIS),* under the *Division of Family Health Services,* implements New Jersey's statewide system of services for infants and toddlers, birth to age three, with developmental delays or disabilities, and their families. *The Department of Health and Senior Services* is appointed by the Governor as the state lead agency for the *NJEIS.*

Benefits under this section include reimbursement of a portion of the family cost share expense incurred by Covered Persons for the provision of certain health care services obtained in accordance with a treatment plan developed as a result of, or in conjunction with, an Individualized Family Service Plan (IFSP) for a child determined eligible for early intervention services through the *NJEIS.*

The IFSP is both a plan and a process. The plan is a written document that identifies the outcomes, services and supports needed for the child and family. The process is ongoing assessment to gather, share, and exchange information between the family and the early intervention practitioners to help parents make informed choices about early intervention services and other needed services for the child and family.

The NJEIS family cost share is a progressive co-payment per hour of direct services provided in accordance with an IFSP that is based upon family size and NJEIS determined income along the federal poverty level guidelines. In order to be eligible for reimbursement, the Covered Person must:

a) Be eligible for early intervention services through the NJEIS;

b) Have been diagnosed with Autism Spectrum Disorder or another Developmental Disability; and

c) Received physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services.

The portion of the family cost share attributable to such services is a Covered Health Care Service under the Policy.

The therapy services a Covered Person received through NJEIS do not reduce the therapy services otherwise available under the Policy.

24. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

25. Pharmaceutical Products - Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *Certificate.* Benefits for medication

normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Rider.*

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we may direct you to a Designated Dispensing Entity. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

26. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

Second and third opinions:

Physician fees for a second opinion, including the review of the results of any laboratory and radiology essential to the second opinion, where another licensed Physician proposes to perform an elective inpatient surgical procedure on a Covered Person. For purposes of this Benefit, an inpatient surgical procedure is one which is scheduled at the convenience of the Covered Person or the Covered Person's Physician without jeopardizing the Covered Person's life or causing serious impairment to the Covered Person's bodily functions. If the second surgical opinion does not confirm that the proposed elective surgical procedure is medically advisable, then Physician Fees for a third surgical opinion shall be covered in the same manner as those covered for a second surgical opinion. A Physician providing a second or third surgical opinion shall be a Physician who is licensed to practice medicine and surgery who holds the rank of Diplomate of an American Board (M.D.) or Certified Specialist (O.D.) in the surgical or medical specialty for which surgery is proposed. In the event that the Physician who provides a second or third surgical opinion also performs the elective surgical procedure being proposed, then no Benefits for the second or third opinion will be paid to that Physician.

27. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered providers when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services.*

Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient.*

When a test is performed or a sample is drawn in the Physician's office, Benefits for the analysis or testing of a lab, radiology/X-ray or other diagnostic service, whether performed in or out of the Physician's office, are described under *Lab, X-ray and Diagnostic - Outpatient.*

28. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

We may also have special prenatal programs to help during Pregnancy. They are voluntary and there is no extra cost for taking part in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the expected date of delivery. It is important that you notify us regarding your Pregnancy.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

29. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

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

Benefits for the services below are required under New Jersey law:

- Screening and diagnostic mammography.
- Screening for colorectal cancer as follows:
  - Annual guaiac-based fecal occult blood test (gFOBT) with high test sensitivity for cancer.
  - Annual immunochemical-based fecal occult blood test (FIT) with high test sensitivity for cancer.
  - Stool DNA (sDNA) test with high test sensitivity for cancer.
  - Screening colonoscopy or Flexible sigmoidoscopy every five years.
  - Colonoscopy every ten years.
  - Double contract barium enema every five years.
  - Computed tomography colonography (virtual colonoscopy) every five years.
- A Pap smear including all laboratory costs associated with the pap smear and any confirmatory test.
- Cervical cancer screening.
- Screening for blood lead measurement for lead poisoning for children. Screening for blood lead measurement includes confirmatory blood lead testing and medical evaluation and any necessary medical follow-up and treatment of lead-poisoned children.
- Bone mineral density tests.

Health Wellness Exams

Benefits are provided for health wellness examinations which include the following tests and services:

- For Covered Persons 20 years of age and older, annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density liporotein (LDL) level and blood high-density lipoprotein (HDL) level.
- For Covered Persons 35 years of age or older, a glaucoma eye test every five years.
- For Covered Persons 40 years of age or older, an annual stool examination for presence of blood.
- For Covered Persons 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years.
- For women 20 years of age or older, a pap smear.
- For women 40 years of age or older, one baseline mammogram and annual mammogram examination. Benefits include coverage for digital tomosynthesis when used for the detection and screening of breast cancer.
- For women under 40 years of age who have a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed Medically Necessary by the woman's provider.
- For adult Covered Persons, recommended immunizations.
- Other tests and services recommended as Medically Necessary by a Physician.
- For all persons 20 years of age or older, an annual consultation with a Physician to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles.

In addition to the mammogram examinations listed above, we will cover an ultrasound evaluation, an MRI, a three-dimensional mammography, or other additional testing of an entire breast or breasts, after a baseline mammogram examination if one of the following conditions is met:

a) The mammogram demonstrates extremely dense breast tissue;

b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or

c) If the Covered Person has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the *Breast Imaging Reporting and Data System established by the American College of Radiology* or other indications as determined by the Covered Person's practitioner.

Breastfeeding Support Services

Benefits include comprehensive lactation support, counseling, and consultation, and the costs for renting or purchasing breastfeeding equipment, in conjunction with each birth, for the duration of breastfeeding for health plan enrollees.

Coverage of comprehensive lactation counseling and lactation consultation includes:

- In-person, one-on-one lactation counseling and lactation consultation, subject to the following conditions:
  - Includes visits that occur inside and outside a hospital or office setting. In-person lactation counseling and lactation consultation shall be covered regardless of location of service provision and shall include home visits.
  - Lactation counseling and lactation consultation will be made available within 24 hours of notification of need.
- Telephonic lactation assistance will be covered in addition to, and not as a substitute for, in-person, one-on-one lactation counseling or lactation consultation, when a Covered Person requests one-on-one, in-person lactation counseling or lactation consultation. The telephonic lactation assistance will be provided within 12 hours of notification of need.
- Group lactation counseling will be covered in addition to, and not as a substitute for, one-on-one, in-person lactation counseling or lactation consultation, if a Covered Person requests one-on-one, in-person lactation counseling or lactation consultation. Group counseling will include educational classes and support groups.

- We will not require prior authorization, prescription or referral for any lactation counseling or lactation consultation, regardless of provider type or setting.
- We will not not impose medical management techniques not described in this section.

Coverage of breastfeeding equipment shall include:

- Purchase of a single-user breast pump, subject to the following conditions:
  - We will cover the purchase of a double electric breast pump. If a Covered Person requests a manual pump in lieu of the double electric breast pump, we will cover the purchase of a manual pump.
  - A double electric breast pump provided shall be of sufficient power and durability to establish and maintain milk supply for the duration of breastfeeding.
  - We will not require documentation of medical necessity, prior authorization, or a prescription.
  - Coverage shall be available at any time during pregnancy and the postpartum period, and shall continue for the duration of breastfeeding as defined by the Covered Person.
  - Coverage for breast pumps shall include repair or replacement if necessary.
- Rental or purchase of a multi-user breast pump, on the recommendation of a licensed health care provider, subject to the following conditions:
  - When recommended by a licensed health care provider, we will provide coverage for a multiuser breast pump.
  - We may determine whether a rental or purchase is covered.
  - Coverage for a multi-user breast pump will be covered without regard to coverage or acquisition of a single-user breast pump.
  - We may require a letter of medical necessity from a lactation consultant or other health care provider for coverage of a multi-user pump. The letter shall not interfere with the timely acquisition of a multi-user pump.
- Coverage of breastfeeding equipment under this section shall include two breast pump kits per birth event, as well as appropriate size breast pump flanges, or other lactation accessories recommended by a health care provider.
- Single-user breast pumps and breast pump kits specified above will be furnished: within 48 hours of notification of need, if requested after the birth of the child; or by the later of two weeks before the Covered Person's expected due date or 72 hours after notification, if requested prior to the birth of the child. If we cannot ensure a Covered Person receives breastfeeding equipment within 48 hours, they may purchase the equipment and we will reimburse all out-of-pocket expenses incurred by the Covered Person, including any balance billing amounts.
- Multi-user breast pumps shall be made available within 12 hours of notification of need. If equipment is not available within 12 hours of notification of need, we will reimburse all out-of-pocket rental expenses incurred by a Covered Person, including any balance billing amounts, until the Covered Person receives breastfeeding equipment.

30. Prosthetic Devices and Orthotics

Prosthetics

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998.* Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME) and Supplies.*

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prosthesis. Internal prosthetics are a Covered Health Care Service for which

Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate.*

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Orthotics

Orthotics that straighten or re-shape a body part. For the purpose of this Benefit this refers to a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

The prosthetic device or orthotic must be ordered or provided by, or under the direction of a Physician who deems the device to be Medically Necessary and must be obtained from a licensed orthotist or prosthetist, or any certified pedorthist.

Benefits are available for repairs and replacement, if deemed to be Medically Necessary by a Physician.

Reimbursement for these items will be at the same rate as under the federal Medicare reimbursement schedule.

31. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly.

Reconstructive procedures include the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children. These procedures that correct an anatomical Congenial Anomaly are not considered Cosmetic Procedures.

Cosmetic Procedures are excluded from coverage. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury or Sickness does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998,* including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

32. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care.* Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

33. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient.*

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

Benefits that apply to certain preventive screenings are described under *Preventive Care Services.*

34. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

35. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal, ear wax removal, and cast application.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

36. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered providers when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.*

37. Transplantation Services

Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.

- Cornea.

Benefits are available for the treatment of Wilms' tumor, including autologous bone marrow transplants when standard chemotherapy is unsuccessful, even when such treatment is considered Experimental or Investigational.

Treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants are a Covered Health Care Service for which Benefits are payable when performed at a Provider that is approved by the National Cancer Institute or performed pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Policy, limited to donor:

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

Transplantation services must be performed at our Designated Facilities in order to receive Network Benefits. Refer to the *Schedule of Benefits* for applicable prior authorization requirements. Please note that not all Network Hospitals are contracted to perform transplants. Please refer to your provider directory or contact us to find out which Hospitals are contracted for this service.

If you reside more than 50 miles from the Designated Facility and are required to travel to obtain transplantation services from the Designated Facility, we will provide for reimbursement of travel and lodging expenses for the Covered Person and one companion. Coverage is limited to $50-$100 lodging per day, up to a maximum Benefit of $10,000 per lifetime.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for transplant services.

38. Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury.*

39. Urinary Catheters

Benefits for indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

40. Virtual Visits

Virtual visits are available via Telehealth or Telemedicine for Covered Health Care Services that include the diagnosis and treatment of less serious, non-emergent medical conditions, including but not limited to, flu, colds, pink eye, rashes and fevers. Virtual visits provide communication of medical information in realtime between the patient and a distant Physician or health specialist, through use of live audio and video technology or audio only outside of a medical facility (for example, from home or from work).

For the purposes of this Benefit, the following definitions apply:

"Telehealth means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, Practitioner consultation, patient and professional health-related education, public health, health administration, and other services in accordance with the provisions of P.L. 2017, c. 117."

"Telemedicine means the delivery of a health care service using electronic communications, information

technology, or other electronic or technological means to bridge the physical distance between a Practitioner and a Covered Person, either with or without the assistance of an intervening Practitioner, and in accordance with the provisions of P.L. 2017, c.117. Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission."

Benefits are available under this Benefit only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

Please Note: Not all medical conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, text or instant-messaging, fax, or for telehealth/telemedicine visits that occur within medical facilities *(CMS* defined originating facilities).

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

To help you find exclusions, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through a Rider to the Policy.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services,* those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits.* Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
7. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health.* This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services.*

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* and Dental Services - Other in *Section 1: Covered Health Care Services.*

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* and Dental Services - Other in *Section 1: Covered Health Care Services.*
3. Dental implants, bone grafts and other implant-related procedures. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* and Dental Services - Other in *Section 1: Covered Health Care Services.*
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly except for treatment of medically diagnosed congenital birth defects and birth abnormalities in Dependents that have been covered under the Certificate from the moment of birth.

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
4. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME) and Supplies* in *Section 1: Covered Health Care Services.*
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.

8. Powered and non-powered exoskeleton devices.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to oral agents for controlling blood sugar or to medications used to treat infertility for which Benefits are provided as described under *Diabetes Services* and *Infertility Services* in *Section 1: Covered Health Care Services.*
2. Self-administered or self-infused medications, except as described under the heading *Diabetes Services* in *Section 1: Covered Health Care Services.* This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments. This exclusion does not apply to diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
5. Growth hormone therapy.
6. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services* or to the treatment for Wilm's tumor as described under *Transplantation Services* in *Section 1: Covered Health Care Services.*

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Arch supports.

G. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.

   This exclusion does not apply to:

   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME) and Supplies and Prosthetic Devices* in *Section 1: Covered Health Care Services.* This exception does not apply to supplies for the administration of medical food products.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
   - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Care Services.*
   - Urinary catheters and related urologic supplies for which Benefits are provided as described under *Urinary Catheters* in *Section 1: Covered Health Care Services.*

2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME) and Supplies* in *Section 1: Covered Health Care Services.*
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

H. Mental Health Condition and Substance Use Disorder

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations,* the exclusions listed directly below apply to services described under *Mental Health Condition and Substance Use Disorder Services* in *Section 1: Covered Health Care Services.*

1. Services performed in connection with conditions not in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be Mental Health Conditions within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
3. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This does not apply to Behavioral Interventions based on *Applied Behavioral Analysis (ABA)* or any Benefits payable under *New Jersey Early Intervention Family Cost Share Expense* in the *Mental Health Condition and Substance Use Disorder Services section.*
4. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*
5. Transitional Living services.

I. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided

as part of treatment for a disease by appropriately licensed or registered providers when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

2. Food of any kind, infant formula, standard milk-based formula and donor breast milk. This exclusion does not apply to enteral formula, donated human breast milk and other modified food products for which Benefits are provided as described under Enteral Nutrition in Section 1: Covered Health Care Services.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

J. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under *Preventive Care Services.*
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot and cold compresses.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
   - Saunas.
   - Stair lifts and stair glides.
   - Strollers.
   - Safety equipment.

- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms.* Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means.

   We pay Benefits for the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

L. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, Autism Spectrum Disorder or another Developmental Disability.
5. Habilitative services for preventive treatment.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
7. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
8. Biofeedback.

9. Services for the evaluation and treatment of (TMJ), whether the services are considered to be medical or dental in nature.

10. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.

11. Surgical and non-surgical treatment of obesity.

12. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

13. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*

14. Helicobacter pylori (H. pylori) serologic testing.

15. Intracellular micronutrient testing.

16. Health care services provided in the emergency department of a Hospital or Alternate Facility that are not for an Emergency.

M. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal address.

3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

   - Has not been involved in your medical care prior to ordering the service, or
   - Is not involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

N. Reproduction

1. The following Infertility treatment-related services:

   - Cryo-preservation and other forms of preservation of reproductive materials. This exclusion does not apply to cryo-preservation when used as standard fertility preservation when medical treatment may cause *Iatrogenic Infertility.*
   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Infertility treatment for infertility resulting from voluntary sterilization procedures.

2. The following services related to a Gestational Carrier or Surrogate:

   - All costs related to reproductive techniques including:
     - Assistive Reproductive Technology (ART).
     - Artificial insemination.
     - Intrauterine insemination.

- ♦ Obtaining and transferring embryo(s).

  The exclusion for costs related to reproductive techniques does not apply when the Gestational Carrier or Surrogate is a Covered Person for whom Benefits are provided as described under *Infertility Services* in *Section 1: Covered Health Care Services.*

- Health care services including:
  - ♦ Inpatient or outpatient prenatal care and/or preventive care.
  - ♦ Screenings and/or diagnostic testing.
  - ♦ Delivery and post-natal care.

  The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

- All fees including:
  - ♦ Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
  - ♦ Surrogate insurance premiums.
  - ♦ Travel or transportation fees.

3. The reversal of voluntary sterilization.
4. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of infertility.

O. Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities:
   - as a result of war or an act of war, if the illness or Injury occurs while you are serving in the military, naval or air forces of any country, combination of countries or international organization; and
   - as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the illness or Injury occurs while you are serving in such forces and are outside the United States and Canada.
4. Health care services during active military duty:
   - as a result of war or an act of war, if the illness or Injury occurs while you are serving in the military, naval or air forces of any country, combination of countries or international organization; and
   - as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the illness or Injury occurs while you are serving in such forces and are outside the United States and Canada.

P. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services.*
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health care services for transplants involving animal organs.

4. Transplant services not received from a Designated Provider will not be paid on a Network basis. Out-of-Network Benefits will apply, if applicable. This exclusion does not apply to cornea transplants.

Q. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back as determined by us. Refer to *Transplantation Services* in *Section 1: Covered Health Care Services* for more information. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services.*

R. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care regardless of whether provided in a home setting or in a facility.
3. Private Duty Nursing.
4. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services.*
5. Rest cures.
6. Services of personal care aides.
7. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

S. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Routine vision exams, including refractive exams to determine the need for vision correction.
3. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Bone anchored hearing aids except when either of the following applies:
   - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
   - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

   More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Policy.

   Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

T. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Health Condition, Substance Use Disorder, condition, disease or its symptoms.
   - Medically Necessary.
   - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations.*
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war:
   - as a result of war or an act of war, if the illness or Injury occurs while you are serving in any civilian non-combatant unit supporting or accompany any military, naval or air forces of any country, combination of countries or international organization; and
   - as a result of the special hazards incident to service in any civilian non-combatant unit supporting or accompanying such forces, provided the illness or Injury occurs while you are serving in such unit and are outside the United States and Canada.
4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived.
7. Charges in excess of the Allowed Amount or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Group. The Group will submit the completed forms to us, along with any required Premium. We will not provide Benefits for health care services that you receive before your effective date of coverage.

What If You Are Hospitalized When Your Coverage Begins?

We will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Policy.

These Benefits will be paid by us unless they are being paid by a prior carrier under such prior carrier's obligations with respect to extension of benefits under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Care Services from Network providers unless rendered to treat an Emergency as described in the Emergency Health Care Services Benefit in *Section 1: Covered Health Care Services* section. Covered Health Care Services received in accordance with the Emergency Health Care Services Benefit will be treated as Network Benefits regardless of whether the services were rendered by a Network or an out-of-Network provider.

Who Is Eligible for Coverage?

The Group determines who is eligible to enroll and who qualifies as a Dependent. Please contact the Benefits administrator of the Group for information on who they have determined is eligible to enroll under this Policy.

Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms.*

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms.*

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

The term spouse also includes Civil Union Partners as defined by, and in accordance with New Jersey law and the valid laws of another jurisdiction under which a civil union relationship was created.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

For a description of the *State of New Jersey Continuation for Over-Age Dependents, see Section 4: When Coverage Ends.*

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth. Coverage for a newborn child begins at the moment of birth and continues for 60 days as if the child were enrolled, without additional Premium for these 60 days.
- Legal adoption.
- Placement for adoption.
- Marriage or civil union.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage or civil union.

- Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP).* Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including legal separation, divorce, dissolution of a civil union or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
  - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
  - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP).* Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Unless you are entitled to *Extended Coverage for Total Disability,* your right to Benefits automatically ends on the date that coverage ends, even if you are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, we will still pay claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Please note that if you are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent." You must notify us when a child no longer meets the requirements for Dependent coverage. If we are not notified, the Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions. Refer to the definition of "Dependent" in *Section 9: Defined Terms* for requirements of Dependent coverage.

- **We Receive Notice to End Coverage**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends on the last day of the calendar month in which we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later.

- **Subscriber Retires or Is Pensioned**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Group's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's Application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Group can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 30 days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. In this case, we will also refund the Premiums that were paid to us for your coverage.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of intellectual disability or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental, or physical disability.
- The Enrolled Dependent child depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent child is incapacitated and dependent unless coverage otherwise ends in accordance with the terms of the Policy.

You must furnish us with proof of the incapacity and dependency within 31 days of the date coverage would have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that exam.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year.

If you do not provide proof of the child's incapacity and dependency within 31 days of our request as described above, coverage for that child will end.

Extended Coverage for Total Disability

Coverage when you are Totally Disabled on the date the entire Policy ends will not end automatically. We will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Twelve months from the date coverage would have ended when the entire Policy ends.
- The date maximum Benefits under the Policy have been received.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA.* Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA.*

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

New Jersey Continuation Rights for Over-Age Dependents (NJCROD)

A dependent who has elected to continue his or her coverage under the group policy under which his or her parent is currently covered pursuant to NJCROD shall not be entitled to further continue coverage under COBRA when continuation pursuant to NJCROD ends. As used in this provision, "Over-Age Dependent" means an Employee's child by blood or law who:

- Has reached the limiting age as described in this *Certificate of Coverage* , under *Section 9: Defined Terms*, but is less than 31 years of age;
- Is not married or part of a civil union or part of a domestic partnership;
- Has no Dependents of his or her own;
- Is either a resident of New Jersey or in enrolled as a Full-time Student at an accredited school; and
- Is not covered under any other group or individual health benefits plan, group health plan, church plan, or health benefits plan, and is not entitled to Medicare.

Eligibility for Continuation through NJCROD

If a Dependent child's group health benefits end or have ended due to his or her attainment of the limiting age described in this Certificate of Coverage, he or she may elect to continue such benefits until his or her 31st birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends sections below.

Conditions for Election - An Over-Age Dependent is only entitled to make an election for continued coverage if all of the following conditions are met:

- The Over-Age-Dependent must provide evidence of prior creditable coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan or Medicare. Such prior coverage must have been in effect on the date the Over-Age-Dependent reached the limiting age, or at any time after such date but prior to making an election for this Over-Age-Dependent coverage.
- The Subscriber of an Over-Age Dependent must be enrolled as having elected Dependent coverage at the time the Over-Age Dependent elects continued coverage. Except, if the employee has no other Dependents, or has a spouse who is covered elsewhere, the Over-Age-Dependent may nevertheless select continued coverage.

Election of Continuation - To continue health benefits, the Over-Age Dependent must make written election to us. The effective date of the continued coverage will be the later of:

- The date the Over-Age Dependent gives written notice to us;
- The date the Over-Age Dependent pays the first premium; or
- The date the Dependent would otherwise lose coverage due to the attainment of the limiting age.

For a Dependent whose coverage has not yet terminated due to reaching the limiting age stated in this *Certificate of Coverage, Section 9: Defined Terms - Dependent,* the written election must be made within 30 days prior to termination of coverage due to the attainment of the limiting age.

For a person who did not qualify as an Over-Age Dependent because he or she fails to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election must be made within 30 days after the person first subsequently meets all of the requirements for an Over-Age Dependent.

This election opportunity is explained in greater detail as follows:

- If a person did not qualify because he or she was married or part of a civil union, the notice must be given within 30 days of the date he or she is no longer married.
- If a person did not qualify because he or she had a Dependent of his or her own, the election must be made within 30 days of the date her or she no longer has a Dependent.
- If a person did not qualify because he or she either was not a resident of New Jersey or was not a Full-time student at an accredited school, the election must be made within 30 days of the date he or she becomes a resident a New Jersey, or becomes a Full-time Student at an accredited school.
- If a person did not qualify because he or she was covered under another group or individual health benefits plan, group health plan, church plan or health benefits plan, or was entitled to Medicare, the election must

be made within 30 days of the date he or she is no longer covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or is no longer entitled to Medicare.

Each year there will be an Open Enrollment Period during which an Over-Age Dependent, who previously did not elect to continue coverage, may make an election to continue coverage. A group Open Enrollment Period will be held at least annually.

Application of a Pre-Existing Conditions Exclusion

An Over-Age Dependent who was covered under prior creditable coverage that terminated no more than 90 days prior to making an election for continuation under this section will be given credit for the time he or she was covered under the credible coverage toward the application of the Pre-Existing Conditions Exclusion under the Policy.

Premium Payments

The first month's Premium must be paid within 30 days of the date the Over-Age Dependent elects continued coverage.

The Over-Age Dependent must pay subsequent Premiums monthly, in advance, at the times and in the manner specified by us. The monthly Premium will be set by us, and must be consistent with the requirements of P.L. 2005, c.375.

Continued Benefits

The continued benefits shall be identical to the coverage provided to the Over-Age Dependent's Subscriber who is covered as an Employee under the Policy. If coverage is modified for Dependents who are under the limiting age, the coverage for Over-Age Dependent's Subscriber who is covered as an employee under the Policy. If coverage is modified for Dependents who are under the limiting age, the coverage for Over-Age Dependents shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

When Continuation Ends

An Over-Age Dependent's continued group health benefits end on the first of the following:

The date the Over-Age Dependent:

- Attains age 31;
- Marries or enters a civil union;
- Acquires a Dependent;
- Is no longer either a resident of New Jersey or enrolled as a Full-time Student at an accredited school; or
- Becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare.

- The end of the period for which Premium has been paid for the Over-Age Dependent, subject to the grace period for such payment;
- The date the Policy ceases to provide coverage to the Over-Age Dependent's Subscriber who is the employee under the Policy.
- The date the Policy under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.
- The date the Over-Age Dependent's Subscriber who is covered as an Employee under the Policy waives Dependent coverage. Except if the Subscriber has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Subscriber waiving Dependent coverage.

State Continuation of Coverage for Totally Disabled Subscribers

If a Subscriber's coverage stops because his or her employment ends and the Subscriber meets the conditions shown below, the Subscriber may choose to continue the coverage then in effect. The Subscriber must meet the following conditions:

- The Subscriber's employment ended because he or she is Totally Disabled.
- The Subscriber must have been covered under the Policy for at least three months before his or her coverage would have stopped.
- The Subscriber must choose to continue coverage within 31 days after the date his or her coverage would have stopped.
- The Subscriber will have to make payments to the Group for the coverage.

Coverage will stop on the earliest of the following:

- The date the Subscriber becomes employed and eligible for another plan of group health coverage.
- The date coverage ends for failure to make timely payment of the Premium.
- The date the Policy ends.

"Totally Disabled" for the purpose of this state continuation means the Subscriber's complete inability due to Injury or Sickness to engage in any and every gainful occupation for which the Subscriber is or becomes reasonably fitted by education, training or experience and that the Subscriber is not engaged in any gainful occupation.

Optional State Continuation of Coverage After the Subscriber's Death

If the Subscriber dies while covered, his or her Dependents' coverage may continue. It will continue with the same benefits and provisions that the Subscriber's Dependents had while the Subscriber was alive. It will continue only while the Policy is in force. It will stop on the earlier of the following:

- The date of the Subscriber's widow's or widower's death, or the date the last child stops being an eligible Dependent, whichever happens later.
- 180 days after the date of the Subscriber's death.

The Subscriber's Dependents will have to make payments to the Group for the coverage.

After the Subscriber's widow's or widower's death, coverage for the Subscriber's Dependent children may be continued. It will continue with the same Benefits and provisions that the Subscriber's Dependents had while the Subscriber's widow or widower was alive. It will continue according to the rules and time limits described above.

Conversion

If your coverage Ends for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

If your marriage or civil union is dissolved, the Subscriber's former spouse may buy conversion coverage. The conversion coverage will be an individual policy. The Subscriber's former spouse may apply for conversion coverage at either of the following times:

- The date the marriage or civil union is dissolved.
- At the end of any period of continuation of coverage under the Policy, but only if the Policy is in force on that date.

Application and payment of the first Premium must be made within 31 days after coverage ends under the Policy.

Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, contact us. However, you are required to meet any applicable deductible and to pay any required Co-payments and Co-insurance to a Network provider.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, if you make an assignment of Benefits, the out-of-Network provider is responsible for requesting payment from us. The out-of-Network provider must file the claim on the standard claim form prescribed by New Jersey that contains all of the information we require, as described below. At your option, you may also submit the claim to us directly.

Your out-of-Network provider should submit a request for payment of Benefits within 90 days after the date of service. If you have assigned benefits to the non-Network provider, as described below, the non-Network provider should submit a request for payment of Benefits within 180 days after the date of service. If this information is not provided to us within one year of the date of service, Benefits for that health care service will be denied or reduced, subject to the appeal provisions in *Section 6, Questions, Complaints and Appeals.* This time limit does not apply if it was not reasonably possible to submit the request in the time required and the request was submitted as soon as reasonably possible. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, we will provide you with the appropriate forms to submit proof of loss. You must submit the completed form to us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card.

When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum RX

PO Box 29077

Hot Springs, AR 71903

If you do not receive the forms for proof of loss within 15 days of our receipt of notice of a claim, you may submit written proof of loss describing the occurrence, character and extent of the loss for which the claim is being made.

Payment of Benefits

We will pay Benefits within the time frames shown below after we receive a request for payment that includes all required information.

- 30 days after we receive a request submitted by electronic means.
- 40 days after we receive a request submitted by other than electronic means. Requests for payment that include all required information which are not paid within these time frames will include an overdue payment of simple interest at the rate of 12% per annum.

If you provide written authorization to allow this, all or a portion of any Allowed Amounts due to a provider will be paid directly to the provider instead of being paid to the Subscriber. We will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

When an assignment is not obtained, we will send the reimbursement directly to the Subscriber for reimbursement to an out-of-Network provider. We may, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to an out-of-Network provider, and the out-of-Network provider submits a claim for payment, you and the out-of-Network provider represent and warrant the following:

- The Covered Health Care Services were actually provided.
- The Covered Health Care Services were Medically Necessary.

In accordance with New Jersey law, a consumer may request a review from the Ombudsman of any disputed insurance claim settlement where there is reasonable cause to believe than an insurer has failed or refused to settle a claim in accordance with the provisions of the policy. Consumers seeking a review must file a complaint with the Ombudsman in any form, which indicates that the complainant is seeking review of a disputed claim. All complaints must be sent to:

The Office of Insurance Claims Ombudsman

20 West State Street

P.O. Box 472

Trenton, NJ 08625-0472

Telephone: (800)446-7467

Telefax: (609)292-2431

Email: ombudsman@dobi.state.nj.us

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the appropriate address.

If the representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

If you are not satisfied with our decision, you have the right to take your complaint to the *New Jersey Department of Banking and Insurance.*

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a Rescission of Coverage determination, you can contact us in writing to request an appeal. You may also designate a representative (like your Physician) to appeal on your behalf.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a provider with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon

or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the Adverse Benefit Determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

There are two stages of internal appeals and one stage for external review. You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 10 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 180 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 20 business days from receipt of a request for review of the first level appeal decision. The second level appeal process will provide you (or your provider, if applicable) the opportunity to pursue your appeal before a panel of Physicians and/or other providers that we select who have not been previously involved in the decision being appealed. This will be considered our final Internal Adverse Benefit Determination.
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 10 business days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 180 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 20 business days from receipt of a request for review of the first level appeal decision. The second level appeal process will provide you (or your provider, if applicable) the opportunity to pursue your appeal before a panel of Physicians and/or other providers that we select who have not been previously involved in the decision being appealed. This will be considered our final Internal Adverse Benefit Determination.
- For appeals of benefit determinations concerning urgent or emergency care, an admission, availability of care, continued stay and health care services for which the claimant received emergency services but has not been discharged from a facility:
    - The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
    - We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
    - If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

This process does not apply to prescheduled treatments, therapies or surgeries.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 180 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 72 hours following receipt of your request for review of the first level appeal decision. This will be considered our final Internal Adverse Benefit Determination.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

If an Adverse Benefit Determination is upheld, the notice of our determination will be culturally and linguistically appropriate and will include information sufficient to identify the claim involved such as the date of service, the name of Your Provider, the claim amount (if applicable) as well as information on the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning. Please note that any request for such diagnosis and treatment information following an Adverse Benefit Determination will be responded to as soon as practicable, and the request itself will not be considered a request for the next level of appeal.

The notice will include the reasons for our decision, the clinical rationale, if applicable, and specific plan provisions on which the determination was based. It will include information on how to file the next level of appeal, if applicable, and any new or additional evidence or rationale, which we relied upon, considered or used in

making our decision. We will provide this information, when applicable, in advance of our final Internal Adverse Benefit Determination.

The notice will also include information on the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists covered persons with claims, internal appeals and external reviews.

You may have the right to external review through an *Independent Utilization Review Organization (IURO)* upon the completion or exhaustion of the internal appeal process and receipt of our final Adverse Benefit Determination. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

External Review Program

If you are not satisfied with the results of our internal appeal process, you may pursue an external review through an *Independent Utilization Review Organization ("IURO")* for final Internal Adverse Benefit Determinations, except where the final Internal Adverse Benefit Determination was based on eligibility, including Rescission of Coverage, or the application of a contract exclusion or limitation not related to medical necessity. You must complete both a first level and second level appeal before you can request a review by an *IURO,* except when:

- We fail to comply with any of the deadlines for completion of the internal appeals process without demonstrating good cause or because of matters beyond our control while in the context of an ongoing, good faith exchange of information between parties and it is not a pattern or practice of noncompliance;
- We for any reason expressly waives our rights to an internal review of any appeal; or
- You and/or Your Provider have applied for expedited external review at the same time as applying for an expedited internal review.

Please note that in such a case where we assert good cause for not meeting the deadlines of the appeals process, you may request a written explanation of the violation. We will provide the explanation within 10 days of the request and will include a specific description of the bases for which we determine the violation should not cause the internal appeals process to be exhausted. If an external reviewer or court agrees with us and rejects the request for immediate review, you will have the opportunity to resubmit your appeal.

To initiate the external review, you or your Designee must:

1. File a written request with the New Jersey Department of Banking and Insurance within 4 months of receiving a final Internal Adverse Benefit Determination on your appeal. The written request must be made on the form supplied to you by Us (enclosed with the appeal decision);
2. You must sign a release that will allow the *IURO* to review all of the necessary medical records that are related to the appeal; and
3. You must also include a check or money order in the amount of $25.00 made payable to: New Jersey Department of Banking and Insurance. Upon a determination of financial hardship, the fee may be waived. In such instances, you must show the Department that you are eligible for either: Pharmaceutical Assistance to the Aged and Disabled, Medicaid, General Assistance, SSI, or New Jersey Unemployment Assistance. Please note that annual filing fees for any one covered person shall not exceed $75.00.

The form, release and check must be sent to:

Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
PO Box 329
Trenton, NJ 08625-0329

Phone: (888) 393-1062

When the Department has all three items, they will assign your appeal to an *IURO.* When the *IURO* receives the appeal, it will conduct a preliminary review. It will accept your appeal for processing only if:

1. You are or were a member of the plan at the time of the event that is the subject of the Adverse Benefit Determination;

2. The service in question reasonably appears to be a Covered Health Care Service under the Certificate;

3. Unless we have failed to comply with the deadlines for completion of the internal appeals process without good cause; we have expressly waived our rights to an internal review; or you have applied for expedited external review at the same time as applying for an expedited internal review, you must have completed both an first level and a second level appeal; and

4. You have provided all information required by the *IURO* and the Department to make the preliminary determination, including the appeal form and a copy of any information provided by us regarding our decision to deny, reduce or terminate the Covered Health Care Service, and a fully executed release to obtain any necessary medical records from us and any other relevant health care provider.

Once the preliminary review is completed, the *IURO* will inform you or your designee, in writing, as to whether or not the appeal is accepted for processing, and if not, the reasons therefore. The *IURO* shall additionally notify you and/or your provider of your right to submit in writing, within five business days of receipt of the notice of acceptance of your appeal, any additional information to be considered in the *IURO's* review. The *IURO* shall provide us with any such additional information within one business day of receipt of the information.

If the appeal is accepted, the *IURO* will conduct a full review to determine whether, as a result of the our final Internal Adverse Benefit Determination, you were deprived of coverage of Covered Health Care Services. In reaching this determination the *IURO* shall take into consideration all pertinent medical records, consulting physician reports and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by us.

The review will be conducted by an expert physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final decisions of the *IURO* will be approved by the medical director of the *IURO,* who will be a New Jersey licensed physician.

The review will be completed within 45 days of the *IURO's* receipt of the appeal application. If the appeal involves care for urgent or emergency care, an admission, availability of care, continued stay, health care services for which the claimant received emergency services but has not been discharged from a facility or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the *IURO* shall complete its review within no more than 48 hours following its receipt of the appeal. If the *IURO's* determination of the appeal provided within no more than 48 hours was not in writing, the *IURO* shall provide written confirmation of its determination within 48 hours of providing the verbal determination.

If the *IURO* determines that the denial, reduction or termination of benefits deprived you of medically necessary Covered Health Care Services, it shall advise to you, your Provider, the Department of Banking and Insurance and us its decision regarding the appropriate, health care services that you should receive. The *IURO's* determination will be binding on both parties, except to the extent that other remedies are available to either party under State or Federal law. If all or part of the *IURO's* decision is in favor of you, we shall promptly provide coverage, including payment on the claim, for the health care services found by the *IURO* to be Covered Health Care Services. If you are not in agreement with the *IURO's* decision, you may seek the services outside of the health plan, at your own expense.

Within 10 business days of our receipt of the determination of the *IURO,* we will submit a written report to the *IURO,* you and/or your Provider, and the Department of Banking and Insurance, indicating how we will implement the *IURO's* determination.

It is your RESPONSIBILITY to initiate the external review process. Any member or any Provider acting on behalf of a member with the member's written consent may initiate the external appeal process by filing a completed application with the *New Jersey State Department of Banking and Insurance.*

Please note that we will provide continued coverage of an ongoing course of treatment pending the outcome of an active first level, second level appeal or external review.

Appeals for Inpatient Substance Use Disorder Services

Substance Use Disorder Services are provided as described in Section 1: Covered Health Care Services.

In the case of an Adverse Benefit Determination of an inpatient stay beyond the first 28 days during each plan year at a Network Facility, we will provide you and your Physician written notice within 24 hours. You or your Physician will then have the right to file an expedited internal appeal of our decision. We will provide you with a written or electronic determination of your appeal within 24 hours following receipt of your request for review of the determination.

If our determination is to uphold a denial, you or your Physician have the right to file an expedited external review through an Independent *Utilization Review Organization (IURO)* upon the completion of the expedited internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below. For instance, you may be covered by this Certificate as an employee and by another Plan as a Dependent of your spouse. If you are covered by more than one Plan, this provision allows us to coordinate what we pay or provide with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which you are covered.

Definitions

The words shown below have special meanings when used in this provision. Please read these definitions carefully. Throughout this provision, these defined terms appear with their initial letter capitalized.

Allowable Expense - The charge for any health care service, supply or other item of expense for which you are liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this Plan is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

We will not consider the difference between the cost of a private Hospital room and that of a semi-private Hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and appropriate.

When this Plan is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, we will only consider corresponding services, supplies or items of expense to which coordinati on of benefits applies as an Allowable Expense.

Claim Determination Period - A calendar year, or any portion of a calendar year, during which you are covered by this Plan and at least one other Plan and incur one or more Allowable Expense(s) under such Plans.

Plan - Coverage with which coordination of benefits is allowed. Plan includes:

- Group insurance and group Subscriber contracts, including insurance continued pursuant to a federal or state continuation law;
- Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a federal or state continuation law;
- Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a federal or state continuation law;
- Group hospital indemnity benefit amounts that exceed $150.00 per day;
- Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance Plan or non-governmental Plan.

Plan does not include:

- Individual or family insurance contracts or Subscriber contracts;
- Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice Plans;
- Group or group-type coverage where the cost of coverage is paid solely by you except that coverage being continued pursuant to a federal or state continuation law shall be considered a Plan;
- Group hospital indemnity benefit amounts of $150.00 per day or less;

- School accident-type coverage;
- A state Plan under Medicaid.

Primary Plan - A Plan whose benefits for your health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either of the below exist:

- The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits provision; or
- All Plans which cover you use order of benefit determination rules consistent with those contained in the Coordination of Benefits provision and under those rules, the plan determines its benefits first.

Reasonable and Customary - An amount that is not more than the usual or customary charge for the service or supply as determined by us, based on a standard which is most often charged for a given service by a provider within the same geographic area.

Secondary Plan - A Plan which is not a Primary Plan. If you are covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

We consider each Plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideratio n the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the Plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each claim determinati on period the Secondary Plan(s) will pay up to the remaining unpaid Allowable Expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "Procedures to be Followed by the Secondary Plan to Calculate Benefits" section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for Medically Necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Order of Benefit Determination Rules

The benefits of the Plan that covers you as an employee, member, Subscriber or retiree shall be determined before those of the Plan that covers you as a Dependent. The coverage as an employee, member, Subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers you as an employee who is neither laid off nor retired, or as a Dependent of such person, shall be determined before those for the Plan that covers you as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers you as an employee, member, Subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers you under a right of continuation pursuant to federal or state law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

- The benefits of the Plan of the parent whose birthday falls earlier in the calendar year shall be determined before those of the parent whose birthday falls later in the calendar year.

- If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the Plan which covered the other parent for a shorter period of time.
- "Birthday," as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
- If the other Plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

- The benefits of the Plan of the parent with custody of the child shall be determined first.
- The benefits of the Plan of the spouse of the parent with custody shall be determined second.
- The benefits of the Plan of the parent without custody shall be determined last.
- If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which Plan is the Primary Plan, the benefits of the Plan that covers the employee, member or Subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Effect on the Benefits of This Plan

In order to determine which procedure to follow it is necessary to consider:

- The basis on which the Primary Plan and the Secondary Plan pay benefits; and
- Whether the provider who provides or arranges the services and supplies is in the Network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the provider bills a charge and you may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a Network provider, bills a charge, you may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If you use the services of a non-Network provider, the Plan will be treated as an R&C Plan even though the Plan under which you are covered allows for a fee schedule.

Payment to the provider may be based on a "capitation". This means that the HMO or other Plan pays the provider a fixed amount per Covered Person. You are liable only for the applicable deductible, Coinsurance or Co-payment. If you use the services of a non-Network provider, the HMO or other Plan will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is R&C Plan and Secondary Plan is R&C Plan

The Secondary Plan shall pay the lesser of:

- The difference between the amount of the billed charges and the amount paid by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan and Secondary Plan is Fee Schedule Plan

If the provider is a Network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- The amount of any deductible, Co-insurance or Co-payment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and you shall not exceed the fee schedule of the Primary Plan. In no event shall you be responsible for any payment in excess of the Co-payment, Co-insurance or deductible of the Secondary Plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a Network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

- The difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

You shall only be liable for the Co-payment, deductible or Co-insurance under the Secondary Plan if you have no liability for Co-payment, deductible or Co-insurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall you be responsible for any payment in excess of the Co-payment, Co-insurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan

If the provider is a Network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- The amount of any deductible, Co-insurance or Co-payment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan

If the Primary Plan is an HMO plan that does not allow for the use of non-Network providers except in the event of urgent care or emergency care and the service or supply you receive from a non-Network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan

If you receive services or supplies from a provider who is in the Network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

- The amount of any deductible, Co-insurance or Co-payment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan

If you receive services or supplies from a provider who is in the Network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, Co-insurance or Co-payment imposed by the Primary Plan. You shall not be liable to pay any deductible, Co-insurance or Co-payments of either the Primary Plan or the Secondary Plan.

Primary Plan is an HMO and Secondary Plan is an HMO

If the Primary Plan is an HMO plan that does not allow for the use of non-Network providers except in the event of urgent care or emergency care and the service or supply you receive from a non-Network provider is not considered as urgent care or emergency care, but the provider is in the Network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan, except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's Policy will cover or pay for the health care that you may receive. The Policy pays for Covered Health Care Services, which are more fully described in this *Certificate.*
- The Policy may not pay for all treatments you or your Physician may believe are needed. If the Policy does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

What Is Our Relationship with Providers and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.

We do not provide health care services or supplies, or practice medicine. We arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. We are not responsible for any act or omission of any provider unless:

- It is determined by a court of law under the provisions of the *New Jersey Health Care Carrier Accountability Act, 2001* that the provider acted as our agent and that we had the right to exercise influence or control, or actually exercised influence or control over the health care treatment decisions of that provider.
- The other elements for establishing our liability under the Act are proven.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Policy. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Policy.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of when the Policy ends.

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor.*

What Is Your Relationship with Providers and Groups?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy unless it is contained in a written application signed by the Group. No such statement shall void or reduce coverage under the Policy or be used in defense of a legal action unless it is contained in a written application signed by the group or a Subscriber, as applicable.

Do We Pay Incentives to Providers?

We pay Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. Your Co-payment and/or Co-insurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment and/or Co-insurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment and/or Co-insurance as described in your *Schedule of Benefits.*

  For example, if we pay a bundled payment to the surgeon for a total knee replacement, your Co-Payment or Co-Insurance will be calculated based on specialist services. If you receive additional services that are included in the bundled payment, you will not be charged another Co-payment or Co-insurance.

We use various payment methods to pay specific Network providers. From time to time, the payment method

may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also call us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. Contact us at www.myuhc.com or the telephone number on your ID card if you have any questions.

Do We Receive Rebates and Other Payments?

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed onto you, they may be taken into account in determining your Co-payment and/or Co-insurance.

Who Interprets Benefits and Other Provisions under the Policy?

Subject to your appeal rights set forth in the Questions, Complaints and Appeals Procedures Section, we will do of the following:

- Make the initial interpretations of Benefits under the Policy.
- Make the initial interpretations of the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate,* the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

This discretionary authority to interpret Benefits, other terms, conditions, limitations and exclusions under the Policy is subject to modification or reversal by a court or regulatory agency with appropriate jurisdiction.

It does not alter or affect your rights under state or federal statutes or regulations, including the right to bring legal action against us. It does not alter or affect your rights to make a complaint or appeal a denial, including use of the *Independent Health Care Appeals Program.*

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and the Group and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Any subsequent changes in Benefits will be shown in a Rider or Amendment issued to Subscribers.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices.*

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices.*

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Is Workers' Compensation Affected?

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

When Do We Receive Refunds of Overpayments?

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

Except in cases of fraudulent claims, we will make a written request for the reimbursement no later than 18 months after the date the first payment of the claim was made. The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

In seeking reimbursement for the overpayment from the provider, we will not collect or attempt to collect:

- the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the provider;
- the funds for the reimbursement if the provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the provider and until the provider's rights to appeal are exhausted; or
- a monetary penalty against the reimbursement request, including but not limited to, an interest charge or a late fee.

We may collect the funds for the reimbursement request by assessing them against payment of any future claims submitted by the provider after the 45th calendar day following the submission of the reimbursement request to the provider or after the provider's rights to appeal have been exhausted if we submit an explanation in writing to the provider in sufficient detail so that the provider can reconcile each Covered Person's bill.

If we determine that the overpayment to the provider is a result of fraud committed by the provider and we have conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, we may collect an overpayment by assessing it against payment of any future claim submitted by the provider.

Is There a Limitation of Action?

No legal action may be brought against us prior to the expiration of 60 days after proof of loss has been filed. Additionally, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

What Is the Entire Policy?

The Policy, this *Certificate,* the *Schedule of Benefits,* the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group.

Section 9: Defined Terms

Allowed Amounts - for Covered Health Care Services, incurred while the Policy is in effect, Allowed Amounts are determined by us as shown in the *Schedule of Benefits.*

Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines. We develop these guidelines, as we determine, after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT),* a publication of the *American Medical Association,* and/or the *Centers for Medicare and Medicaid Services (CMS).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Condition Services or Substance Use Disorder Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us and the Group. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - the total of the Allowed Amount you must pay for Covered Health Care Services per year before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Assisted Reproductive Technology (ART) - the term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Behavioral Interventions Based on *Applied Behavioral Analysis (ABA)* - interventions or strategies based upon learning theory that are intended to improve socially important behavior of an individual using instructional and environmental modifications that have been evaluated through scientific research using reliable and objective measurements, including the empirical identification of functional relations between behavior and environmental factors. Behavior intervention strategies based on ABA include, but are not limited to:

- chaining;
- functional analysis;
- functional assessment;
- functional communication training;
- modeling, including video modeling (also known as imitation training);

- procedures designed to reduce challenging and dangerous behaviors (e.g. differential reinforcement, extinction, time out, and response cost);
- prompting; and
- reinforcement systems, including differential reinforcement, shaping and strategies to promote generalization.

Benefits - your right to payment for Covered Health Care Services that are available under the Policy.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Civil Union Partners - an individual who is a partner in a civil union. A civil union is defined as, the legally recognized union of two eligible individuals, of the same sex, established pursuant to (or otherwise compliant with) New Jersey law. A civil union also includes relationships entered into under the laws of other jurisdictions provided such relationships provide all of the rights and benefits of marriage.

Co-insurance - the charge, stated as a percentage of the Allowed Amount, that you are required to pay for certain Covered Health Care Services.

Congenital Anomaly - a developmental defect that is present at the time of birth.

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Co-payment.
- The Allowed Amount.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Health Condition, Substance Use Disorder, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits.*
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations.*

Covered Person - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Certificate* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - the Subscriber's legal spouse, Civil Union Partner or a child of the Subscriber or the Subscriber's spouse, Civil Union Partner. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins,* the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.

- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

The following conditions apply:

- A Dependent includes a child listed above who is under age 26 .
- A child is no longer eligible as a Dependent on the last day of the month following the date the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child.*

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month following the date the child reaches age 26 .

If we are not notified that a child no longer meets the above requirements, the Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

For a description of the State of New Jersey Continuation for Over-Age Dependents, see *Section 4: When Coverage Ends.*

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers are Designated Dispensing Entities.

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that has been identified as a Designated Provider. The *Schedule of Benefits* will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service for the treatment of specific diseases or condition; or
- We have identified through our designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting us at www.myuhc.c om or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services via Telehealth or Telemedicine.

Developmental Disability or Developmentally Disabled - also referred to as neurodevelopmental disability or neurodevelopmentally disabled, means a neurodevelopmental disorder which is referenced by the *American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and any subsequent editions.*

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has a Domestic Partnership under either statutory or common law.

Domestic Partnership - a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons. They must:

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same permanent residence and the common necessities of life.

- They must be financially interdependent and they have furnished documents to support one of the following conditions of such financial interdependence:
  - They have a single dedicated relationship of at least 6 - 18 months.
  - They have joint ownership of a residence.
  - They have at least two of the following:
    - A joint ownership of an automobile.
    - A joint checking, bank or investment account.
    - A joint credit account.
    - A lease for a residence identifying both partners as tenants.
    - A will and/or life insurance policies which designates the other as primary beneficiary.

The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Policy. An Eligible Person must live within the United States.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Health Care Services - with respect to an Emergency:

- A medical screening exam (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, Mental Health Condition, Substance Use Disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use; except that coverage is provided for a drug which has been prescribed for a treatment for which the drug has not been approved by the *FDA* provided the drug is recognized for the specific treatment for which the drug has been prescribed in one of the following established reference compendia: (1) the *U.S. Pharmacopoeia Drug Information Guide for the Health Care*

Professional (USPDI); (2) The *American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHES-DI)* or, it is recommended by a clinical study or review article in a major peer reviewed professional journal. However, there is no coverage for any drug which the *FDA* has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
  - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services:* and
  - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The Gestational Carrier does not provide the egg and is therefore not biologically related to the child.

Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Home Health Agency - a program or organization authorized by law to provide health care services in the home or is Medicare certified.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Iatrogenic Infertility - an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Infertility - the disease or condition that results in the abnormal function of the reproductive system, as determined pursuant to the *American Society for Reproductive Medicine* practice guidelines by a physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology or that the patient has met one of the following conditions:

- A male is unable to impregnate a female;
- A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
- A female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;
- A female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision;
- A female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision;
- Partners are unable to conceive as a result of involuntary medical sterility;
- A person is unable to carry a pregnancy to live birth; or
- A previous determination of infertility pursuant to New Jersey state law.

Inherited Metabolic Disease - a disease caused by an inherited abnormality of body chemistry.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient Mental Health Condition or Substance Use Disorder treatment program. The program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Low Protein Modified Food Product - a food product that is specifically formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease, but does not include a natural food that is naturally low in protein.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medically Necessary - health care services that are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Medical Practice.*
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Health Condition, Substance Use Disorder, disease or its symptoms.
- Not mainly for your convenience or that of your Physician or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

With respect to Substance Use Disorder Services, and as described under *Mental Health Conditions and Substance Use Disorder Services* in *Section 1: Covered Health Care Services,* the prospective determination of medical necessity shall be made by the Covered Person's practitioner for the first 180 days of treatment during each year. For the balance of the year, the determination of medical necessity is made by us. The determination of medical necessity for Substance Use Disorder Services shall use an evidence-based and peer reviewed clinical tool as designated in regulation by the *Commissioner of Human Services in consultation with the Department of Health.*

With respect to Pharmaceutical Products, no prescribed drug shall be excluded on the basis that the drug has not been approved by the *United States Food and Drug Administration (USFDA)* for the use for which the drug has been prescribed, if such drug is recognized as Medically Necessary for the specific treatment for which it has been prescribed by the *American Hospital Formulary Service Drug Information,* the *United States Pharmacopoeia Drug Information* or a clinical study or review article in a major peer reviewed professional journal.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other providers on UHCprovider.com.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act,* as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Condition Services - services for the diagnosis and treatment of those Mental Health Conditions or psychiatric categories that are listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.* The fact that a condition is listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health Condition/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Condition Services and Substance Use Disorder Services.

Mental Health Condition - a condition which is referenced by the *American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* and any subsequent editions.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services by way of their participation in the Shared Savings Program. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of our products. In this case, the provider will be

a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy. The Group sets the period of time that is the Open Enrollment Period.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Care Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any audiologist, podiatrist, dentist, psychologist, chiropractor, chiropodist, optometrist, nurse midwife, physical therapist, psychologist, registered professional nurse, speech-language pathologist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. For purposes of Behavioral Interventions Based on *Applied Behavioral Analysis (ABA)* and Related Structured Behavioral Programs for the treatment of Autism Spectrum Disorders, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst - Doctoral or as a Board Certified Behavior Analyst. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Group that includes all of the following:

- Group Policy.
- Certificate.
- *Schedule of Benefits.*
- Group *Application.*
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Group.

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Related Structured Behavioral Programs - services delivered by a qualified practitioner that are comprised of multiple intervention strategies (that is, behavioral intervention packages) based upon the principles of ABA. These packages may include but are not limited to:

- activity schedules;
- discrete trial instruction;
- incidental teaching;
- natural environment training;
- picture exchange communication system;
- pivotal response treatment;
- script and script-fading procedures; and
- self-management.

Rescission - a retroactive cancellation or discontinuance of coverage, e.g., policy void from enrollment, or benefits previously paid that are declared void, due to fraud or intentional misrepresentation of material fact.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Condition Services or Substance Use Disorder Services. It must meet all of the following requirements:

- Provides a program of treatment, approved by the Mental Health Condition/Substance Use Disorder Designee, under the active participation and direction of a Physician and, approved by the Mental Health Condition/Substance Use Disorder Designee. With respect to Substance Use Disorder Services, and as described under *Mental Health Conditions and Substance Use Disorder Services in Section 1: Covered Health Care Services,* the prospective determination of medical necessity shall be made by the Covered Person's practitioner for the first 180 days of treatment during each year. For the balance of the year, the determination of medical necessity is made by us.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Health Care Services not described in this *Certificate.* Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. (Note that Benefits for Outpatient Prescription Drugs, while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.) Riders are effective only when signed by us and the Group and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Same Terms and Conditions - means that the insurer cannot apply more restrictive non-quantitative limitations, such as utilization review and other criteria or more quantitative limitations such as Co-payments, deductibles,

aggregate or annual limits or benefit limits to Mental Health Condition and Substance Use Disorder Services than those applied to substantially all other medical or surgical benefits.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Shared Savings Program - a program in which we may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider. When this happens, you may experience lower out-of-pocket amounts. Co-insurance and any applicable deductible would still apply to the reduced charge. Policy provisions or administrative practices supersede the scheduled rate, and a different rate is determined by us. This means, when contractually permitted, we may pay the lesser of the Shared Savings Program discount or an amount determined by us, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider. In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by us. If this happens, you should call the telephone number shown on your ID card. Shared Savings Program providers are not Network providers and are not credentialed by us.

To determine whether a provider is part of the Shared Savings Program by contacting us at www.myuhc.com or the telephone number on your ID card.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Certificate includes Mental Health Condition or Substance Use Disorder, regardless of the cause or origin of the Mental Health Condition or Substance Use Disorder.

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

Substance Use Disorder - a disorder defined to be consistent with generally recognized independent standards of current medical practice referenced in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders.*

Substance Use Disorder Services - services for the diagnosis and treatment of alcoholism and Substance Use Disorders that are listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.* The fact that a disorder is listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Living - Mental Health Condition Services and Substance Use Disorder Services provided through

transitional living facilities, group homes and supervised apartments which provide 24-hour supervision and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

These include:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Care Services that are non-life-threatening but that require care by a provider within 24 hours.

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

How Do You Access Benefits?

Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider.

Emergency Health Care Services are always paid as Network Benefits whether provided by a Network or out-of-Network provider. For facility charges, these are Benefits for Covered Health Care Services that are billed by a Network facility and provided under the direction of either a Network or out-of-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or an out-of-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to out-of-Network providers who have agreed to discount their billed charges for Covered Health Care Services. Refer to the definition of Shared Savings Program in *Section 9: Defined Terms* of the *Certificate* for details about how the Shared Savings Program applies.

You must show your identification card (ID card) or have your provider verify your eligibility by calling us every time you request health care services from a Network provider. If you do not show your ID card or have your provider verify your eligibility, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive. If you have not received your ID card from us, or if you have lost your ID card, please contact us as soon as possible. If you need to seek services and do not have your ID card, please direct your provider to verify your eligibility by calling us to ensure proper payment of claims.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits.*

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Group, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

Certain Pharmaceutical Products may be subject to prior authorization due to the following:

- they contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Pharmaceutical Product;
- they contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Pharmaceutical Product;
- there are Therapeutically Equivalent alternatives available; or
- they have an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Pharmaceutical Product.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the

Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. If you do not obtain prior authorization as required, the amount you are required to pay will be increased, as described in each Covered Health Care Service section of this *Schedule of Benefits.* Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in the *Certificate* in *Section 7: Coordination of Benefits.* You are not required to obtain authorization before receiving Covered Health Care Services.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a Policy year basis.

Out-of-Pocket Limits are calculated on a Policy year basis.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Policy year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The Annual Deductible for Network Benefits includes the amount you pay for both Network and Out-of-Network Benefits for outpatient prescription drugs provided under the *Outpatient Prescription Drug Rider.* Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not apply to services provided by capitated providers or to out-of-network lead poisoning screenings for children.	***Network*** For single coverage, the Annual Deductible is $1,400 . If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $2,800 . No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied. ***Out-of-Network*** For single coverage, the Annual Deductible is $3,250 . If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $6,500 . No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit for Network Benefits includes the amount you pay for both Network and Out-of-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider.* Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and,	***Network*** For single coverage, the Out-of-Pocket Limit is $3,500 . If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Limit stated above does not apply. For family coverage, the family Out-of-Pocket Limit is $6,850 . The Out-of-Pocket Limit includes the Annual

Payment Term And Description	Amounts
once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	Deductible. ***Out-of-Network*** For single coverage, the Out-of-Pocket Limit is $7,000 . If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Limit stated above does not apply. For family coverage, the family Out-of-Pocket Limit is $14,000 . The Out-of-Pocket Limit includes the Annual Deductible.
Co-payment	
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Co-payment. • 50% of the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. Network services will not be subject to both a Co-payment and a Co-insurance, except as described in the *Emergency Health Care Services Outpatient* section. If a Co-payment applies, there will not be any Co-insurance required of the Covered Person.	
Co-insurance	
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. Network services will not be subject to both a Co-payment and a Co-insurance, except as described in the *Emergency Health Care Services - Outpatient* section. If a Co-insurance applies, there will not be any Co-payment required of the Covered Person.	

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency air ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Emergency Ambulance	***Network*** *Ground Ambulance* None	Yes	Yes
	Air Ambulance None	Yes	Yes
	Out-of-Network Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	***Network*** *Ground Ambulance* None	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Air Ambulance None	Yes	Yes
	Out-of-Network *Ground Ambulance* 20%	Yes	Yes
	Air Ambulance 20%	Yes	Yes
2. Cellular and Gene Therapy			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
3. Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	***Network*** Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient)*, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
4. Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. **It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	***Network*** None	Yes	Yes
	Out-of-Network 20%	Yes	Yes
5. Dental Services - Accident Only			
	Network None	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network Same as Network	Same as Network	Same as Network
6. Dental Services - Other			
Prior Authorization Requirement For Network and Out-of-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins or as soon as is reasonably possible. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient)*, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
7. Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	***Network*** Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of DME are not subject to the limit stated under *Durable Medical Equipment (DME) and Supplies.*	***Network*** Depending upon where the Covered Health Care Service is provided, *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient)*, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME)*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	and Supplies and in the *Outpatient Prescription Drug Rider.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider.*		
8. Durable Medical Equipment (DME) and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Benefits are limited to a single purchase of a type of DME every three years. Repair and/or replacement of DME would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums. To receive Network Benefits, you must purchase, rent or obtain the DME from the vendor we identify or purchase it directly from the prescribing Network Physician.	***Network*** None	Yes	Yes
	Out-of-Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
9. Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible.	***Network*** None	Yes	Yes
	Out-of-Network Same as Network	Same as Network	Same as Network
10. Enteral Nutrition			
	Network None	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 20%	Yes	Yes
11. Fertility Preservation for Iatrogenic Infertility			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network None	Yes	Yes
	Out-of-Network 20%	Yes	Yes
12. Gender Dysphoria			
Prior Authorization Requirement for Surgical Treatment For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay. **It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.**			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Prior Authorization Requirement for Non-Surgical Treatment Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*			
	Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider.*		
13. Habilitative Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Inpatient services limited per year as follows: • Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services.*	***Network*** *Inpatient* Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient)*, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Outpatient therapies: • Physical therapy. • Occupational therapy. • Manipulative Treatments. • Speech therapy. • Post-cochlear implant aural therapy. • Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*	*Outpatient* None	Yes	Yes
	Out-of-Network *Inpatient* Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Medical Services, Hospital - Inpatient), Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Outpatient 20%	Yes	Yes
14. Hearing Aids			
For Covered Persons age 15 and younger, limited to one hearing aid per hearing impaired ear every 24 months. For Covered Persons age 16 and older, limited to $2,500 per hearing aid for each hearing impaired ear every 24 months. Accessories, fittings and repairs are not subject to the $2,500 limit.	***Network*** None	Yes	Yes
	Out-of-Network 20%	Yes	Yes
15. Hearing Loss Screening			
	Network None	No	No
	Out-of-Network None	No	No

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Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
16. Hemophilia Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days prior to receiving services or as soon as reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network None	Yes	Yes
	Out-of-Network 20%	Yes	Yes
17. Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	***Network*** None	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 20%	Yes	Yes
18. Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.			
	Network None	Yes	Yes
	Out-of-Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
19. Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions. Your cost share for Covered Health Care Services rendered during a hospitalization in a Network Hospital will be limited to the Co-payment, deductible or Co-insurance applicable to Network services as long as all notification requirements have been met. This applies to Covered Health Care Services received at a Network Hospital regardless of whether the admitting Physician is a Network or out-of-Network provider. However, although the inpatient services will be treated as Network services, the services of the out-of-Network admitting physician will be treated as out-of-Network services.			
	Network None	Yes	Yes
	Out-of-Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
20. Infertility Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Limited to four completed egg retrievals (and the procedures and treatments associated with such retrievals) while covered under this plan or any plan with the same employer.	***Network*** None	Yes	Yes
	Out-of-Network 20%	Yes	Yes
21. Lab, X-Ray and Diagnostic - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Lab Testing - Outpatient Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.	***Network*** None	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 20%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient	***Network*** None	Yes	Yes
	Out-of-Network 20%	Yes	Yes
22. Major Diagnostic and Imaging - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network None	Yes	Yes
	Out-of-Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
23. Mental Health Care and Substance Use Disorder Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance Use Disorder Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Out-of-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).* If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network *Inpatient* None	Yes	Yes
	Outpatient Autism Spectrum Disorder and Other Developmental Disabilities - Habilitative Services: None	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	New Jersey Early Intervention System (NJEIS) Family Cost Share Expense: None	Yes	Yes
	All other Mental Health Condition and Substance Use Disorder Services: None	Yes	Yes
	None for Partial Hospitalization/ Intensive Outpatient Treatment	Yes	Yes
	Out-of-Network *Inpatient* 20%	Yes	Yes
	Outpatient 20%	Yes	Yes

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Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	20% for Partial Hospitalization/ Intensive Outpatient Treatment	Yes	Yes
24. Ostomy Supplies			
	Network None	Yes	Yes
	Out-of-Network 20%	Yes	Yes
25. Pharmaceutical Products - Outpatient			
	Network None	Yes	Yes
	Out-of-Network 20%	Yes	Yes

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Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
26. Physician Fees for Surgical and Medical Services			
Covered Health Care Services provided by an out-of-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Network Benefits. In order to obtain the highest level of Benefits, you should follow the Network status of these providers prior to obtaining Covered Health Care Services.	***Network*** None	Yes	Yes
	Out-of-Network 20%	Yes	Yes
27. Physician's Office Services - Sickness and Injury			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient.* • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*	***Network*** None	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.*			
	Out-of-Network 20%	Yes	Yes
28. Pregnancy - Maternity Services			

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

	Network Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
29. Preventive Care Services			
Physician office services	***Network*** None	No	No
	Out-of-Network 20%	Yes	Yes
Lab, X-ray or other preventive tests Please note the Annual Deductible does not apply to out-of-network lead poisoning screenings for children.	***Network*** None	No	No
	Out-of-Network 20%	Yes	Yes
Breast pumps	***Network*** None	No	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 20%	Yes	Yes
30. Prosthetic Devices and Orthotics			
Please Note: Reimbursement for these items will be at the same rate as under the federal Medicare reimbursement schedule.	***Network*** None	Yes	Yes
	Out-of-Network 20%	Yes	Yes
31. Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).			
	Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits will be		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
32. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows: • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 Manipulative Treatments. • 20 visits of speech therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. Limits do not apply for the treatment of Autism Spectrum Disorder or another Developmental Disability.	***Network*** None	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 20%	Yes	Yes
33. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network None	Yes	Yes
	Out-of-Network 20%	Yes	Yes
34. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
Limited to 60 days per year.	***Network*** None	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Out-of-Network 20%	Yes	Yes
35. Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network None	Yes	Yes
	Out-of-Network 20%	Yes	Yes
36. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Network None	Yes	Yes
	Out-of-Network 20%	Yes	Yes
37. Transplantation Services			

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

For Network Benefits, transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.	***Network*** Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient)*, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*
	Out-of-Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and*

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Medical Services, Hospital - Inpatient), Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
38. Urgent Care Center Services			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient.* • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.*	***Network*** None	Yes	Yes
	Out-of-Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
39. Urinary Catheters			
	Network None	Yes	Yes
	Out-of-Network 20%	Yes	Yes
We also provide benefits for Virtual Visits. We contract with one or more entities to create a Designated Virtual Network. Each of these entities creating the Virtual network contracts with individual providers or groups of providers. We refer to a provider in the Designated Virtual Network as a Designated Virtual Network Provider.			
40. Virtual Visits			
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.	None	Yes	Yes

Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits. For Network Benefits, you are not responsible for any difference between Allowed Amount and the amount the provider bills. For Out-of-Network Benefits, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount we will pay for Allowed Amounts. Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.

- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, the Allowed Amount are the fee(s) that we negotiate with the out-of-Network provider.
- When Covered Health Care Services are received from an out-of-Network provider as a result of an Emergency or as arranged by us, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

For Out-of-Network Benefits, Allowed Amounts are based on either of the following:

- When Covered Health Care Services are received from an out-of-Network provider, Allowed Amounts are determined, based on either of the following:
  - 140% of the published rates allowed by the Centers for Medicare and Medicaid Services *CMS* for Medicare for the same or similar service within the geographic market, with the exception of the following:
    - 50% of *CMS* for the same or similar laboratory service.
    - 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
  - When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or similar methodology. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group.* Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
    - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS,* and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book),* or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
    - When a rate for a laboratory service is not published by CMS for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
    - When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.
  - Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.

    We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically put in place within 30 to 90 days after *CMS* updates its data.

    IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.
- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.

Provider Network

We arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to choose your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.myuhc.com or the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Not all Network Hospitals are contracted to perform transplants. Please refer to your provider directory or contact us to find out which hospitals are contracted for this service.

Continuation of Treatment when a Physician Leaves the Network

If a Covered Person is receiving post-operative follow-up care, oncological treatment, psychiatric treatment or obstetrical care by a Physician who was a Network Physician at the time the treatment was initiated, the Covered Person may continue to be treated by that Physician for the duration of the treatment even if the Physician leaves the Network. The continued treatment is subject to the following time periods:

- Up to six months for post-operative follow-up care.
- Up to one year for oncological treatment and psychiatric treatment.
- Through the duration of a Pregnancy and up to six weeks after delivery for obstetrical care.
- Up to four months for other Covered Health Care Services where it is medically necessary for the Covered Person to continue treatment with that Physician.
- Covered Health Care Services for the continued treatment are covered as Network Benefits. Reimbursement for Health Services will be made according to the same fee schedule used for Network Services.
- During the time a Covered Person receives continued treatment by a Physician who has left the Network, we will provide Network Benefits for any treatment or services provided to the Covered Person in a Hospital, regardless of whether the Hospital is a Network Hospital.

Designated Providers

For Transplants we may direct you to a Designated Provider chosen by us. If you require certain complex Covered Health Care Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you reside more than 50 miles from the Designated Provider and are required to travel to obtain such Covered Health Care Services from the Designated Provider, we will provide for reimbursement of travel and lodging expenses for the Covered Person and one companion. Coverage is limited to $50 - $100 lodging per day, up to a maximum Benefit of $10,000 per lifetime.

In both cases, Network Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by us.

You or your Network Physician must notify us of special service needs that might warrant referral to a Designated Provider. If you do not notify us in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Network Benefits will not be paid.

Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Care Services for which Benefits are provided under the Policy.

Health Care Services from Out-of-Network Providers Paid as Network Benefits

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Primary Care Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Primary Care Physician to coordinate care through an out-of-Network provider.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you do not use the selected Network Physician, Covered Health Care Services will be paid as Out-of-Network Benefits.

Real Appeal Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Real Appeal

Real Appeal provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 13 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live Virtual Coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

For purposes of Real Appeal, the definition of Physician in your *Certificate of Coverage* is revised to include a Virtual Coach. The Real Appeal program was designed and built by a panel of physicians and licensed nutritionists. While Real Appeal's Virtual Coaches are not licensed by or registered with the State of New Jersey, they undergo extensive training through Real Appeal.

For purposes of Real Appeal, the definition of Covered Health Care Services in your Certificate of Coverage is revised to include individualized services and may include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained Virtual Coach for clinical weight loss.

If you would like information regarding these Covered Health Care Services, you may contact us through www.realappeal.com, https://member.realappeal.com or at the number shown on your ID card.

UnitedHealthcare Insurance Company



William J Golden, President

Kidney Donor Travel and Lodging Program Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides a donor travel and lodging allowance related to living kidney transplantation.

Because this Rider is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company.

Kidney Donor Travel and Lodging Program

The *Kidney Donor Travel and Lodging Program* provides support for living kidney donors when the intended recipient of the kidney is a Covered Person under the Policy. The program provides an allowance for travel and lodging expenses for an approved living kidney donor and travel companion. The living kidney donor is not required to be a Covered Person under the Policy.

Donors must be approved by us for participation in this program. This program provides an allowance for incurred travel and lodging expenses only and is independent of any existing medical coverage available for the donor or Covered Person. Once approved, an allowance of up to $6,000 per donor will be provided for travel and lodging expenses incurred as a part of the entire kidney donation process, based on the *U.S. General Services Administration* travel rates. Expenses incurred will include travel and lodging expenses for the donor's first evaluation through follow-up evaluation(s) up to two years after donor surgery.

If you would like additional information regarding the *Kidney Donor Travel and Lodging Program*, you may contact us at www.myuhc.com.

UnitedHealthcare Insurance Company



William J Golden, President

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms.*

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in the *Certificate.*

UnitedHealthcare Insurance Company



William J Golden, President

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee makes tier placement changes on our behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product. Economic factors are considered when two or more drugs are equivalent in terms of safety, effectiveness and clinical outcome.

Please refer to the *Outpatient Prescription Drug Schedule of Benefits* for more information concerning prior authorization requirements.

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. We will provide a 30 day written notice prior to the effective date of any change. Please call the number on the back of your ID card to determine whether a specific drug is included under the drug formulary.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim.* When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Springs, AR 71903

Designated Specialty Pharmacies

If you require certain Specialty Prescription Drug Products for disease states, medical conditions, or certain treatments such as:

- Hepatitis C
- Multiple Sclerosis
- Rheumatologic and related conditions (Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Juvenile Rheumatoid Arthritis, Psoriasis)
- Growth Hormone
- Anemia, neutropenia, thrombocytopenia
- Infertility
- HIV/AIDS
- Transplant
- Oral Oncology
- Pulmonary Arterial Hypertension
- Osteoporosis
- Cystic Fibrosis
- Gaucher's Disease
- Iron Overload
- Endocrine disorders/Neurologic disorders such as infantile spasms
- Hemophilia
- Enzyme Deficiencies/Liposomal Storage Disorders

We may direct you to a Designated Specialty Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Specialty Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Specialty Pharmacy, you will be subject to the out-of-Network Benefit for that Prescription Drug Product.

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Specialty Pharmacy in 15-day supplies up to 90 days and at a pro-rated Co-payment or Co-insurance. You will receive a 15-day supply of their Specialty Prescription Drug Product to find out if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Specialty Pharmacy will contact you each time prior to dispensing the 15-day supply to confirm if you are tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program,* by contacting us at www.myuhc.com or the telephone number on your ID card.

When Do We Limit Selection of Pharmacies?

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, we may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date we notify you, we will choose a Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Co-payment and/or Co-insurance.

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and

apart from this *Outpatient Prescription Drug Rider.* Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider.* We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers.

Special Programs

You may qualify for certain programs in which you may receive an enhanced benefit based on your adherence/compliance with medication or treatment regimens, and/or taking part in health management programs. For certain qualifying medications, you may receive a savings on your standard Co-payment if you are taking the medication regularly and you refill your medication within 30 days before the date you are scheduled to run out of medication. If you don't refill your medication within 30 days before the date you are scheduled to run out of medication, you will pay your standard Co-payment. You may access further information on these programs and which medications are included through the internet at www.myuhc.com or by calling the telephone number on your ID Card. Please note this program is subject to change without notice.

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Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Co-payments and/or Co-insurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Specialty Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Specialty Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Specialty Pharmacy, you will be subject to the out-of-Network Benefit for that Specialty Prescription Drug Product.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Specialty Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

The *Outpatient Prescription Drug Rider* offers limited Network Pharmacy providers. You can confirm that your pharmacy is a Network Pharmacy by calling the telephone number on your ID card or you can access a directory of Network Pharmacies online at www.myuhc.com.

Prescription Drugs from a Retail Out-of-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail out-of-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim.* We will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail out-of-Network Pharmacy supply limits apply.

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy and supply limits apply.

Please contact us at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits that are stated in the Schedule of Benefits. For a single Co-payment or Co-insurance, the Insured may receive a Prescription Drug Product up to the stated supply limit. We will cover up to a consecutive 90-day supply of a Prescription Drug Product, as written by the Physician, subject to the drug manufacturer's packaging size, or based on supply limits.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed.

NOTE: Some products are subject to additional supply limits other than day limits based on New Jersey State Law or on criteria that we have developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing by contacting us at www.myuhc.com or the telephone number on your ID card.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* also apply to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact us at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. No prescribed drug shall be excluded on the basis that the drug has not been approved by the *United States Food and Drug Administration (USFDA)* for which the drug has been prescribed, if such drug is recognized as Medically Necessary for the specific treatment for which it has been prescribed by the *American Hospital Formulary Service Drug Information,* the *United States Pharmacopoeia Drug Information* or a clinical study or review article in a major peer reviewed professional journal.
6. Prescription Drug Products for any condition, Injury, Sickness or Mental Health Condition arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received. The failure of a self-employed person, limited liability partnership, limited liability company or partnership to elect to obtain worker's compensation coverage for the self-employed person, the limited liability partners, the limited liability company members or the partners shall not affect Benefits available under this Rider.
7. Any product dispensed for the purpose of appetite suppression or weight loss.
8. A Pharmaceutical Product for which Benefits are provided in your *Certificate.* This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
9. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate.* Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
11. Certain unit dose packaging or repackagers of Prescription Drug Products.
12. Medications used for cosmetic purposes except for coverage for newborn children including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
13. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
15. Treatment for toenail Onychomycosis (toenail fungus).

16. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 3.)

17. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, except for over-the-counter PPACA Zero Cost Share Preventive Care Medications are eligible for coverage as if they were a Prescription Drug Product and are obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form unless the prescribing provider certifies the medical necessity of the drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

18. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

19. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.

20. Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.

21. A Prescription Drug Product that contains marijuana, including medical marijuana.

22. Dental products, including but not limited to prescription fluoride topicals.

23. Diagnostic kits and products.

24. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Section 3: Defined Terms

Brand-name - a Prescription Drug Product which is manufactured and marketed under a trademark or name by a specific drug manufacturer.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Specialty Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Specialty Pharmacies.

Generic - a Prescription Drug Product that is Chemically Equivalent to a Brand-name drug.

Infertility - the disease or condition that results in the abnormal function of the reproductive system, as determined pursuant to the *American Society for Reproductive Medicine* practice guidelines by a physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology or that the patient has met one of the following conditions:

- A male is unable to impregnate a female;
- A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
- A female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;
- A female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision;
- A female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision;
- Partners are unable to conceive as a result of involuntary medical sterility;
- A person is unable to carry a pregnancy to live birth; or
- A previous determination of infertility pursuant to New Jersey state law.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- Six months following date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration.*

Out-of-Network Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA).* This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered in a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose meters, including continuous glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Co-payment or Co-insurance may change, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the *Schedule of Benefits.* For a single Co-payment or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. We will cover up to a consecutive 90-day supply of a Prescription Drug Product, as written by the Physician, subject to the drug manufacturer's packaging size, or based on supply limits.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed.

Note: Some products are subject to additional supply limits other than day limits based on New Jersey State Law or on criteria that the company has developed. Supply limits are subject, from time to time, to review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at www.myuhc.com or the telephone number on your ID card.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Out-of-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at an out-of-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

Certain Prescription Drug Products may be subject to prior authorization due to the following:

- they contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product;
- they contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product;
- there are Therapeutically Equivalent alternatives available;
- they have an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product; or
- they are packaged with a device or application, including smart package sensors and/or embedded drug sensors.

Please note that outpatient Prescription Drug Products to treat Substance Use Disorder will be provided when determined Medically Necessary by the Covered Person's Physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization review.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.co m or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at an out-of-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim.*

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Co-payment or Co-insurance and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Approval Process for Prescription Drug Products that the Covered Person wants considered at a Lower Tier Co-payment

The prescribing Physician must request our prior approval for a lower tier Co-payment for a higher tier drug by contacting us at the telephone number on your ID card and providing all relevant information . We will respond to the Physician by telephone within one business day after the receipt of all requested documentation from the Physician. If we fail to respond within that time period, the request is deemed approved. The request for approval must be based on the Physician's certification that the Prescription Drug Product is medically necessary as defined below and the current drugs available in the lower tiers are not effective for the Covered Person.

A Prescription Drug Product which is not on the Prescription Drug List will be considered medically necessary if:

- It is approved by the *U.S. Federal Food and Drug Administration ("FDA")* or its use is supported by one or more citations included or approved for inclusion in *The American Hospital Formulary Drug Information* or the

United States Pharmacopeia Drug Information, or it is recommended by a clinical study or review article in a major peer reviewed professional journal; and

- The prescribing Physician states that all Prescription Drug Products on the Prescription Drug List used to treat each disease state has been ineffective in the treatment of your disease or condition, or all such drugs have caused or are reasonably expected to cause you adverse or harmful reactions.

If the request is denied by telephone, we will also provide you and the Physician a written denial within 5 business days of the request. The written denial will include the clinical reason for the denial.

If you are dissatisfied with our decision, you should follow the procedures described in the *Certificate* for questions, complaints and appeals. If you want to contest our decision you may apply to the Independent Health Care Appeals Program for a review. You must make your application within 60 days of the date you were notified of the decision. Your notification of our decision will include specific instructions as to how you or your provider may arrange for an external appeal and will also include any forms required to initiate the appeal.

Emergency

Prescription Drug Products dispensed at an out-of-Network Pharmacy for an emergency are payable for the Out-of-Network Reimbursement Rate, minus the applicable Network Co-payment or Co-insurance.

Extended Coverage during Total Disability

Extended Coverage for Total Disability described in the *Certificate* applies to Prescription Drug coverage.

Pharmacy Charges for Additional Services

A pharmacy may charge you for services rendered by the pharmacy that are in addition to charges for the Prescription Drug Product, for dispensing the drug or for prescription counseling. Services rendered by the pharmacy for which additional charges are imposed are subject to the approval of the *Board of Pharmacy.* A pharmacy must disclose to you the charges for the additional services and your out-of-pocket cost for those services prior to dispensing the Prescription Drug Product. A pharmacy may not impose any additional charges for patient counseling or for other services required by the Board of Pharmacy or State or federal law.

What Do You Pay?

You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your *Certificate* before Benefits for Prescription Drug Products under this Rider are available to you. We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.

Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Co-payment or Co-insurance described in the Benefit Information table. You are not responsible for paying a Co-payment or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Limit stated in your *Certificate:*

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate. ***Co-payment and Co-insurance*** Your Co-payment or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Co-payment or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. Your Co-payment or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at www.myuhc.com or the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive an enhanced benefit based on your actions	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Preventive Medications.

Payment Term And Description	Amounts
such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. Please refer to your *Outpatient Prescription Drug Rider* for more information concerning this program. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card. **Co-payment/Co-insurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment or Co-insurance for one or more Prescription Orders or Refills. **NOTE:** The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment or Co-insurance.	

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay?
Specialty Prescription Drug Products	
The following supply limits apply. • As written by the provider, up to a consecutive 90-day supply of a Specialty Prescription Drug Product, subject to the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Some products are subject to additional supply limits other than day limits based on New Jersey State Law or on criteria we have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Specialty Pharmacy.	Your Co-payment or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement. For up to a 31-day supply, you pay: ***Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: $7 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: $25 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: $45 per Prescription Order or Refill. ***Out-of-Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: $7 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: $25 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: $45 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay?
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, subject to the drug manufacturer's packaging size, or based on supply limits. Some products are subject to additional supply limits other than day limits based on New Jersey State Law or on criteria we have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. • For a contraceptive up to a three month supply for the first dispensing. For refills of the same contraceptive, up to a six-month supply, regardless of whether coverage under the Policy was in effect at the time of the first dispensing. Coverage will not extend beyond the date your coverage ends under this Policy. The Co-payment or Co-insurance that applies will reflect the number of days dispensed. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed.	Your Co-payment or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For up to a 31-day supply, you pay: For a Tier 1 Prescription Drug Product: $7 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $25 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $45 per Prescription Order or Refill.
Prescription Drugs from a Retail Out-of-Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, subject to the drug manufacturer's packaging size, or	Your Co-payment or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay?
based on supply limits. Some products are subject to additional supply limits other than day limits based on New Jersey State Law or on criteria we have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. • For a contraceptive, up to a three month supply for the first dispensing. For refills of the same contraceptive, up to a six-month supply, regardless of whether coverage under the Policy was in effect at the time of the first dispensing. Coverage will not extend beyond the date your coverage ends under this Policy. The Co-payment or Co-insurance that applies will reflect the number of days dispensed. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed.	For up to a 31-day supply, you pay: For a Tier 1 Prescription Drug Product: $7 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $25 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $45 per Prescription Order or Refill.
Prescription Drug Products from a Mail Order Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, subject to the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products.* Some products are subject to additional	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For up to a 31-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $7 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $25 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $45 per Prescription Order

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay?
supply limits other than day limits based on criteria we have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.	or Refill. For up to a 60-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $14 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $90 per Prescription Order or Refill. For up to a 90-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $17.50 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $62.50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $112.50 per Prescription Order or Refill.

Language Assistance Services

We[1] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語**(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

Notice of Non-Discrimination

We[1] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

[1] For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Certificate of Coverage (Certificate)* and *Schedule of Benefits.* A summary of those changes and the dates the changes are effective appear below. These changes will apply to any "non-grandfathered" plan. Contact your Plan Administrator to determine whether or not your plan is a "grandfathered" or a "non-grandfathered plan". Under the *Patient Protection and Affordable Care Act (PPACA)* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

  Ambulatory patient services; emergency services, hospitalization; laboratory services; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:

  - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000.
  - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000.
  - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

  Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law).

  On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

  Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the policy is subject to the statute known as *Michelle's Law.* This law amends *ERISA, the Public Health Service Act,* and the *Internal Revenue Code* and requires group health plans,

which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or Injury.

- If you do not have a grandfathered plan, If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:
  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
  - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
  - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
  - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*
- Retroactive rescission of coverage under the policy is permitted, with 30 days advance written notice, only in the following two circumstances:
  - The individual performs an act, practice or omission that constitutes fraud.
  - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:
  - Direct access to OB/GYN care without a referral or authorization requirement.
  - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
  - Prior authorization is not required before you receive services in the emergency department of a hospital.

    If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Effective for policies that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

Pre-Existing Conditions:

Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA),* as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or UnitedHealthcare for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call UnitedHealthcare at the number listed on your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from UnitedHealthcare will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call UnitedHealthcare at the number listed on your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits.*

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, we will review our decision. We will also send you our written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, they will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call UnitedHealthcare at the number listed on your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact UnitedHealthcare at the number listed on your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you. (http://www.dol.gov.ebsa/healthreform/ - click link for Consumer Assistance Programs).

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998,* Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage 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 or issuer 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, under Federal law, plans and issuers 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, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

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

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

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it

within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

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

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information through the submission of your appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

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

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2018:

We[2] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws relating to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as www.myuhc.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollee's information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the *Secretary of the Department of Health and Human Services,* if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
    - 1. HIV/AIDS;
    - 2. Mental health;
    - 3. Genetic tests;
    - 4. Alcohol and drug abuse;
    - 5. Sexually transmitted diseases and reproductive health information; and
    - 6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your health plan website, such as www.myuhc.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your health plan ID card or you may contact the *UnitedHealth Group Customer Call Center* Representative at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

[2]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Health Management Corporation; Rocky Mountain HealthCare Options, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2018

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors:
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communicati ons on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-866-633-2446 or TTY 711.

[3]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women's and Children's Health, LLC; AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Connextions HCI, LLC; LifePrint East, Inc.; Life Print Health, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare

Service LLC; UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

UNITEDHEALTH GROUP

HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2018

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. Show the categories of health information that are subject to these more restrictive laws; and
2. Give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
We are not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AR, CA, DE, NE, NY, PR, RI, UT, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS

Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, ME, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NH, NM, NV, NY, NC, OR, PA, PR, RI, TX, VT, WA, WV, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect HIV/AIDS-related information only with your written consent.	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA

Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, AR, CO, IL, LA, MD, NE, NJ, NY, NM, RI, TN, TX, UT, WI

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA).*

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration.*

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description.* The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to 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. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA.*

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA,* there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor,* or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor,* 200 Constitution Avenue, N.W., Washington,

D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration.*

UnitedHealthcare Insurance Company

UnitedHealthcare Choice Plus

Certificate of Coverage, Riders, Amendments, and Notices

for

NBA SERVICES CORP.

Group Number: GA6S0882BW **Health Plan:** BX - T5 **Prescription Code:** 2V
Effective Date: October 1, 2021

Offered and Underwritten by
UnitedHealthcare Insurance Company

Riders, Amendments, and Notices

begin immediately following the last page

of the Certificate of Coverage

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Group. The *Certificate* describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's *Application* and payment of the required Policy Charges.

In addition to this *Certificate,* the Policy includes:

- The *Schedule of Benefits.*
- The Group's *Application.*
- Riders, including the *Outpatient Prescription Drug Rider*.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate.* When this happens we will send you a new *Certificate,* Rider or Amendment.

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends.*

We are delivering the Policy in New Jersey . The Policy is subject to the laws of the state of New Jersey and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, New Jersey law governs the Policy.

Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms.*

How Do You Use This Document?

Read your entire *Certificate* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *Certificate* at www.myuhc.com.

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations.* Read *Section 8: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this *Certificate* and any summaries provided to you by the Group, this *Certificate* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact Us?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins.* To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Policy issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms.*

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. If you have questions about this, contact your Group.

Be Aware the Policy Does Not Pay for All Health Care Services

The Policy does not pay for all health care services. Benefits are limited to Covered Health Care Services. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

We understand that there are many variables that influence the decisions you make regarding your care, including the coverage available under this plan. However, final care decisions are between you and your Physician. Your Physicians are solely responsible for all health services that you receive.

Choose Your Physician

It is your responsibility to select the providers who will deliver your care. We arrange for Physicians and other providers and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other providers who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. **If you do not obtain prior authorization as required, the amount you are required to pay will be increased, as described in the** *Schedule of Benefits.* For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits.*

Pay Your Share

You must meet any applicable deductible and pay a Co-payment or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits.* You must also pay any amount that exceeds the Allowed Amount.

Please note: For bundled payments discussed in *Do We Pay Incentives to Providers?* in *Section 8: General Legal Provisions,* your Co-payment and/or Co-insurance will be calculated based on the provider type that received the bundled payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment and/or Co-insurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment and/or Co-insurance as described in your *Schedule of Benefits.*

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions.

Show Your ID Card

You should show your ID card or have your provider verify your eligibility by calling us every time you request health care services. If you do not show your ID card or have your provider verify your eligibility, the provider may fail to bill the correct entity for the services delivered. If you have not received your ID card from us, or if you have lost your ID card, please contact us as soon as possible. If you need to seek services and do not have your ID card, please direct your provider to verify your eligibility by calling us to ensure proper payment of claims.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you have the right to make an assignment of Benefits, whereby your provider may request payment from us. You may also request payment on your own behalf at your option. Claims must be filed in a format that contains all of the information we require, as described in *Section 5: How to File a Claim.*

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health care services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under the Policy for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether the Policy will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

Subject to your appeal rights set forth under *Section 6: Questions, Complaints and Appeal,* we will do the following:

- Make an initial interpretation of Benefits and the other terms, limitations and exclusions set out in this *Certificate,* the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may assign this authority to other persons or entities that may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Care Services

We pay Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits,* unless the service is excluded in *Section 2: Exclusions and Limitations.* This means we only pay our portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, we pay Benefits after we receive your or your out-of-Network provider's request for payment that includes all required information. See *Section 5: How to File a Claim.*

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT),* a publication of the *American Medical Association,* and/or the *Centers for Medicare and Medicaid Services (CMS).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service

billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at www.myuhc.com or the telephone number on your ID card.

We may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, we will use a comparable methodology(ies). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group.* Refer to our website at www.myuhc.com for informatio n regarding the vendor that provides the applicable methodology.

Offer Health Education Services to You

We may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms.)*
- You receive Covered Health Care Services while the Policy is in effect or during any extension of benefits period.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Policy.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Health Condition, Substance Use Disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Policy.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Co-payment and/or Co-insurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.

- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

2. Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services.*

3. Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI).)*
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs,* the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards *(IRBs)* before you are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Policy.

4. Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.
- Tetralogy of fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services.*

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for *CHD* services.

5. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Medicine, "M.D.", Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.".
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

6. Dental Services - Other

Services including surgery, general anesthesia and associated Hospital or Alternate Facility charges when the dentist and Physician determine that the services are necessary for the safe and effective treatment of one of the following:

- A dental condition.
- A medical condition covered under the Policy which requires hospitalization or general anesthesia for dental services rendered by a Doctor of Medicine, "M.D.", Doctor of Dental Surgery, "D.D.S.", or Doctor of Medical Dentistry, "D.M.D." regardless of where the dental services are provided.

Services are limited to Covered Persons who are one of the following:

- A child under 5 years of age.
- A person who is severely disabled.

Services for the diagnosis or treatment of a dental disease are not Covered Health Care Services.

7. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services to ensure that a person with diabetes is educated regarding the proper self-management and treatment of their diabetic condition, including information on proper diet. Services must be ordered by a Physician and provided by appropriately licensed or registered providers.

Covered Health Care Services for self-management and diet education are limited to the following:

- Visits as Medically Necessary upon the diagnosis of diabetes.
- Visits as Medically Necessary upon diagnosis by a Physician or nurse practitioner/clinical nurse specialist of a significant change in the person's symptoms or conditions which necessitate changes in that person's self-management.
- Visits as Medically Necessary upon the determination of a Physician or nurse practitioner/ clinical nurse specialist that reeducation or refresher education is necessary.

Diabetes self-management education must be provided by one of the following:

- A dietitian who is registered by a nationally-recognized professional association of dietitians.
- A provider recognized as a certified diabetes educator by the *American Association of Diabetes Educators.*

A registered pharmacist qualified regarding management education for diabetes by any institution recognized by the *Board of Pharmacy* of the State of New Jersey.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment (DME) and Supplies.* Benefits for blood glucose meters including continuous glucose monitors and blood glucose monitors for the legally blind, insulin syringes with needles, test strips for blood glucose monitors and visual reading and urine test strips, ketone test strips and tablets, insulin, injection aids, oral agents for controlling blood sugar and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider.*

8. Durable Medical Equipment (DME) and Supplies

Benefits are provided for DME and certain supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Mobility Devices.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services.*
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate.*

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998.*

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits.*

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations,* under *Medical Supplies and Equipment.*

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate.*

9. Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits are not available for services to treat a condition that does not meet the definition of an Emergency. This exclusion does not apply to the medical screening exam required to determine whether an Emergency exists.

10. Enteral Nutrition

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies.
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

For the purpose of this Benefit, "enteral formulas" include:

- Amino acid-based elemental formulas.
- Extensively hydrolyzed protein formulas.
- Modified nutrient content formulas.

For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment;
- Chronic physical disability;
- Intellectual disability; or
- Loss of life.

Donated Human Breast Milk

Benefits are provided for donated human breast milk for Covered Persons under the age of six months subject to the following conditions:

- The Covered Person is medically or physically unable to receive maternal breast milk or participate in breast feeding, or the Covered Person's mother is medically or physically unable to produce breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; and
- The Covered Person's practitioner issued an order for the donated human breast milk.

We also cover pasteurized donated human breast milk as ordered by the Covered Person's practitioner for Covered Persons under the age of six months if the Covered Person meets any of the following conditions:

- A body weight below healthy levels determined by the Covered Person's practitioner;
- A congenital or acquired condition that places the Covered Person at a high risk for development of necrotizing enterocolitis; or
- A congenital or acquired condition that may benefit from the use of donor breast milk as determined by the New Jersey Department of Health.

As used in this provision, pasteurized donated human breast milk means milk obtained from a human milk bank that meets the quality guidelines established by the New Jersey Department of Health. If there is no supply of human breast milk that meets such guidelines there will be no coverage under this provision.

The pasteurized donated human breast milk may include human milk fortifiers if indicated by the Covered Person's practitioner.

11. Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause infertility such as chemotherapy, radiation treatment, and oophorectomy due to cancer. Services include the following procedures:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under your *Outpatient Prescription Drug Rider* or under *Pharmaceutical Products* in this section.

Benefits are not available future implantation.

Benefits are not available for long-term storage costs (greater than one year).

12. Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

13. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition to learn, improve or keep skills and functioning for daily living. We will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative Benefits under this section do not include physical therapy, occupational therapy or speech therapy for Autism Spectrum Disorder or other Developmental Disabilities. Benefits for these services are payable as described in *Mental Health Condition and Substance Use Disorder Services.*

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- Treatment is administered by any of the following:
  - Licensed speech-language pathologist.
  - Licensed audiologist.
  - Licensed occupational therapist.
  - Licensed physical therapist.
  - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential Treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided:

- Treatment plan.
- Medical records.
- Clinical notes.
- Other necessary data to allow us to prove that medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress that is capable of being demonstrated, we may request a treatment plan that includes:

- Diagnosis.
- Proposed treatment by type, frequency, and expected duration of treatment.
- Expected treatment goals.
- Frequency of treatment plan updates.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care.* Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME) and Supplies* and *Prosthetic Devices and Orthotics.*

14. Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear.

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing aid, associated accessories, and associated fitting charges, testing and repair of a hearing aid.

For Covered Persons age 16 and older, if more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, we will pay only the amount that we would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this Certificate. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

15. Hearing Loss Screening

Covered Health Care Services include screening for newborn hearing loss by appropriate electro physiologic screening measures and periodic monitoring of infants for delayed onset hearing loss. No Copayment amount or Annual Deductible applies to these Benefits.

16. Hemophilia Services

Covered Health Care Services include home treatment of routine bleeding episodes due to hemophilia. The treatment must be supervised by a state-approved hemophilia treatment center. Benefits are provided for blood products including, but not limited to Factor VIII, Factor IX and Cryoprecipitate as well as blood infusion equipment including, but not limited to, syringes and needles.

17. Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required or when continued hospitalization would otherwise be required.

Benefits are available for full-time nursing care and full-time care by an aide on a short-term basis if needed. Home Health Agency services include physical, occupational, or speech therapy, medical social work and nutritional services.

Benefits are available for the following items to the extent that they would have been available if the Covered Person were confined in a Hospital:

- Medical supplies.
- Drugs and medications ordered by a Physician.
- Laboratory services given or ordered in a Hospital.
- Special meals.
- Diagnostic, therapeutic or surgical services provided on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for

Physician-directed medical management.

18. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call us at the telephone number on your ID card for information about our guidelines for hospice care.

19. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours following a simple mastectomy.
- 72 hours following a modified radical mastectomy.

If you agree, the attending provider may discharge you earlier than these minimum time frames.

Your cost share for Covered Health Care Services rendered during a hospitalization in a Network Hospital will be limited to the Co-payment, deductible or Co-insurance applicable to Network services as long as all request for prior authorization requirements have been met. Please refer to your Schedule of Benefits for the Co-payment, deductible, Co-insurance and prior authorization requirements that apply to your plan. This applies to Covered Health Care Services received at a Network Hospital regardless of whether the admitting Physician is a Network or out-of-Network provider. However, although the inpatient services will be treated as Network services, the services of the out-of-Network admitting Physician will be treated as out-of-Network services.

20. Infertility Services

Benefits will be provided to the same extent as for any other medical condition under the Policy. Diagnosis and treatment of Infertility including but not limited to:

- Diagnosis and diagnostic tests.
- Medications.
- Surgery.
- Gamete intrafallopian transfer.
- Four completed egg retrievals per Covered Person while covered under this plan or any plan with the same employer.
- Medical costs of egg and sperm donors.
- Benefits for gamete intrafallopian transfer are limited to a Covered Person who meets all of the following conditions:
- The Covered Person has used all reasonable, less expensive and Medically Necessary treatments and is still unable to become pregnant or carry a pregnancy.
- The Covered Person has not reached the limit of four completed egg retrievals.
- The Covered Person is 45 years of age or younger.

Services must be performed at facilities that conform to standards established by the *American Society for Reproductive Medicine* or the *American College of Obstetrics and Gynecologists.*

For the purposes of this Benefit, "therapeutic donor insemination" means insemination with a donor sperm sample for the purpose of conceiving a child.

21. Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*
- Prostate cancer screening which includes an annual diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services.*

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient.*

22. Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services, including digital tomosynthesis, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

23. Mental Health Condition and Substance Use Disorder Services

Mental Health Condition and Substance Use Disorder Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office subject to the Same Terms and Conditions that apply to other medical or surgical benefits. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.

- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Mental Health Condition Services for Autism Spectrum Disorder include Behavioral Interventions Based on *Applied Behavioral Analysis (ABA)* and Related Structured Behavioral Programs as prescribed through a treatment plan.

Substance Use Disorder Services are provided at Network Facilities subject to the following:

- the prospective determination of medical necessity is made by the Covered Person's practitioner for the first 180 days of treatment during each year and for the balance of the year the determination of medical necessity is made by us;
- Prior Authorization is not required for the first 180 days of inpatient and/or outpatient treatment during each year but may be required for inpatient treatment for the balance of the year;
- concurrent and retrospective review are not required for the first 28 days of inpatient treatment during each year but concurrent and retrospective review may be required for the balance of the year;
- retrospective review is not required for the first 28 days of intensive outpatient and partial hospitalization services during each year but retrospective review may be required for the balance of the year;
- retrospective review is not required for the first 180 days of outpatient treatment including outpatient prescription drugs, during each year but retrospective review may be required for the balance of the year; and
- If no Network Facility is available to provide in-patient services, we shall approve an in-plan exception and provide benefits for in-patient services at an Out-of-Network Facility.
- The first 180 days per plan year assumes 180 inpatient days whether consecutive or intermittent. Extended outpatient services such as Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment are counted as inpatient days. Any unused inpatient days may be exchanged for two outpatient visits.

Please note: Benefits for days 29 and after of inpatient care will be subject to concurrent review. A request for approval of inpatient care beyond the first 28 days must be submitted for concurrent review before the expiration of the initial 28-day period. A request for approval of inpatient care beyond any period that is approved under concurrent review must be submitted within the period that was previously approved.

We will not initiate concurrent review more frequently than at two-week intervals. If we determine that continued inpatient care is no longer Medically Necessary, we will provide written notice within 24 hours to the Covered Person and the Covered Person's Physician of the decision and the right to file an appeal, as described in *Appeals for Inpatient Substance Use Disorder Services* in *Section 6: Questions, Complaints and Appeals.*

The Mental Health Condition/Substance Use Disorder Designee provides administrative services for all levels of care.

We encourage you, but do not require you, to contact the Mental Health Condition/Substance Use Disorder Designee for referrals to providers and coordination of care.

Autism Spectrum Disorder and Other Developmental Disabilities Habilitative Services:

For Covered Persons with a primary diagnosis of Autism Spectrum Disorder or another Developmental Disability, Benefits under this section include:

- Physical therapy provided by a licensed physical therapist.
- Speech and language pathology services provided by a licensed speech and language pathologist.
- Occupational therapy provided by a licensed occupational therapist.

Benefits for these therapies will be provided as prescribed through a treatment plan and will not be denied on the basis that the treatment is not restorative.

The treatment plan must include all elements necessary to appropriately provide Benefits, including, but not limited to:

- a diagnosis;
- proposed treatment by type, frequency, and duration;
- the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated;
- and the treating Physician's signature.

We may request an updated treatment plan once every six months from your Physician to review medical necessity, unless a more frequent review is agreed upon by us and your Physician, due to emerging clinical circumstances.

New Jersey Early Intervention System (NJEIS) Family Cost Share Expense:

The *New Jersey Early Intervention System (NJEIS),* under the *Division of Family Health Services,* implements New Jersey's statewide system of services for infants and toddlers, birth to age three, with developmental delays or disabilities, and their families. *The Department of Health and Senior Services* is appointed by the Governor as the state lead agency for the *NJEIS.*

Benefits under this section include reimbursement of a portion of the family cost share expense incurred by Covered Persons for the provision of certain health care services obtained in accordance with a treatment plan developed as a result of, or in conjunction with, an Individualized Family Service Plan (IFSP) for a child determined eligible for early intervention services through the *NJEIS.*

The IFSP is both a plan and a process. The plan is a written document that identifies the outcomes, services and supports needed for the child and family. The process is ongoing assessment to gather, share, and exchange information between the family and the early intervention practitioners to help parents make informed choices about early intervention services and other needed services for the child and family.

The NJEIS family cost share is a progressive co-payment per hour of direct services provided in accordance with an IFSP that is based upon family size and NJEIS determined income along the federal poverty level guidelines. In order to be eligible for reimbursement, the Covered Person must:

a) Be eligible for early intervention services through the NJEIS;

b) Have been diagnosed with Autism Spectrum Disorder or another Developmental Disability; and

c) Received physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services.

The portion of the family cost share attributable to such services is a Covered Health Care Service under the Policy.

The therapy services a Covered Person received through NJEIS do not reduce the therapy services otherwise available under the Policy.

24. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

25. Pharmaceutical Products - Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *Certificate.* Benefits for medication

normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Rider.*

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we may direct you to a Designated Dispensing Entity. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

26. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

Second and third opinions:

Physician fees for a second opinion, including the review of the results of any laboratory and radiology essential to the second opinion, where another licensed Physician proposes to perform an elective inpatient surgical procedure on a Covered Person. For purposes of this Benefit, an inpatient surgical procedure is one which is scheduled at the convenience of the Covered Person or the Covered Person's Physician without jeopardizing the Covered Person's life or causing serious impairment to the Covered Person's bodily functions. If the second surgical opinion does not confirm that the proposed elective surgical procedure is medically advisable, then Physician Fees for a third surgical opinion shall be covered in the same manner as those covered for a second surgical opinion. A Physician providing a second or third surgical opinion shall be a Physician who is licensed to practice medicine and surgery who holds the rank of Diplomate of an American Board (M.D.) or Certified Specialist (O.D.) in the surgical or medical specialty for which surgery is proposed. In the event that the Physician who provides a second or third surgical opinion also performs the elective surgical procedure being proposed, then no Benefits for the second or third opinion will be paid to that Physician.

27. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered providers when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services.*

Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient.*

When a test is performed or a sample is drawn in the Physician's office, Benefits for the analysis or testing of a lab, radiology/X-ray or other diagnostic service, whether performed in or out of the Physician's office, are described under *Lab, X-ray and Diagnostic - Outpatient.*

28. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

We may also have special prenatal programs to help during Pregnancy. They are voluntary and there is no extra cost for taking part in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the expected date of delivery. It is important that you notify us regarding your Pregnancy.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

29. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

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

Benefits for the services below are required under New Jersey law:

- Screening and diagnostic mammography.
- Screening for colorectal cancer as follows:
  - Annual guaiac-based fecal occult blood test (gFOBT) with high test sensitivity for cancer.
  - Annual immunochemical-based fecal occult blood test (FIT) with high test sensitivity for cancer.
  - Stool DNA (sDNA) test with high test sensitivity for cancer.
  - Screening colonoscopy or Flexible sigmoidoscopy every five years.
  - Colonoscopy every ten years.
  - Double contract barium enema every five years.
  - Computed tomography colonography (virtual colonoscopy) every five years.
- A Pap smear including all laboratory costs associated with the pap smear and any confirmatory test.
- Cervical cancer screening.
- Screening for blood lead measurement for lead poisoning for children. Screening for blood lead measurement includes confirmatory blood lead testing and medical evaluation and any necessary medical follow-up and treatment of lead-poisoned children.
- Bone mineral density tests.

Health Wellness Exams

Benefits are provided for health wellness examinations which include the following tests and services:

- For Covered Persons 20 years of age and older, annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density liporotein (LDL) level and blood high-density lipoprotein (HDL) level.
- For Covered Persons 35 years of age or older, a glaucoma eye test every five years.
- For Covered Persons 40 years of age or older, an annual stool examination for presence of blood.
- For Covered Persons 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years.
- For women 20 years of age or older, a pap smear.
- For women 40 years of age or older, one baseline mammogram and annual mammogram examination. Benefits include coverage for digital tomosynthesis when used for the detection and screening of breast cancer.
- For women under 40 years of age who have a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed Medically Necessary by the woman's provider.
- For adult Covered Persons, recommended immunizations.
- Other tests and services recommended as Medically Necessary by a Physician.
- For all persons 20 years of age or older, an annual consultation with a Physician to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles.

In addition to the mammogram examinations listed above, we will cover an ultrasound evaluation, an MRI, a three-dimensional mammography, or other additional testing of an entire breast or breasts, after a baseline mammogram examination if one of the following conditions is met:

a) The mammogram demonstrates extremely dense breast tissue;

b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or

c) If the Covered Person has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the *Breast Imaging Reporting and Data System established by the American College of Radiology* or other indications as determined by the Covered Person's practitioner.

Breastfeeding Support Services

Benefits include comprehensive lactation support, counseling, and consultation, and the costs for renting or purchasing breastfeeding equipment, in conjunction with each birth, for the duration of breastfeeding for health plan enrollees.

Coverage of comprehensive lactation counseling and lactation consultation includes:

- In-person, one-on-one lactation counseling and lactation consultation, subject to the following conditions:
  - Includes visits that occur inside and outside a hospital or office setting. In-person lactation counseling and lactation consultation shall be covered regardless of location of service provision and shall include home visits.
  - Lactation counseling and lactation consultation will be made available within 24 hours of notification of need.
- Telephonic lactation assistance will be covered in addition to, and not as a substitute for, in-person, one-on-one lactation counseling or lactation consultation, when a Covered Person requests one-on-one, in-person lactation counseling or lactation consultation. The telephonic lactation assistance will be provided within 12 hours of notification of need.
- Group lactation counseling will be covered in addition to, and not as a substitute for, one-on-one, in-person lactation counseling or lactation consultation, if a Covered Person requests one-on-one, in-person lactation counseling or lactation consultation. Group counseling will include educational classes and support groups.

- We will not require prior authorization, prescription or referral for any lactation counseling or lactation consultation, regardless of provider type or setting.
- We will not not impose medical management techniques not described in this section.

Coverage of breastfeeding equipment shall include:

- Purchase of a single-user breast pump, subject to the following conditions:
  - We will cover the purchase of a double electric breast pump. If a Covered Person requests a manual pump in lieu of the double electric breast pump, we will cover the purchase of a manual pump.
  - A double electric breast pump provided shall be of sufficient power and durability to establish and maintain milk supply for the duration of breastfeeding.
  - We will not require documentation of medical necessity, prior authorization, or a prescription.
  - Coverage shall be available at any time during pregnancy and the postpartum period, and shall continue for the duration of breastfeeding as defined by the Covered Person.
  - Coverage for breast pumps shall include repair or replacement if necessary.
- Rental or purchase of a multi-user breast pump, on the recommendation of a licensed health care provider, subject to the following conditions:
  - When recommended by a licensed health care provider, we will provide coverage for a multiuser breast pump.
  - We may determine whether a rental or purchase is covered.
  - Coverage for a multi-user breast pump will be covered without regard to coverage or acquisition of a single-user breast pump.
  - We may require a letter of medical necessity from a lactation consultant or other health care provider for coverage of a multi-user pump. The letter shall not interfere with the timely acquisition of a multi-user pump.
- Coverage of breastfeeding equipment under this section shall include two breast pump kits per birth event, as well as appropriate size breast pump flanges, or other lactation accessories recommended by a health care provider.
- Single-user breast pumps and breast pump kits specified above will be furnished: within 48 hours of notification of need, if requested after the birth of the child; or by the later of two weeks before the Covered Person's expected due date or 72 hours after notification, if requested prior to the birth of the child. If we cannot ensure a Covered Person receives breastfeeding equipment within 48 hours, they may purchase the equipment and we will reimburse all out-of-pocket expenses incurred by the Covered Person, including any balance billing amounts.
- Multi-user breast pumps shall be made available within 12 hours of notification of need. If equipment is not available within 12 hours of notification of need, we will reimburse all out-of-pocket rental expenses incurred by a Covered Person, including any balance billing amounts, until the Covered Person receives breastfeeding equipment.

30. Prosthetic Devices and Orthotics

Prosthetics

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998.* Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME) and Supplies.*

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prosthesis. Internal prosthetics are a Covered Health Care Service for which

Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate.*

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Orthotics

Orthotics that straighten or re-shape a body part. For the purpose of this Benefit this refers to a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

The prosthetic device or orthotic must be ordered or provided by, or under the direction of a Physician who deems the device to be Medically Necessary and must be obtained from a licensed orthotist or prosthetist, or any certified pedorthist.

Benefits are available for repairs and replacement, if deemed to be Medically Necessary by a Physician.

Reimbursement for these items will be at the same rate as under the federal Medicare reimbursement schedule.

31. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly.

Reconstructive procedures include the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children. These procedures that correct an anatomical Congenial Anomaly are not considered Cosmetic Procedures.

Cosmetic Procedures are excluded from coverage. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury or Sickness does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998,* including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

32. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care.* Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

33. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient.*

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

Benefits that apply to certain preventive screenings are described under *Preventive Care Services.*

34. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

35. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal, ear wax removal, and cast application.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

36. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered providers when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.*

37. Transplantation Services

Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.

- Cornea.

Benefits are available for the treatment of Wilms' tumor, including autologous bone marrow transplants when standard chemotherapy is unsuccessful, even when such treatment is considered Experimental or Investigational.

Treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants are a Covered Health Care Service for which Benefits are payable when performed at a Provider that is approved by the National Cancer Institute or performed pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Policy, limited to donor:

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

Transplantation services must be performed at our Designated Facilities in order to receive Network Benefits. Refer to the *Schedule of Benefits* for applicable prior authorization requirements. Please note that not all Network Hospitals are contracted to perform transplants. Please refer to your provider directory or contact us to find out which Hospitals are contracted for this service.

If you reside more than 50 miles from the Designated Facility and are required to travel to obtain transplantation services from the Designated Facility, we will provide for reimbursement of travel and lodging expenses for the Covered Person and one companion. Coverage is limited to $50-$100 lodging per day, up to a maximum Benefit of $10,000 per lifetime.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for transplant services.

38. Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury.*

39. Urinary Catheters

Benefits for indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

40. Virtual Visits

Virtual visits are available via Telehealth or Telemedicine for Covered Health Care Services that include the diagnosis and treatment of less serious, non-emergent medical conditions, including but not limited to, flu, colds, pink eye, rashes and fevers. Virtual visits provide communication of medical information in realtime between the patient and a distant Physician or health specialist, through use of live audio and video technology or audio only outside of a medical facility (for example, from home or from work).

For the purposes of this Benefit, the following definitions apply:

"Telehealth means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, Practitioner consultation, patient and professional health-related education, public health, health administration, and other services in accordance with the provisions of P.L. 2017, c. 117."

"Telemedicine means the delivery of a health care service using electronic communications, information

technology, or other electronic or technological means to bridge the physical distance between a Practitioner and a Covered Person, either with or without the assistance of an intervening Practitioner, and in accordance with the provisions of P.L. 2017, c.117. Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission."

Benefits are available under this Benefit only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

Please Note: Not all medical conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, text or instant-messaging, fax, or for telehealth/telemedicine visits that occur within medical facilities *(CMS* defined originating facilities).

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

To help you find exclusions, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through a Rider to the Policy.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services,* those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits.* Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
7. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health.* This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services.*

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* and Dental Services - Other in *Section 1: Covered Health Care Services.*

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* and Dental Services - Other in *Section 1: Covered Health Care Services.*
3. Dental implants, bone grafts and other implant-related procedures. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* and Dental Services - Other in *Section 1: Covered Health Care Services.*
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly except for treatment of medically diagnosed congenital birth defects and birth abnormalities in Dependents that have been covered under the Certificate from the moment of birth.

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
4. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME) and Supplies* in *Section 1: Covered Health Care Services.*
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.

8. Powered and non-powered exoskeleton devices.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to oral agents for controlling blood sugar or to medications used to treat infertility for which Benefits are provided as described under *Diabetes Services* and *Infertility Services* in *Section 1: Covered Health Care Services.*
2. Self-administered or self-infused medications, except as described under the heading *Diabetes Services* in *Section 1: Covered Health Care Services.* This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments. This exclusion does not apply to diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
5. Growth hormone therapy.
6. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services* or to the treatment for Wilm's tumor as described under *Transplantation Services* in *Section 1: Covered Health Care Services.*

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Arch supports.

G. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.

   This exclusion does not apply to:

   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME) and Supplies and Prosthetic Devices* in *Section 1: Covered Health Care Services.* This exception does not apply to supplies for the administration of medical food products.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
   - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Care Services.*
   - Urinary catheters and related urologic supplies for which Benefits are provided as described under *Urinary Catheters* in *Section 1: Covered Health Care Services.*

2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME) and Supplies* in *Section 1: Covered Health Care Services.*
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

H. Mental Health Condition and Substance Use Disorder

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations,* the exclusions listed directly below apply to services described under *Mental Health Condition and Substance Use Disorder Services* in *Section 1: Covered Health Care Services.*

1. Services performed in connection with conditions not in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be Mental Health Conditions within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
3. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This does not apply to Behavioral Interventions based on *Applied Behavioral Analysis (ABA)* or any Benefits payable under *New Jersey Early Intervention Family Cost Share Expense* in the *Mental Health Condition and Substance Use Disorder Services section.*
4. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*
5. Transitional Living services.

I. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided

as part of treatment for a disease by appropriately licensed or registered providers when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

2. Food of any kind, infant formula, standard milk-based formula and donor breast milk. This exclusion does not apply to enteral formula, donated human breast milk and other modified food products for which Benefits are provided as described under Enteral Nutrition in Section 1: Covered Health Care Services.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

J. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under *Preventive Care Services.*
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot and cold compresses.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
   - Saunas.
   - Stair lifts and stair glides.
   - Strollers.
   - Safety equipment.

- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms.* Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means.

   We pay Benefits for the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

L. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, Autism Spectrum Disorder or another Developmental Disability.
5. Habilitative services for preventive treatment.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
7. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
8. Biofeedback.

9. Services for the evaluation and treatment of (TMJ), whether the services are considered to be medical or dental in nature.

10. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.

11. Surgical and non-surgical treatment of obesity.

12. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

13. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*

14. Helicobacter pylori (H. pylori) serologic testing.

15. Intracellular micronutrient testing.

16. Health care services provided in the emergency department of a Hospital or Alternate Facility that are not for an Emergency.

M. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal address.

3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

   - Has not been involved in your medical care prior to ordering the service, or
   - Is not involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

N. Reproduction

1. The following Infertility treatment-related services:

   - Cryo-preservation and other forms of preservation of reproductive materials. This exclusion does not apply to cryo-preservation when used as standard fertility preservation when medical treatment may cause *Iatrogenic Infertility.*
   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Infertility treatment for infertility resulting from voluntary sterilization procedures.

2. The following services related to a Gestational Carrier or Surrogate:

   - All costs related to reproductive techniques including:
     - Assistive Reproductive Technology (ART).
     - Artificial insemination.
     - Intrauterine insemination.

- ♦ Obtaining and transferring embryo(s).

  The exclusion for costs related to reproductive techniques does not apply when the Gestational Carrier or Surrogate is a Covered Person for whom Benefits are provided as described under *Infertility Services* in *Section 1: Covered Health Care Services.*

- Health care services including:
  - ♦ Inpatient or outpatient prenatal care and/or preventive care.
  - ♦ Screenings and/or diagnostic testing.
  - ♦ Delivery and post-natal care.

  The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

- All fees including:
  - ♦ Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
  - ♦ Surrogate insurance premiums.
  - ♦ Travel or transportation fees.

3. The reversal of voluntary sterilization.
4. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of infertility.

O. Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities:
   - as a result of war or an act of war, if the illness or Injury occurs while you are serving in the military, naval or air forces of any country, combination of countries or international organization; and
   - as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the illness or Injury occurs while you are serving in such forces and are outside the United States and Canada.
4. Health care services during active military duty:
   - as a result of war or an act of war, if the illness or Injury occurs while you are serving in the military, naval or air forces of any country, combination of countries or international organization; and
   - as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the illness or Injury occurs while you are serving in such forces and are outside the United States and Canada.

P. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services.*
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health care services for transplants involving animal organs.

4. Transplant services not received from a Designated Provider will not be paid on a Network basis. Out-of-Network Benefits will apply, if applicable. This exclusion does not apply to cornea transplants.

Q. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back as determined by us. Refer to *Transplantation Services* in *Section 1: Covered Health Care Services* for more information. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services.*

R. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care regardless of whether provided in a home setting or in a facility.
3. Private Duty Nursing.
4. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services.*
5. Rest cures.
6. Services of personal care aides.
7. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

S. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Routine vision exams, including refractive exams to determine the need for vision correction.
3. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Bone anchored hearing aids except when either of the following applies:
   - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
   - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

   More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Policy.

   Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

T. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Health Condition, Substance Use Disorder, condition, disease or its symptoms.
   - Medically Necessary.
   - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations.*
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war:
   - as a result of war or an act of war, if the illness or Injury occurs while you are serving in any civilian non-combatant unit supporting or accompany any military, naval or air forces of any country, combination of countries or international organization; and
   - as a result of the special hazards incident to service in any civilian non-combatant unit supporting or accompanying such forces, provided the illness or Injury occurs while you are serving in such unit and are outside the United States and Canada.
4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived.
7. Charges in excess of the Allowed Amount or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Group. The Group will submit the completed forms to us, along with any required Premium. We will not provide Benefits for health care services that you receive before your effective date of coverage.

What If You Are Hospitalized When Your Coverage Begins?

We will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Policy.

These Benefits will be paid by us unless they are being paid by a prior carrier under such prior carrier's obligations with respect to extension of benefits under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Care Services from Network providers unless rendered to treat an Emergency as described in the Emergency Health Care Services Benefit in *Section 1: Covered Health Care Services* section. Covered Health Care Services received in accordance with the Emergency Health Care Services Benefit will be treated as Network Benefits regardless of whether the services were rendered by a Network or an out-of-Network provider.

Who Is Eligible for Coverage?

The Group determines who is eligible to enroll and who qualifies as a Dependent. Please contact the Benefits administrator of the Group for information on who they have determined is eligible to enroll under this Policy.

Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms.*

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms.*

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

The term spouse also includes Civil Union Partners as defined by, and in accordance with New Jersey law and the valid laws of another jurisdiction under which a civil union relationship was created.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

For a description of the *State of New Jersey Continuation for Over-Age Dependents, see Section 4: When Coverage Ends.*

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth. Coverage for a newborn child begins at the moment of birth and continues for 60 days as if the child were enrolled, without additional Premium for these 60 days.
- Legal adoption.
- Placement for adoption.
- Marriage or civil union.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage or civil union.

- Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP).* Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including legal separation, divorce, dissolution of a civil union or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
  - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
  - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP).* Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Unless you are entitled to *Extended Coverage for Total Disability,* your right to Benefits automatically ends on the date that coverage ends, even if you are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, we will still pay claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Please note that if you are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent." You must notify us when a child no longer meets the requirements for Dependent coverage. If we are not notified, the Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions. Refer to the definition of "Dependent" in *Section 9: Defined Terms* for requirements of Dependent coverage.

- **We Receive Notice to End Coverage**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends on the last day of the calendar month in which we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later.

- **Subscriber Retires or Is Pensioned**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Group's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's Application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Group can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 30 days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. In this case, we will also refund the Premiums that were paid to us for your coverage.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of intellectual disability or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental, or physical disability.
- The Enrolled Dependent child depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent child is incapacitated and dependent unless coverage otherwise ends in accordance with the terms of the Policy.

You must furnish us with proof of the incapacity and dependency within 31 days of the date coverage would have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that exam.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year.

If you do not provide proof of the child's incapacity and dependency within 31 days of our request as described above, coverage for that child will end.

Extended Coverage for Total Disability

Coverage when you are Totally Disabled on the date the entire Policy ends will not end automatically. We will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Twelve months from the date coverage would have ended when the entire Policy ends.
- The date maximum Benefits under the Policy have been received.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA.* Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA.*

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

New Jersey Continuation Rights for Over-Age Dependents (NJCROD)

A dependent who has elected to continue his or her coverage under the group policy under which his or her parent is currently covered pursuant to NJCROD shall not be entitled to further continue coverage under COBRA when continuation pursuant to NJCROD ends. As used in this provision, "Over-Age Dependent" means an Employee's child by blood or law who:

- Has reached the limiting age as described in this *Certificate of Coverage* , under *Section 9: Defined Terms*, but is less than 31 years of age;
- Is not married or part of a civil union or part of a domestic partnership;
- Has no Dependents of his or her own;
- Is either a resident of New Jersey or in enrolled as a Full-time Student at an accredited school; and
- Is not covered under any other group or individual health benefits plan, group health plan, church plan, or health benefits plan, and is not entitled to Medicare.

Eligibility for Continuation through NJCROD

If a Dependent child's group health benefits end or have ended due to his or her attainment of the limiting age described in this Certificate of Coverage, he or she may elect to continue such benefits until his or her 31st birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends sections below.

Conditions for Election - An Over-Age Dependent is only entitled to make an election for continued coverage if all of the following conditions are met:

- The Over-Age-Dependent must provide evidence of prior creditable coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan or Medicare. Such prior coverage must have been in effect on the date the Over-Age-Dependent reached the limiting age, or at any time after such date but prior to making an election for this Over-Age-Dependent coverage.
- The Subscriber of an Over-Age Dependent must be enrolled as having elected Dependent coverage at the time the Over-Age Dependent elects continued coverage. Except, if the employee has no other Dependents, or has a spouse who is covered elsewhere, the Over-Age-Dependent may nevertheless select continued coverage.

Election of Continuation - To continue health benefits, the Over-Age Dependent must make written election to us. The effective date of the continued coverage will be the later of:

- The date the Over-Age Dependent gives written notice to us;
- The date the Over-Age Dependent pays the first premium; or
- The date the Dependent would otherwise lose coverage due to the attainment of the limiting age.

For a Dependent whose coverage has not yet terminated due to reaching the limiting age stated in this *Certificate of Coverage, Section 9: Defined Terms - Dependent,* the written election must be made within 30 days prior to termination of coverage due to the attainment of the limiting age.

For a person who did not qualify as an Over-Age Dependent because he or she fails to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election must be made within 30 days after the person first subsequently meets all of the requirements for an Over-Age Dependent.

This election opportunity is explained in greater detail as follows:

- If a person did not qualify because he or she was married or part of a civil union, the notice must be given within 30 days of the date he or she is no longer married.
- If a person did not qualify because he or she had a Dependent of his or her own, the election must be made within 30 days of the date her or she no longer has a Dependent.
- If a person did not qualify because he or she either was not a resident of New Jersey or was not a Full-time student at an accredited school, the election must be made within 30 days of the date he or she becomes a resident a New Jersey, or becomes a Full-time Student at an accredited school.
- If a person did not qualify because he or she was covered under another group or individual health benefits plan, group health plan, church plan or health benefits plan, or was entitled to Medicare, the election must

be made within 30 days of the date he or she is no longer covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or is no longer entitled to Medicare.

Each year there will be an Open Enrollment Period during which an Over-Age Dependent, who previously did not elect to continue coverage, may make an election to continue coverage. A group Open Enrollment Period will be held at least annually.

Application of a Pre-Existing Conditions Exclusion

An Over-Age Dependent who was covered under prior creditable coverage that terminated no more than 90 days prior to making an election for continuation under this section will be given credit for the time he or she was covered under the credible coverage toward the application of the Pre-Existing Conditions Exclusion under the Policy.

Premium Payments

The first month's Premium must be paid within 30 days of the date the Over-Age Dependent elects continued coverage.

The Over-Age Dependent must pay subsequent Premiums monthly, in advance, at the times and in the manner specified by us. The monthly Premium will be set by us, and must be consistent with the requirements of P.L. 2005, c.375.

Continued Benefits

The continued benefits shall be identical to the coverage provided to the Over-Age Dependent's Subscriber who is covered as an Employee under the Policy. If coverage is modified for Dependents who are under the limiting age, the coverage for Over-Age Dependent's Subscriber who is covered as an employee under the Policy. If coverage is modified for Dependents who are under the limiting age, the coverage for Over-Age Dependents shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

When Continuation Ends

An Over-Age Dependent's continued group health benefits end on the first of the following:

The date the Over-Age Dependent:

- Attains age 31;
- Marries or enters a civil union;
- Acquires a Dependent;
- Is no longer either a resident of New Jersey or enrolled as a Full-time Student at an accredited school; or
- Becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare.

- The end of the period for which Premium has been paid for the Over-Age Dependent, subject to the grace period for such payment;
- The date the Policy ceases to provide coverage to the Over-Age Dependent's Subscriber who is the employee under the Policy.
- The date the Policy under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.
- The date the Over-Age Dependent's Subscriber who is covered as an Employee under the Policy waives Dependent coverage. Except if the Subscriber has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Subscriber waiving Dependent coverage.

State Continuation of Coverage for Totally Disabled Subscribers

If a Subscriber's coverage stops because his or her employment ends and the Subscriber meets the conditions shown below, the Subscriber may choose to continue the coverage then in effect. The Subscriber must meet the following conditions:

- The Subscriber's employment ended because he or she is Totally Disabled.
- The Subscriber must have been covered under the Policy for at least three months before his or her coverage would have stopped.
- The Subscriber must choose to continue coverage within 31 days after the date his or her coverage would have stopped.
- The Subscriber will have to make payments to the Group for the coverage.

Coverage will stop on the earliest of the following:

- The date the Subscriber becomes employed and eligible for another plan of group health coverage.
- The date coverage ends for failure to make timely payment of the Premium.
- The date the Policy ends.

"Totally Disabled" for the purpose of this state continuation means the Subscriber's complete inability due to Injury or Sickness to engage in any and every gainful occupation for which the Subscriber is or becomes reasonably fitted by education, training or experience and that the Subscriber is not engaged in any gainful occupation.

Optional State Continuation of Coverage After the Subscriber's Death

If the Subscriber dies while covered, his or her Dependents' coverage may continue. It will continue with the same benefits and provisions that the Subscriber's Dependents had while the Subscriber was alive. It will continue only while the Policy is in force. It will stop on the earlier of the following:

- The date of the Subscriber's widow's or widower's death, or the date the last child stops being an eligible Dependent, whichever happens later.
- 180 days after the date of the Subscriber's death.

The Subscriber's Dependents will have to make payments to the Group for the coverage.

After the Subscriber's widow's or widower's death, coverage for the Subscriber's Dependent children may be continued. It will continue with the same Benefits and provisions that the Subscriber's Dependents had while the Subscriber's widow or widower was alive. It will continue according to the rules and time limits described above.

Conversion

If your coverage Ends for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

If your marriage or civil union is dissolved, the Subscriber's former spouse may buy conversion coverage. The conversion coverage will be an individual policy. The Subscriber's former spouse may apply for conversion coverage at either of the following times:

- The date the marriage or civil union is dissolved.
- At the end of any period of continuation of coverage under the Policy, but only if the Policy is in force on that date.

Application and payment of the first Premium must be made within 31 days after coverage ends under the Policy.

Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, contact us. However, you are required to meet any applicable deductible and to pay any required Co-payments and Co-insurance to a Network provider.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, if you make an assignment of Benefits, the out-of-Network provider is responsible for requesting payment from us. The out-of-Network provider must file the claim on the standard claim form prescribed by New Jersey that contains all of the information we require, as described below. At your option, you may also submit the claim to us directly.

Your out-of-Network provider should submit a request for payment of Benefits within 90 days after the date of service. If you have assigned benefits to the non-Network provider, as described below, the non-Network provider should submit a request for payment of Benefits within 180 days after the date of service. If this information is not provided to us within one year of the date of service, Benefits for that health care service will be denied or reduced, subject to the appeal provisions in *Section 6, Questions, Complaints and Appeals.* This time limit does not apply if it was not reasonably possible to submit the request in the time required and the request was submitted as soon as reasonably possible. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, we will provide you with the appropriate forms to submit proof of loss. You must submit the completed form to us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card.

When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum RX

PO Box 29077

Hot Springs, AR 71903

If you do not receive the forms for proof of loss within 15 days of our receipt of notice of a claim, you may submit written proof of loss describing the occurrence, character and extent of the loss for which the claim is being made.

Payment of Benefits

We will pay Benefits within the time frames shown below after we receive a request for payment that includes all required information.

- 30 days after we receive a request submitted by electronic means.
- 40 days after we receive a request submitted by other than electronic means. Requests for payment that include all required information which are not paid within these time frames will include an overdue payment of simple interest at the rate of 12% per annum.

If you provide written authorization to allow this, all or a portion of any Allowed Amounts due to a provider will be paid directly to the provider instead of being paid to the Subscriber. We will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

When an assignment is not obtained, we will send the reimbursement directly to the Subscriber for reimbursement to an out-of-Network provider. We may, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to an out-of-Network provider, and the out-of-Network provider submits a claim for payment, you and the out-of-Network provider represent and warrant the following:

- The Covered Health Care Services were actually provided.
- The Covered Health Care Services were Medically Necessary.

In accordance with New Jersey law, a consumer may request a review from the Ombudsman of any disputed insurance claim settlement where there is reasonable cause to believe than an insurer has failed or refused to settle a claim in accordance with the provisions of the policy. Consumers seeking a review must file a complaint with the Ombudsman in any form, which indicates that the complainant is seeking review of a disputed claim. All complaints must be sent to:

The Office of Insurance Claims Ombudsman

20 West State Street

P.O. Box 472

Trenton, NJ 08625-0472

Telephone: (800)446-7467

Telefax: (609)292-2431

Email: ombudsman@dobi.state.nj.us

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the appropriate address.

If the representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

If you are not satisfied with our decision, you have the right to take your complaint to the *New Jersey Department of Banking and Insurance.*

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a Rescission of Coverage determination, you can contact us in writing to request an appeal. You may also designate a representative (like your Physician) to appeal on your behalf.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a provider with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon

or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the Adverse Benefit Determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

There are two stages of internal appeals and one stage for external review. You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 10 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 180 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 20 business days from receipt of a request for review of the first level appeal decision. The second level appeal process will provide you (or your provider, if applicable) the opportunity to pursue your appeal before a panel of Physicians and/or other providers that we select who have not been previously involved in the decision being appealed. This will be considered our final Internal Adverse Benefit Determination.
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 10 business days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 180 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 20 business days from receipt of a request for review of the first level appeal decision. The second level appeal process will provide you (or your provider, if applicable) the opportunity to pursue your appeal before a panel of Physicians and/or other providers that we select who have not been previously involved in the decision being appealed. This will be considered our final Internal Adverse Benefit Determination.
- For appeals of benefit determinations concerning urgent or emergency care, an admission, availability of care, continued stay and health care services for which the claimant received emergency services but has not been discharged from a facility:
    - The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
    - We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
    - If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

This process does not apply to prescheduled treatments, therapies or surgeries.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 180 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 72 hours following receipt of your request for review of the first level appeal decision. This will be considered our final Internal Adverse Benefit Determination.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

If an Adverse Benefit Determination is upheld, the notice of our determination will be culturally and linguistically appropriate and will include information sufficient to identify the claim involved such as the date of service, the name of Your Provider, the claim amount (if applicable) as well as information on the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning. Please note that any request for such diagnosis and treatment information following an Adverse Benefit Determination will be responded to as soon as practicable, and the request itself will not be considered a request for the next level of appeal.

The notice will include the reasons for our decision, the clinical rationale, if applicable, and specific plan provisions on which the determination was based. It will include information on how to file the next level of appeal, if applicable, and any new or additional evidence or rationale, which we relied upon, considered or used in

making our decision. We will provide this information, when applicable, in advance of our final Internal Adverse Benefit Determination.

The notice will also include information on the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists covered persons with claims, internal appeals and external reviews.

You may have the right to external review through an *Independent Utilization Review Organization (IURO)* upon the completion or exhaustion of the internal appeal process and receipt of our final Adverse Benefit Determination. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

External Review Program

If you are not satisfied with the results of our internal appeal process, you may pursue an external review through an *Independent Utilization Review Organization ("IURO")* for final Internal Adverse Benefit Determinations, except where the final Internal Adverse Benefit Determination was based on eligibility, including Rescission of Coverage, or the application of a contract exclusion or limitation not related to medical necessity. You must complete both a first level and second level appeal before you can request a review by an *IURO,* except when:

- We fail to comply with any of the deadlines for completion of the internal appeals process without demonstrating good cause or because of matters beyond our control while in the context of an ongoing, good faith exchange of information between parties and it is not a pattern or practice of noncompliance;
- We for any reason expressly waives our rights to an internal review of any appeal; or
- You and/or Your Provider have applied for expedited external review at the same time as applying for an expedited internal review.

Please note that in such a case where we assert good cause for not meeting the deadlines of the appeals process, you may request a written explanation of the violation. We will provide the explanation within 10 days of the request and will include a specific description of the bases for which we determine the violation should not cause the internal appeals process to be exhausted. If an external reviewer or court agrees with us and rejects the request for immediate review, you will have the opportunity to resubmit your appeal.

To initiate the external review, you or your Designee must:

1. File a written request with the New Jersey Department of Banking and Insurance within 4 months of receiving a final Internal Adverse Benefit Determination on your appeal. The written request must be made on the form supplied to you by Us (enclosed with the appeal decision);
2. You must sign a release that will allow the *IURO* to review all of the necessary medical records that are related to the appeal; and
3. You must also include a check or money order in the amount of $25.00 made payable to: New Jersey Department of Banking and Insurance. Upon a determination of financial hardship, the fee may be waived. In such instances, you must show the Department that you are eligible for either: Pharmaceutical Assistance to the Aged and Disabled, Medicaid, General Assistance, SSI, or New Jersey Unemployment Assistance. Please note that annual filing fees for any one covered person shall not exceed $75.00.

The form, release and check must be sent to:

Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
PO Box 329
Trenton, NJ 08625-0329

Phone: (888) 393-1062

When the Department has all three items, they will assign your appeal to an *IURO.* When the *IURO* receives the appeal, it will conduct a preliminary review. It will accept your appeal for processing only if:

1. You are or were a member of the plan at the time of the event that is the subject of the Adverse Benefit Determination;

2. The service in question reasonably appears to be a Covered Health Care Service under the Certificate;

3. Unless we have failed to comply with the deadlines for completion of the internal appeals process without good cause; we have expressly waived our rights to an internal review; or you have applied for expedited external review at the same time as applying for an expedited internal review, you must have completed both an first level and a second level appeal; and

4. You have provided all information required by the *IURO* and the Department to make the preliminary determination, including the appeal form and a copy of any information provided by us regarding our decision to deny, reduce or terminate the Covered Health Care Service, and a fully executed release to obtain any necessary medical records from us and any other relevant health care provider.

Once the preliminary review is completed, the *IURO* will inform you or your designee, in writing, as to whether or not the appeal is accepted for processing, and if not, the reasons therefore. The *IURO* shall additionally notify you and/or your provider of your right to submit in writing, within five business days of receipt of the notice of acceptance of your appeal, any additional information to be considered in the *IURO's* review. The *IURO* shall provide us with any such additional information within one business day of receipt of the information.

If the appeal is accepted, the *IURO* will conduct a full review to determine whether, as a result of the our final Internal Adverse Benefit Determination, you were deprived of coverage of Covered Health Care Services. In reaching this determination the *IURO* shall take into consideration all pertinent medical records, consulting physician reports and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by us.

The review will be conducted by an expert physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final decisions of the *IURO* will be approved by the medical director of the *IURO,* who will be a New Jersey licensed physician.

The review will be completed within 45 days of the *IURO's* receipt of the appeal application. If the appeal involves care for urgent or emergency care, an admission, availability of care, continued stay, health care services for which the claimant received emergency services but has not been discharged from a facility or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the *IURO* shall complete its review within no more than 48 hours following its receipt of the appeal. If the *IURO's* determination of the appeal provided within no more than 48 hours was not in writing, the *IURO* shall provide written confirmation of its determination within 48 hours of providing the verbal determination.

If the *IURO* determines that the denial, reduction or termination of benefits deprived you of medically necessary Covered Health Care Services, it shall advise to you, your Provider, the Department of Banking and Insurance and us its decision regarding the appropriate, health care services that you should receive. The *IURO's* determination will be binding on both parties, except to the extent that other remedies are available to either party under State or Federal law. If all or part of the *IURO's* decision is in favor of you, we shall promptly provide coverage, including payment on the claim, for the health care services found by the *IURO* to be Covered Health Care Services. If you are not in agreement with the *IURO's* decision, you may seek the services outside of the health plan, at your own expense.

Within 10 business days of our receipt of the determination of the *IURO,* we will submit a written report to the *IURO,* you and/or your Provider, and the Department of Banking and Insurance, indicating how we will implement the *IURO's* determination.

It is your RESPONSIBILITY to initiate the external review process. Any member or any Provider acting on behalf of a member with the member's written consent may initiate the external appeal process by filing a completed application with the *New Jersey State Department of Banking and Insurance.*

Please note that we will provide continued coverage of an ongoing course of treatment pending the outcome of an active first level, second level appeal or external review.

Appeals for Inpatient Substance Use Disorder Services

Substance Use Disorder Services are provided as described in Section 1: Covered Health Care Services.

In the case of an Adverse Benefit Determination of an inpatient stay beyond the first 28 days during each plan year at a Network Facility, we will provide you and your Physician written notice within 24 hours. You or your Physician will then have the right to file an expedited internal appeal of our decision. We will provide you with a written or electronic determination of your appeal within 24 hours following receipt of your request for review of the determination.

If our determination is to uphold a denial, you or your Physician have the right to file an expedited external review through an Independent *Utilization Review Organization (IURO)* upon the completion of the expedited internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below. For instance, you may be covered by this Certificate as an employee and by another Plan as a Dependent of your spouse. If you are covered by more than one Plan, this provision allows us to coordinate what we pay or provide with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which you are covered.

Definitions

The words shown below have special meanings when used in this provision. Please read these definitions carefully. Throughout this provision, these defined terms appear with their initial letter capitalized.

Allowable Expense - The charge for any health care service, supply or other item of expense for which you are liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this Plan is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

We will not consider the difference between the cost of a private Hospital room and that of a semi-private Hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and appropriate.

When this Plan is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, we will only consider corresponding services, supplies or items of expense to which coordinati on of benefits applies as an Allowable Expense.

Claim Determination Period - A calendar year, or any portion of a calendar year, during which you are covered by this Plan and at least one other Plan and incur one or more Allowable Expense(s) under such Plans.

Plan - Coverage with which coordination of benefits is allowed. Plan includes:

- Group insurance and group Subscriber contracts, including insurance continued pursuant to a federal or state continuation law;
- Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a federal or state continuation law;
- Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a federal or state continuation law;
- Group hospital indemnity benefit amounts that exceed $150.00 per day;
- Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance Plan or non-governmental Plan.

Plan does not include:

- Individual or family insurance contracts or Subscriber contracts;
- Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice Plans;
- Group or group-type coverage where the cost of coverage is paid solely by you except that coverage being continued pursuant to a federal or state continuation law shall be considered a Plan;
- Group hospital indemnity benefit amounts of $150.00 per day or less;

- School accident-type coverage;
- A state Plan under Medicaid.

Primary Plan - A Plan whose benefits for your health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either of the below exist:

- The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits provision; or
- All Plans which cover you use order of benefit determination rules consistent with those contained in the Coordination of Benefits provision and under those rules, the plan determines its benefits first.

Reasonable and Customary - An amount that is not more than the usual or customary charge for the service or supply as determined by us, based on a standard which is most often charged for a given service by a provider within the same geographic area.

Secondary Plan - A Plan which is not a Primary Plan. If you are covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

We consider each Plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideratio n the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the Plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each claim determinati on period the Secondary Plan(s) will pay up to the remaining unpaid Allowable Expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "Procedures to be Followed by the Secondary Plan to Calculate Benefits" section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for Medically Necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Order of Benefit Determination Rules

The benefits of the Plan that covers you as an employee, member, Subscriber or retiree shall be determined before those of the Plan that covers you as a Dependent. The coverage as an employee, member, Subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers you as an employee who is neither laid off nor retired, or as a Dependent of such person, shall be determined before those for the Plan that covers you as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers you as an employee, member, Subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers you under a right of continuation pursuant to federal or state law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

- The benefits of the Plan of the parent whose birthday falls earlier in the calendar year shall be determined before those of the parent whose birthday falls later in the calendar year.

- If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the Plan which covered the other parent for a shorter period of time.
- "Birthday," as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
- If the other Plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

- The benefits of the Plan of the parent with custody of the child shall be determined first.
- The benefits of the Plan of the spouse of the parent with custody shall be determined second.
- The benefits of the Plan of the parent without custody shall be determined last.
- If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which Plan is the Primary Plan, the benefits of the Plan that covers the employee, member or Subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Effect on the Benefits of This Plan

In order to determine which procedure to follow it is necessary to consider:

- The basis on which the Primary Plan and the Secondary Plan pay benefits; and
- Whether the provider who provides or arranges the services and supplies is in the Network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the provider bills a charge and you may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a Network provider, bills a charge, you may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If you use the services of a non-Network provider, the Plan will be treated as an R&C Plan even though the Plan under which you are covered allows for a fee schedule.

Payment to the provider may be based on a "capitation". This means that the HMO or other Plan pays the provider a fixed amount per Covered Person. You are liable only for the applicable deductible, Coinsurance or Co-payment. If you use the services of a non-Network provider, the HMO or other Plan will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is R&C Plan and Secondary Plan is R&C Plan

The Secondary Plan shall pay the lesser of:

- The difference between the amount of the billed charges and the amount paid by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan and Secondary Plan is Fee Schedule Plan

If the provider is a Network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- The amount of any deductible, Co-insurance or Co-payment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and you shall not exceed the fee schedule of the Primary Plan. In no event shall you be responsible for any payment in excess of the Co-payment, Co-insurance or deductible of the Secondary Plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a Network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

- The difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

You shall only be liable for the Co-payment, deductible or Co-insurance under the Secondary Plan if you have no liability for Co-payment, deductible or Co-insurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall you be responsible for any payment in excess of the Co-payment, Co-insurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan

If the provider is a Network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- The amount of any deductible, Co-insurance or Co-payment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan

If the Primary Plan is an HMO plan that does not allow for the use of non-Network providers except in the event of urgent care or emergency care and the service or supply you receive from a non-Network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan

If you receive services or supplies from a provider who is in the Network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

- The amount of any deductible, Co-insurance or Co-payment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan

If you receive services or supplies from a provider who is in the Network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, Co-insurance or Co-payment imposed by the Primary Plan. You shall not be liable to pay any deductible, Co-insurance or Co-payments of either the Primary Plan or the Secondary Plan.

Primary Plan is an HMO and Secondary Plan is an HMO

If the Primary Plan is an HMO plan that does not allow for the use of non-Network providers except in the event of urgent care or emergency care and the service or supply you receive from a non-Network provider is not considered as urgent care or emergency care, but the provider is in the Network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan, except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's Policy will cover or pay for the health care that you may receive. The Policy pays for Covered Health Care Services, which are more fully described in this *Certificate.*
- The Policy may not pay for all treatments you or your Physician may believe are needed. If the Policy does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

What Is Our Relationship with Providers and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.

We do not provide health care services or supplies, or practice medicine. We arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. We are not responsible for any act or omission of any provider unless:

- It is determined by a court of law under the provisions of the *New Jersey Health Care Carrier Accountability Act, 2001* that the provider acted as our agent and that we had the right to exercise influence or control, or actually exercised influence or control over the health care treatment decisions of that provider.
- The other elements for establishing our liability under the Act are proven.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Policy. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Policy.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of when the Policy ends.

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor.*

What Is Your Relationship with Providers and Groups?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy unless it is contained in a written application signed by the Group. No such statement shall void or reduce coverage under the Policy or be used in defense of a legal action unless it is contained in a written application signed by the group or a Subscriber, as applicable.

Do We Pay Incentives to Providers?

We pay Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. Your Co-payment and/or Co-insurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment and/or Co-insurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment and/or Co-insurance as described in your *Schedule of Benefits.*

  For example, if we pay a bundled payment to the surgeon for a total knee replacement, your Co-Payment or Co-Insurance will be calculated based on specialist services. If you receive additional services that are included in the bundled payment, you will not be charged another Co-payment or Co-insurance.

We use various payment methods to pay specific Network providers. From time to time, the payment method

may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also call us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. Contact us at www.myuhc.com or the telephone number on your ID card if you have any questions.

Do We Receive Rebates and Other Payments?

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed onto you, they may be taken into account in determining your Co-payment and/or Co-insurance.

Who Interprets Benefits and Other Provisions under the Policy?

Subject to your appeal rights set forth in the Questions, Complaints and Appeals Procedures Section, we will do of the following:

- Make the initial interpretations of Benefits under the Policy.
- Make the initial interpretations of the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate,* the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

This discretionary authority to interpret Benefits, other terms, conditions, limitations and exclusions under the Policy is subject to modification or reversal by a court or regulatory agency with appropriate jurisdiction.

It does not alter or affect your rights under state or federal statutes or regulations, including the right to bring legal action against us. It does not alter or affect your rights to make a complaint or appeal a denial, including use of the *Independent Health Care Appeals Program.*

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and the Group and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Any subsequent changes in Benefits will be shown in a Rider or Amendment issued to Subscribers.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices.*

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices.*

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Is Workers' Compensation Affected?

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

When Do We Receive Refunds of Overpayments?

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

Except in cases of fraudulent claims, we will make a written request for the reimbursement no later than 18 months after the date the first payment of the claim was made. The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

In seeking reimbursement for the overpayment from the provider, we will not collect or attempt to collect:

- the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the provider;
- the funds for the reimbursement if the provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the provider and until the provider's rights to appeal are exhausted; or
- a monetary penalty against the reimbursement request, including but not limited to, an interest charge or a late fee.

We may collect the funds for the reimbursement request by assessing them against payment of any future claims submitted by the provider after the 45th calendar day following the submission of the reimbursement request to the provider or after the provider's rights to appeal have been exhausted if we submit an explanation in writing to the provider in sufficient detail so that the provider can reconcile each Covered Person's bill.

If we determine that the overpayment to the provider is a result of fraud committed by the provider and we have conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, we may collect an overpayment by assessing it against payment of any future claim submitted by the provider.

Is There a Limitation of Action?

No legal action may be brought against us prior to the expiration of 60 days after proof of loss has been filed. Additionally, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

What Is the Entire Policy?

The Policy, this *Certificate,* the *Schedule of Benefits,* the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group.

Section 9: Defined Terms

Allowed Amounts - for Covered Health Care Services, incurred while the Policy is in effect, Allowed Amounts are determined by us as shown in the *Schedule of Benefits.*

Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines. We develop these guidelines, as we determine, after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT),* a publication of the *American Medical Association,* and/or the *Centers for Medicare and Medicaid Services (CMS).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Condition Services or Substance Use Disorder Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us and the Group. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - the total of the Allowed Amount you must pay for Covered Health Care Services per year before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Assisted Reproductive Technology (ART) - the term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Behavioral Interventions Based on *Applied Behavioral Analysis (ABA)* - interventions or strategies based upon learning theory that are intended to improve socially important behavior of an individual using instructional and environmental modifications that have been evaluated through scientific research using reliable and objective measurements, including the empirical identification of functional relations between behavior and environmental factors. Behavior intervention strategies based on ABA include, but are not limited to:

- chaining;
- functional analysis;
- functional assessment;
- functional communication training;
- modeling, including video modeling (also known as imitation training);

- procedures designed to reduce challenging and dangerous behaviors (e.g. differential reinforcement, extinction, time out, and response cost);
- prompting; and
- reinforcement systems, including differential reinforcement, shaping and strategies to promote generalization.

Benefits - your right to payment for Covered Health Care Services that are available under the Policy.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Civil Union Partners - an individual who is a partner in a civil union. A civil union is defined as, the legally recognized union of two eligible individuals, of the same sex, established pursuant to (or otherwise compliant with) New Jersey law. A civil union also includes relationships entered into under the laws of other jurisdictions provided such relationships provide all of the rights and benefits of marriage.

Co-insurance - the charge, stated as a percentage of the Allowed Amount, that you are required to pay for certain Covered Health Care Services.

Congenital Anomaly - a developmental defect that is present at the time of birth.

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Co-payment.
- The Allowed Amount.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Health Condition, Substance Use Disorder, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits.*
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations.*

Covered Person - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Certificate* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - the Subscriber's legal spouse, Civil Union Partner or a child of the Subscriber or the Subscriber's spouse, Civil Union Partner. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins,* the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.

- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

The following conditions apply:

- A Dependent includes a child listed above who is under age 26 .
- A child is no longer eligible as a Dependent on the last day of the month following the date the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child.*

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month following the date the child reaches age 26 .

If we are not notified that a child no longer meets the above requirements, the Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

For a description of the State of New Jersey Continuation for Over-Age Dependents, see *Section 4: When Coverage Ends.*

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers are Designated Dispensing Entities.

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that has been identified as a Designated Provider. The *Schedule of Benefits* will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service for the treatment of specific diseases or condition; or
- We have identified through our designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting us at www.myuhc.c om or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services via Telehealth or Telemedicine.

Developmental Disability or Developmentally Disabled - also referred to as neurodevelopmental disability or neurodevelopmentally disabled, means a neurodevelopmental disorder which is referenced by the *American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and any subsequent editions.*

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has a Domestic Partnership under either statutory or common law.

Domestic Partnership - a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons. They must:

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same permanent residence and the common necessities of life.

- They must be financially interdependent and they have furnished documents to support one of the following conditions of such financial interdependence:
  - They have a single dedicated relationship of at least 6 - 18 months.
  - They have joint ownership of a residence.
  - They have at least two of the following:
    - A joint ownership of an automobile.
    - A joint checking, bank or investment account.
    - A joint credit account.
    - A lease for a residence identifying both partners as tenants.
    - A will and/or life insurance policies which designates the other as primary beneficiary.

The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Policy. An Eligible Person must live within the United States.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Health Care Services - with respect to an Emergency:

- A medical screening exam (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, Mental Health Condition, Substance Use Disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use; except that coverage is provided for a drug which has been prescribed for a treatment for which the drug has not been approved by the *FDA* provided the drug is recognized for the specific treatment for which the drug has been prescribed in one of the following established reference compendia: (1) the *U.S. Pharmacopoeia Drug Information Guide for the Health Care*

Professional (USPDI); (2) The *American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHES-DI)* or, it is recommended by a clinical study or review article in a major peer reviewed professional journal. However, there is no coverage for any drug which the *FDA* has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
  - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services:* and
  - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The Gestational Carrier does not provide the egg and is therefore not biologically related to the child.

Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Home Health Agency - a program or organization authorized by law to provide health care services in the home or is Medicare certified.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Iatrogenic Infertility - an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Infertility - the disease or condition that results in the abnormal function of the reproductive system, as determined pursuant to the *American Society for Reproductive Medicine* practice guidelines by a physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology or that the patient has met one of the following conditions:

- A male is unable to impregnate a female;
- A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
- A female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;
- A female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision;
- A female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision;
- Partners are unable to conceive as a result of involuntary medical sterility;
- A person is unable to carry a pregnancy to live birth; or
- A previous determination of infertility pursuant to New Jersey state law.

Inherited Metabolic Disease - a disease caused by an inherited abnormality of body chemistry.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient Mental Health Condition or Substance Use Disorder treatment program. The program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Low Protein Modified Food Product - a food product that is specifically formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease, but does not include a natural food that is naturally low in protein.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medically Necessary - health care services that are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Medical Practice.*
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Health Condition, Substance Use Disorder, disease or its symptoms.
- Not mainly for your convenience or that of your Physician or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

With respect to Substance Use Disorder Services, and as described under *Mental Health Conditions and Substance Use Disorder Services* in *Section 1: Covered Health Care Services,* the prospective determination of medical necessity shall be made by the Covered Person's practitioner for the first 180 days of treatment during each year. For the balance of the year, the determination of medical necessity is made by us. The determination of medical necessity for Substance Use Disorder Services shall use an evidence-based and peer reviewed clinical tool as designated in regulation by the *Commissioner of Human Services in consultation with the Department of Health.*

With respect to Pharmaceutical Products, no prescribed drug shall be excluded on the basis that the drug has not been approved by the *United States Food and Drug Administration (USFDA)* for the use for which the drug has been prescribed, if such drug is recognized as Medically Necessary for the specific treatment for which it has been prescribed by the *American Hospital Formulary Service Drug Information,* the *United States Pharmacopoeia Drug Information* or a clinical study or review article in a major peer reviewed professional journal.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other providers on UHCprovider.com.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act,* as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Condition Services - services for the diagnosis and treatment of those Mental Health Conditions or psychiatric categories that are listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.* The fact that a condition is listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health Condition/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Condition Services and Substance Use Disorder Services.

Mental Health Condition - a condition which is referenced by the *American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* and any subsequent editions.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services by way of their participation in the Shared Savings Program. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of our products. In this case, the provider will be

a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy. The Group sets the period of time that is the Open Enrollment Period.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Care Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any audiologist, podiatrist, dentist, psychologist, chiropractor, chiropodist, optometrist, nurse midwife, physical therapist, psychologist, registered professional nurse, speech-language pathologist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. For purposes of Behavioral Interventions Based on *Applied Behavioral Analysis (ABA)* and Related Structured Behavioral Programs for the treatment of Autism Spectrum Disorders, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst - Doctoral or as a Board Certified Behavior Analyst. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Group that includes all of the following:

- Group Policy.
- Certificate.
- *Schedule of Benefits.*
- Group *Application.*
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Group.

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Related Structured Behavioral Programs - services delivered by a qualified practitioner that are comprised of multiple intervention strategies (that is, behavioral intervention packages) based upon the principles of ABA. These packages may include but are not limited to:

- activity schedules;
- discrete trial instruction;
- incidental teaching;
- natural environment training;
- picture exchange communication system;
- pivotal response treatment;
- script and script-fading procedures; and
- self-management.

Rescission - a retroactive cancellation or discontinuance of coverage, e.g., policy void from enrollment, or benefits previously paid that are declared void, due to fraud or intentional misrepresentation of material fact.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Condition Services or Substance Use Disorder Services. It must meet all of the following requirements:

- Provides a program of treatment, approved by the Mental Health Condition/Substance Use Disorder Designee, under the active participation and direction of a Physician and, approved by the Mental Health Condition/Substance Use Disorder Designee. With respect to Substance Use Disorder Services, and as described under *Mental Health Conditions and Substance Use Disorder Services in Section 1: Covered Health Care Services,* the prospective determination of medical necessity shall be made by the Covered Person's practitioner for the first 180 days of treatment during each year. For the balance of the year, the determination of medical necessity is made by us.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Health Care Services not described in this *Certificate.* Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. (Note that Benefits for Outpatient Prescription Drugs, while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.) Riders are effective only when signed by us and the Group and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Same Terms and Conditions - means that the insurer cannot apply more restrictive non-quantitative limitations, such as utilization review and other criteria or more quantitative limitations such as Co-payments, deductibles,

aggregate or annual limits or benefit limits to Mental Health Condition and Substance Use Disorder Services than those applied to substantially all other medical or surgical benefits.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Shared Savings Program - a program in which we may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider. When this happens, you may experience lower out-of-pocket amounts. Co-insurance and any applicable deductible would still apply to the reduced charge. Policy provisions or administrative practices supersede the scheduled rate, and a different rate is determined by us. This means, when contractually permitted, we may pay the lesser of the Shared Savings Program discount or an amount determined by us, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider. In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by us. If this happens, you should call the telephone number shown on your ID card. Shared Savings Program providers are not Network providers and are not credentialed by us.

To determine whether a provider is part of the Shared Savings Program by contacting us at www.myuhc.com or the telephone number on your ID card.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Certificate includes Mental Health Condition or Substance Use Disorder, regardless of the cause or origin of the Mental Health Condition or Substance Use Disorder.

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

Substance Use Disorder - a disorder defined to be consistent with generally recognized independent standards of current medical practice referenced in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders.*

Substance Use Disorder Services - services for the diagnosis and treatment of alcoholism and Substance Use Disorders that are listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.* The fact that a disorder is listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Living - Mental Health Condition Services and Substance Use Disorder Services provided through

transitional living facilities, group homes and supervised apartments which provide 24-hour supervision and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

These include:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Care Services that are non-life-threatening but that require care by a provider within 24 hours.

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

How Do You Access Benefits?

Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider.

Emergency Health Care Services are always paid as Network Benefits whether provided by a Network or out-of-Network provider. For facility charges, these are Benefits for Covered Health Care Services that are billed by a Network facility and provided under the direction of either a Network or out-of-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or an out-of-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to out-of-Network providers who have agreed to discount their billed charges for Covered Health Care Services. Refer to the definition of Shared Savings Program in *Section 9: Defined Terms* of the *Certificate* for details about how the Shared Savings Program applies.

You must show your identification card (ID card) or have your provider verify your eligibility by calling us every time you request health care services from a Network provider. If you do not show your ID card or have your provider verify your eligibility, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive. If you have not received your ID card from us, or if you have lost your ID card, please contact us as soon as possible. If you need to seek services and do not have your ID card, please direct your provider to verify your eligibility by calling us to ensure proper payment of claims.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits.*

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Group, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

Certain Pharmaceutical Products may be subject to prior authorization due to the following:

- they contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Pharmaceutical Product;
- they contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Pharmaceutical Product;
- there are Therapeutically Equivalent alternatives available; or
- they have an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Pharmaceutical Product.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the

Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. If you do not obtain prior authorization as required, the amount you are required to pay will be increased, as described in each Covered Health Care Service section of this *Schedule of Benefits.* Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in the *Certificate* in *Section 7: Coordination of Benefits.* You are not required to obtain authorization before receiving Covered Health Care Services.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a Policy year basis.

Out-of-Pocket Limits are calculated on a Policy year basis.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Policy year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not apply to services provided by capitated providers or to out-of-network lead poisoning screenings for children.	***Network*** $250 per Covered Person, not to exceed $500 for all Covered Persons in a family. ***Out-of-Network*** $1,000 per Covered Person, not to exceed $2,000 for all Covered Persons in a family.
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit for Network Benefits includes the amount you pay for both Network and Out-of-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider.* Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services.	***Network*** $3,500 per Covered Person, not to exceed $7,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible. ***Out-of-Network*** $7,000 per Covered Person, not to exceed $14,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

Payment Term And Description	Amounts
• The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	

Co-payment

Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of:

- The applicable Co-payment.
- 50% of the Allowed Amount.

Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.

Network services will not be subject to both a Co-payment and a Co-insurance, except as described in the *Emergency Health Care Services Outpatient* section. If a Co-payment applies, there will not be any Co-insurance required of the Covered Person.

Co-insurance

Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount) each time you receive certain Covered Health Care Services.

Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.

Network services will not be subject to both a Co-payment and a Co-insurance, except as described in the *Emergency Health Care Services - Outpatient* section. If a Co-insurance applies, there will not be any Co-payment required of the Covered Person.

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency air ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Emergency Ambulance	***Network*** *Ground Ambulance* 10%	Yes	Yes
	Air Ambulance 10%	Yes	Yes
	Out-of-Network Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	***Network*** *Ground Ambulance* 10%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Air Ambulance 10%	Yes	Yes
	Out-of-Network *Ground Ambulance* 30%	Yes	Yes
	Air Ambulance 30%	Yes	Yes
2. Cellular and Gene Therapy			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
3. Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	***Network*** Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient)*, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
4. Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. **It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	***Network*** 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
5. Dental Services - Accident Only			
	Network 10%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network Same as Network	Same as Network	Same as Network
6. Dental Services - Other			
Prior Authorization Requirement For Network and Out-of-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins or as soon as is reasonably possible. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient)*, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
7. Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	***Network*** Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of DME are not subject to the limit stated under *Durable Medical Equipment (DME) and Supplies.*	***Network*** Depending upon where the Covered Health Care Service is provided, *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient)*, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME)*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	and Supplies and in the *Outpatient Prescription Drug Rider.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider.*		
8. Durable Medical Equipment (DME) and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Benefits are limited to a single purchase of a type of DME every three years. Repair and/or replacement of DME would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums. To receive Network Benefits, you must purchase, rent or obtain the DME from the vendor we identify or purchase it directly from the prescribing Network Physician.	***Network*** 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
9. Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible.	***Network*** $100 per visit .	Yes	No
	Out-of-Network Same as Network	Same as Network	Same as Network
10. Enteral Nutrition			
	Network 10%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 30%	Yes	Yes
11. Fertility Preservation for Iatrogenic Infertility			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
12. Gender Dysphoria			
Prior Authorization Requirement for Surgical Treatment For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay. **It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.**			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Prior Authorization Requirement for Non-Surgical Treatment Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*			
	Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider.*		
13. Habilitative Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Inpatient services limited per year as follows: • Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services.*	***Network*** *Inpatient* Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient)*, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Outpatient therapies: • Physical therapy. • Occupational therapy. • Manipulative Treatments. • Speech therapy. • Post-cochlear implant aural therapy. • Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*	*Outpatient* $15 per visit per visit for Manipulative Treatment $15 per visit for all other habilitative services	Yes	No
	Out-of-Network *Inpatient* Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Medical Services, Hospital - Inpatient), Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Outpatient 30%	Yes	Yes
14. Hearing Aids			
For Covered Persons age 15 and younger, limited to one hearing aid per hearing impaired ear every 24 months. For Covered Persons age 16 and older, limited to $2,500 per hearing aid for each hearing impaired ear every 24 months. Accessories, fittings and repairs are not subject to the $2,500 limit.	***Network*** $15 per hearing aid.	Yes	No
	Out-of-Network 30%	Yes	Yes
15. Hearing Loss Screening			
	Network None	No	No
	Out-of-Network None	No	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
16. Hemophilia Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days prior to receiving services or as soon as reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
17. Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	***Network*** 10%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 30%	Yes	Yes
18. Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
19. Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions. Your cost share for Covered Health Care Services rendered during a hospitalization in a Network Hospital will be limited to the Co-payment, deductible or Co-insurance applicable to Network services as long as all notification requirements have been met. This applies to Covered Health Care Services received at a Network Hospital regardless of whether the admitting Physician is a Network or out-of-Network provider. However, although the inpatient services will be treated as Network services, the services of the out-of-Network admitting physician will be treated as out-of-Network services.			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
20. Infertility Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Limited to four completed egg retrievals (and the procedures and treatments associated with such retrievals) while covered under this plan or any plan with the same employer.	***Network*** 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
21. Lab, X-Ray and Diagnostic - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Lab Testing - Outpatient Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.	***Network*** 10%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 30%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient	***Network*** 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
22. Major Diagnostic and Imaging - Outpatient			

Prior Authorization Requirement

For Out-of-Network Benefits for CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
23. Mental Health Care and Substance Use Disorder Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance Use Disorder Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Out-of-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).* If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network *Inpatient* 10%	Yes	Yes
	Outpatient Autism Spectrum Disorder and Other Developmental Disabilities - Habilitative Services: None after you	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	pay a Co-payment of $15 per visit		
	New Jersey Early Intervention System (NJEIS) Family Cost Share Expense: None after you pay a Co-payment of $15 per visit	Yes	No
	All other Mental Health Condition and Substance Use Disorder Services: 10% for Partial Hospitalization/ Intensive Outpatient Treatment $15 per visit	Yes Yes	Yes No
	Out-of-Network *Inpatient* 30%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Outpatient 30%	Yes	Yes
	30% for Partial Hospitalization/ Intensive Outpatient Treatment	Yes	Yes
24. Ostomy Supplies			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
25. Pharmaceutical Products - Outpatient			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
26. Physician Fees for Surgical and Medical Services			
Covered Health Care Services provided by an out-of-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Network Benefits. In order to obtain the highest level of Benefits, you should follow the Network status of these providers prior to obtaining Covered Health Care Services.	***Network*** 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
27. Physician's Office Services - Sickness and Injury			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient.* • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*	***Network*** $15 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.*			
	Out-of-Network 30%	Yes	Yes
28. Pregnancy - Maternity Services			

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

	Network Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
29. Preventive Care Services			
Physician office services	***Network*** None	No	No
	Out-of-Network 30%	Yes	Yes
Lab, X-ray or other preventive tests Please note the Annual Deductible does not apply to out-of-network lead poisoning screenings for children.	***Network*** None	No	No
	Out-of-Network 30%	Yes	Yes
Breast pumps	***Network*** None	No	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 30%	Yes	Yes
30. Prosthetic Devices and Orthotics			
Please Note: Reimbursement for these items will be at the same rate as under the federal Medicare reimbursement schedule.	***Network*** None after you pay a Copayment of $15 per device.	Yes	No
	Out-of-Network 30%	Yes	Yes
31. Reconstructive Procedures			

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient)*, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient)*, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
32. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows: • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 Manipulative Treatments. • 20 visits of speech therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy.	***Network*** $15 per visit for Manipulative Treatment $15 per visit for all other rehabilitation services	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Limits do not apply for the treatment of Autism Spectrum Disorder or another Developmental Disability.			
	Out-of-Network 30%	Yes	Yes
33. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
34. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			

Prior Authorization Requirement

For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Limited to 60 days per year.	***Network*** 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
35. Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
36. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
37. Transplantation Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
For Network Benefits, transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.	***Network*** Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided *(Physician's Office Services, Outpatient Facility, Physician's Fees for Surgical and Medical Services, Hospital - Inpatient),* Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
38. Urgent Care Center Services			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient.* • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under	***Network*** $50 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Surgery - Outpatient. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.*			
	Out-of-Network 30%	Yes	Yes
39. Urinary Catheters			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
We also provide benefits for Virtual Visits. We contract with one or more entities to create a Designated Virtual Network. Each of these entities creating the Virtual network contracts with individual providers or groups of providers. We refer to a provider in the Designated Virtual Network as a Designated Virtual Network Provider.			
40. Virtual Visits			
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.	None	Yes	No

Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits. For Network Benefits, you are not responsible for any difference between Allowed Amount and the amount the provider bills. For Out-of-Network Benefits, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount we will pay for Allowed Amounts. Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, the Allowed Amount are the fee(s) that we negotiate with the out-of-Network provider.
- When Covered Health Care Services are received from an out-of-Network provider as a result of an Emergency or as arranged by us, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

For Out-of-Network Benefits, Allowed Amounts are based on either of the following:

- When Covered Health Care Services are received from an out-of-Network provider, Allowed Amounts are determined, based on either of the following:
  - 140% of the published rates allowed by the Centers for Medicare and Medicaid Services *CMS* for Medicare for the same or similar service within the geographic market, with the exception of the following:
    - 50% of *CMS* for the same or similar laboratory service.
    - 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
  - When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or similar methodology. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group.* Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
    - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS,* and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book),* or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
    - When a rate for a laboratory service is not published by CMS for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
    - When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.
  - Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically put in place within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.

Provider Network

We arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to choose your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.myuhc.com or the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Not all Network Hospitals are contracted to perform transplants. Please refer to your provider directory or contact us to find out which hospitals are contracted for this service.

Continuation of Treatment when a Physician Leaves the Network

If a Covered Person is receiving post-operative follow-up care, oncological treatment, psychiatric treatment or obstetrical care by a Physician who was a Network Physician at the time the treatment was initiated, the Covered Person may continue to be treated by that Physician for the duration of the treatment even if the Physician leaves the Network. The continued treatment is subject to the following time periods:

- Up to six months for post-operative follow-up care.
- Up to one year for oncological treatment and psychiatric treatment.
- Through the duration of a Pregnancy and up to six weeks after delivery for obstetrical care.
- Up to four months for other Covered Health Care Services where it is medically necessary for the Covered Person to continue treatment with that Physician.
- Covered Health Care Services for the continued treatment are covered as Network Benefits. Reimbursement for Health Services will be made according to the same fee schedule used for Network Services.
- During the time a Covered Person receives continued treatment by a Physician who has left the Network, we will provide Network Benefits for any treatment or services provided to the Covered Person in a Hospital, regardless of whether the Hospital is a Network Hospital.

Designated Providers

For Transplants we may direct you to a Designated Provider chosen by us. If you require certain complex Covered Health Care Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you reside more than 50 miles from the Designated Provider and are required to travel to obtain such Covered Health Care Services from the Designated Provider, we will provide for reimbursement of travel and lodging expenses for the Covered Person and one companion. Coverage is limited to $50 - $100 lodging per day, up to a maximum Benefit of $10,000 per lifetime.

In both cases, Network Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by us.

You or your Network Physician must notify us of special service needs that might warrant referral to a Designated Provider. If you do not notify us in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Network Benefits will not be paid. Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Care Services for which Benefits are provided under the Policy.

Health Care Services from Out-of-Network Providers Paid as Network Benefits

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Primary Care Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Primary Care Physician to coordinate care through an out-of-Network provider.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you do not use the selected Network Physician, Covered Health Care Services will be paid as Out-of-Network Benefits.

Real Appeal Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Real Appeal

Real Appeal provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 13 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live Virtual Coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

For purposes of Real Appeal, the definition of Physician in your *Certificate of Coverage* is revised to include a Virtual Coach. The Real Appeal program was designed and built by a panel of physicians and licensed nutritionists. While Real Appeal's Virtual Coaches are not licensed by or registered with the State of New Jersey, they undergo extensive training through Real Appeal.

For purposes of Real Appeal, the definition of Covered Health Care Services in your Certificate of Coverage is revised to include individualized services and may include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained Virtual Coach for clinical weight loss.

If you would like information regarding these Covered Health Care Services, you may contact us through www.realappeal.com, https://member.realappeal.com or at the number shown on your ID card.

UnitedHealthcare Insurance Company



William J Golden, President

Kidney Donor Travel and Lodging Program Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides a donor travel and lodging allowance related to living kidney transplantation.

Because this Rider is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company.

Kidney Donor Travel and Lodging Program

The *Kidney Donor Travel and Lodging Program* provides support for living kidney donors when the intended recipient of the kidney is a Covered Person under the Policy. The program provides an allowance for travel and lodging expenses for an approved living kidney donor and travel companion. The living kidney donor is not required to be a Covered Person under the Policy.

Donors must be approved by us for participation in this program. This program provides an allowance for incurred travel and lodging expenses only and is independent of any existing medical coverage available for the donor or Covered Person. Once approved, an allowance of up to $6,000 per donor will be provided for travel and lodging expenses incurred as a part of the entire kidney donation process, based on the *U.S. General Services Administration* travel rates. Expenses incurred will include travel and lodging expenses for the donor's first evaluation through follow-up evaluation(s) up to two years after donor surgery.

If you would like additional information regarding the *Kidney Donor Travel and Lodging Program*, you may contact us at www.myuhc.com.

UnitedHealthcare Insurance Company



William J Golden, President

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms.*

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in the *Certificate.*

UnitedHealthcare Insurance Company



William J Golden, President

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee makes tier placement changes on our behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product. Economic factors are considered when two or more drugs are equivalent in terms of safety, effectiveness and clinical outcome.

Please refer to the *Outpatient Prescription Drug Schedule of Benefits* for more information concerning prior authorization requirements.

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. We will provide a 30 day written notice prior to the effective date of any change. Please call the number on the back of your ID card to determine whether a specific drug is included under the drug formulary.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim.* When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Springs, AR 71903

Designated Specialty Pharmacies

If you require certain Specialty Prescription Drug Products for disease states, medical conditions, or certain treatments such as:

- Hepatitis C
- Multiple Sclerosis
- Rheumatologic and related conditions (Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Juvenile Rheumatoid Arthritis, Psoriasis)
- Growth Hormone
- Anemia, neutropenia, thrombocytopenia
- Infertility
- HIV/AIDS
- Transplant
- Oral Oncology
- Pulmonary Arterial Hypertension
- Osteoporosis
- Cystic Fibrosis
- Gaucher's Disease
- Iron Overload
- Endocrine disorders/Neurologic disorders such as infantile spasms
- Hemophilia
- Enzyme Deficiencies/Liposomal Storage Disorders

We may direct you to a Designated Specialty Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Specialty Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Specialty Pharmacy, you will be subject to the out-of-Network Benefit for that Prescription Drug Product.

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Specialty Pharmacy in 15-day supplies up to 90 days and at a pro-rated Co-payment or Co-insurance. You will receive a 15-day supply of their Specialty Prescription Drug Product to find out if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Specialty Pharmacy will contact you each time prior to dispensing the 15-day supply to confirm if you are tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program,* by contacting us at www.myuhc.com or the telephone number on your ID card.

When Do We Limit Selection of Pharmacies?

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, we may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date we notify you, we will choose a Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Co-payment and/or Co-insurance.

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and

apart from this *Outpatient Prescription Drug Rider.* Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider.* We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers.

Special Programs

You may qualify for certain programs in which you may receive an enhanced benefit based on your adherence/compliance with medication or treatment regimens, and/or taking part in health management programs. For certain qualifying medications, you may receive a savings on your standard Co-payment if you are taking the medication regularly and you refill your medication within 30 days before the date you are scheduled to run out of medication. If you don't refill your medication within 30 days before the date you are scheduled to run out of medication, you will pay your standard Co-payment. You may access further information on these programs and which medications are included through the internet at www.myuhc.com or by calling the telephone number on your ID Card. Please note this program is subject to change without notice.

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Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Co-payments and/or Co-insurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Specialty Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Specialty Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Specialty Pharmacy, you will be subject to the out-of-Network Benefit for that Specialty Prescription Drug Product.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Specialty Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

The *Outpatient Prescription Drug Rider* offers limited Network Pharmacy providers. You can confirm that your pharmacy is a Network Pharmacy by calling the telephone number on your ID card or you can access a directory of Network Pharmacies online at www.myuhc.com.

This *Outpatient Prescription Drug Rider* offers limited Network Pharmacy providers. You can confirm that your pharmacy is a Network Pharmacy by calling the telephone number on your ID card or you can access a directory of Network Pharmacies online at www.myuhc.com.

Prescription Drugs from a Retail Out-of-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail out-of-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim.* We will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail out-of-Network Pharmacy supply limits apply.

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy and supply limits apply.

Please contact us at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits that are stated in the Schedule of Benefits. For a single Co-payment or Co-insurance, the Insured may receive a Prescription Drug Product up to the stated supply limit. We will cover up to a consecutive 90-day supply of a Prescription Drug Product, as written by the Physician, subject to the drug manufacturer's packaging size, or based on supply limits.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed.

NOTE: Some products are subject to additional supply limits other than day limits based on New Jersey State Law or on criteria that we have developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing by contacting us at www.myuhc.com or the telephone number on your ID card.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* also apply to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact us at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. No prescribed drug shall be excluded on the basis that the drug has not been approved by the *United States Food and Drug Administration (USFDA)* for which the drug has been prescribed, if such drug is recognized as Medically Necessary for the specific treatment for which it has been prescribed by the *American Hospital Formulary Service Drug Information,* the *United States Pharmacopoeia Drug Information* or a clinical study or review article in a major peer reviewed professional journal.
6. Prescription Drug Products for any condition, Injury, Sickness or Mental Health Condition arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received. The failure of a self-employed person, limited liability partnership, limited liability company or partnership to elect to obtain worker's compensation coverage for the self-employed person, the limited liability partners, the limited liability company members or the partners shall not affect Benefits available under this Rider.
7. Any product dispensed for the purpose of appetite suppression or weight loss.
8. A Pharmaceutical Product for which Benefits are provided in your *Certificate.* This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
9. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate.* Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
11. Certain unit dose packaging or repackagers of Prescription Drug Products.
12. Medications used for cosmetic purposes except for coverage for newborn children including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
13. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
15. Treatment for toenail Onychomycosis (toenail fungus).

16. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 3.)

17. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, except for over-the-counter PPACA Zero Cost Share Preventive Care Medications are eligible for coverage as if they were a Prescription Drug Product and are obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form unless the prescribing provider certifies the medical necessity of the drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

18. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

19. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.

20. Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.

21. A Prescription Drug Product that contains marijuana, including medical marijuana.

22. Dental products, including but not limited to prescription fluoride topicals.

23. Diagnostic kits and products.

24. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Section 3: Defined Terms

Brand-name - a Prescription Drug Product which is manufactured and marketed under a trademark or name by a specific drug manufacturer.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Specialty Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Specialty Pharmacies.

Generic - a Prescription Drug Product that is Chemically Equivalent to a Brand-name drug.

Infertility - the disease or condition that results in the abnormal function of the reproductive system, as determined pursuant to the *American Society for Reproductive Medicine* practice guidelines by a physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology or that the patient has met one of the following conditions:

- A male is unable to impregnate a female;
- A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
- A female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;
- A female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision;
- A female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision;
- Partners are unable to conceive as a result of involuntary medical sterility;
- A person is unable to carry a pregnancy to live birth; or
- A previous determination of infertility pursuant to New Jersey state law.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- Six months following date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration.*

Out-of-Network Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA).* This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered in a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose meters, including continuous glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Co-payment or Co-insurance may change, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the *Schedule of Benefits.* For a single Co-payment or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. We will cover up to a consecutive 90-day supply of a Prescription Drug Product, as written by the Physician, subject to the drug manufacturer's packaging size, or based on supply limits.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed.

Note: Some products are subject to additional supply limits other than day limits based on New Jersey State Law or on criteria that the company has developed. Supply limits are subject, from time to time, to review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at www.myuhc.com or the telephone number on your ID card.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Out-of-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at an out-of-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

Certain Prescription Drug Products may be subject to prior authorization due to the following:

- they contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product;
- they contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product;
- there are Therapeutically Equivalent alternatives available;
- they have an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product; or
- they are packaged with a device or application, including smart package sensors and/or embedded drug sensors.

Please note that outpatient Prescription Drug Products to treat Substance Use Disorder will be provided when determined Medically Necessary by the Covered Person's Physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization review.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.co m or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at an out-of-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim.*

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Co-payment or Co-insurance and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Approval Process for Prescription Drug Products that the Covered Person wants considered at a Lower Tier Co-payment

The prescribing Physician must request our prior approval for a lower tier Co-payment for a higher tier drug by contacting us at the telephone number on your ID card and providing all relevant information . We will respond to the Physician by telephone within one business day after the receipt of all requested documentation from the Physician. If we fail to respond within that time period, the request is deemed approved. The request for approval must be based on the Physician's certification that the Prescription Drug Product is medically necessary as defined below and the current drugs available in the lower tiers are not effective for the Covered Person.

A Prescription Drug Product which is not on the Prescription Drug List will be considered medically necessary if:

- It is approved by the *U.S. Federal Food and Drug Administration ("FDA")* or its use is supported by one or more citations included or approved for inclusion in *The American Hospital Formulary Drug Information* or the

United States Pharmacopeia Drug Information, or it is recommended by a clinical study or review article in a major peer reviewed professional journal; and

- The prescribing Physician states that all Prescription Drug Products on the Prescription Drug List used to treat each disease state has been ineffective in the treatment of your disease or condition, or all such drugs have caused or are reasonably expected to cause you adverse or harmful reactions.

If the request is denied by telephone, we will also provide you and the Physician a written denial within 5 business days of the request. The written denial will include the clinical reason for the denial.

If you are dissatisfied with our decision, you should follow the procedures described in the *Certificate* for questions, complaints and appeals. If you want to contest our decision you may apply to the Independent Health Care Appeals Program for a review. You must make your application within 60 days of the date you were notified of the decision. Your notification of our decision will include specific instructions as to how you or your provider may arrange for an external appeal and will also include any forms required to initiate the appeal.

Emergency

Prescription Drug Products dispensed at an out-of-Network Pharmacy for an emergency are payable for the Out-of-Network Reimbursement Rate, minus the applicable Network Co-payment or Co-insurance.

Extended Coverage during Total Disability

Extended Coverage for Total Disability described in the *Certificate* applies to Prescription Drug coverage.

Pharmacy Charges for Additional Services

A pharmacy may charge you for services rendered by the pharmacy that are in addition to charges for the Prescription Drug Product, for dispensing the drug or for prescription counseling. Services rendered by the pharmacy for which additional charges are imposed are subject to the approval of the *Board of Pharmacy.* A pharmacy must disclose to you the charges for the additional services and your out-of-pocket cost for those services prior to dispensing the Prescription Drug Product. A pharmacy may not impose any additional charges for patient counseling or for other services required by the Board of Pharmacy or State or federal law.

What Do You Pay?

You are responsible for paying the applicable Co-payment or Co-insurance described in the Benefit Information table. You are not responsible for paying a Co-payment or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Limit stated in your *Certificate:*

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate. ***Co-payment and Co-insurance*** Your Co-payment or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Co-payment or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. Your Co-payment or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at www.myuhc.com or the telephone number on your ID card. **Special Programs:** We may have certain programs in which you may receive an enhanced benefit based on your actions	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Preventive Medications.

Payment Term And Description	Amounts
such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. Please refer to your *Outpatient Prescription Drug Rider* for more information concerning this program. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card. **Co-payment/Co-insurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment or Co-insurance for one or more Prescription Orders or Refills. **NOTE:** The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment or Co-insurance.	

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay?
Specialty Prescription Drug Products	
The following supply limits apply. • As written by the provider, up to a consecutive 90-day supply of a Specialty Prescription Drug Product, subject to the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Some products are subject to additional supply limits other than day limits based on New Jersey State Law or on criteria we have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Specialty Pharmacy.	Your Co-payment or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement. For up to a 31-day supply, you pay: ***Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: $35 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: $60 per Prescription Order or Refill. ***Out-of-Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: $35 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: $60 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay?
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, subject to the drug manufacturer's packaging size, or based on supply limits. Some products are subject to additional supply limits other than day limits based on New Jersey State Law or on criteria we have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. • For a contraceptive up to a three month supply for the first dispensing. For refills of the same contraceptive, up to a six-month supply, regardless of whether coverage under the Policy was in effect at the time of the first dispensing. Coverage will not extend beyond the date your coverage ends under this Policy. The Co-payment or Co-insurance that applies will reflect the number of days dispensed. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed.	Your Co-payment or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For up to a 31-day supply, you pay: For a Tier 1 Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $60 per Prescription Order or Refill.
Prescription Drugs from a Retail Out-of-Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, subject to the drug manufacturer's packaging size, or	Your Co-payment or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay?
based on supply limits. Some products are subject to additional supply limits other than day limits based on New Jersey State Law or on criteria we have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. • For a contraceptive, up to a three month supply for the first dispensing. For refills of the same contraceptive, up to a six-month supply, regardless of whether coverage under the Policy was in effect at the time of the first dispensing. Coverage will not extend beyond the date your coverage ends under this Policy. The Co-payment or Co-insurance that applies will reflect the number of days dispensed. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed.	For up to a 31-day supply, you pay: For a Tier 1 Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $60 per Prescription Order or Refill.
Prescription Drug Products from a Mail Order Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, subject to the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products.* Some products are subject to additional	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For up to a 31-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $60 per Prescription Order

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay?
supply limits other than day limits based on criteria we have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.	or Refill. For up to a 60-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $20 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $70 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $120 per Prescription Order or Refill. For up to a 90-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $25 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $87.50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $150 per Prescription Order or Refill.

Language Assistance Services

We[1] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語**(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

Notice of Non-Discrimination

We[1] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

[1] For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Certificate of Coverage (Certificate)* and *Schedule of Benefits.* A summary of those changes and the dates the changes are effective appear below. These changes will apply to any "non-grandfathered" plan. Contact your Plan Administrator to determine whether or not your plan is a "grandfathered" or a "non-grandfathered plan". Under the *Patient Protection and Affordable Care Act (PPACA)* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

  Ambulatory patient services; emergency services, hospitalization; laboratory services; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:

  - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000.
  - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000.
  - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

  Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law).

  On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

  Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the policy is subject to the statute known as *Michelle's Law.* This law amends *ERISA, the Public Health Service Act,* and the *Internal Revenue Code* and requires group health plans,

which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or Injury.

- If you do not have a grandfathered plan, If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:
  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
  - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
  - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
  - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*
- Retroactive rescission of coverage under the policy is permitted, with 30 days advance written notice, only in the following two circumstances:
  - The individual performs an act, practice or omission that constitutes fraud.
  - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:
  - Direct access to OB/GYN care without a referral or authorization requirement.
  - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
  - Prior authorization is not required before you receive services in the emergency department of a hospital.

    If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Effective for policies that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

Pre-Existing Conditions:

Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA),* as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or UnitedHealthcare for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call UnitedHealthcare at the number listed on your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from UnitedHealthcare will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call UnitedHealthcare at the number listed on your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits.*

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, we will review our decision. We will also send you our written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, they will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call UnitedHealthcare at the number listed on your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact UnitedHealthcare at the number listed on your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you. (http://www.dol.gov.ebsa/healthreform/ - click link for Consumer Assistance Programs).

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998,* Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage 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 or issuer 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, under Federal law, plans and issuers 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, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

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

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

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it

within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

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

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information through the submission of your appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

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

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2018:

We[2] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws relating to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as www.myuhc.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollee's information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the *Secretary of the Department of Health and Human Services,* if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
    - 1. HIV/AIDS;
    - 2. Mental health;
    - 3. Genetic tests;
    - 4. Alcohol and drug abuse;
    - 5. Sexually transmitted diseases and reproductive health information; and
    - 6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your health plan website, such as www.myuhc.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your health plan ID card or you may contact the *UnitedHealth Group Customer Call Center* Representative at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

[2]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Health Management Corporation; Rocky Mountain HealthCare Options, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2018

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors:
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communicati ons on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-866-633-2446 or TTY 711.

[3]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women's and Children's Health, LLC; AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Connextions HCI, LLC; LifePrint East, Inc.; Life Print Health, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare

Service LLC; UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

UNITEDHEALTH GROUP

HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2018

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. Show the categories of health information that are subject to these more restrictive laws; and
2. Give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
We are not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AR, CA, DE, NE, NY, PR, RI, UT, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS

Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, ME, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NH, NM, NV, NY, NC, OR, PA, PR, RI, TX, VT, WA, WV, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect HIV/AIDS-related information only with your written consent.	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA

Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, AR, CO, IL, LA, MD, NE, NJ, NY, NM, RI, TN, TX, UT, WI

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA).*

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration.*

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description.* The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to 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. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA.*

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA,* there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor,* or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor,* 200 Constitution Avenue, N.W., Washington,

D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration.*



NBA Services Corp.

Your Group Long Term Disability Plan

Policy No. 619109 012

Underwritten by Unum Life Insurance Company of America

10/7/2020

CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy and certificate are delivered in and are governed by the laws of the state of New Jersey and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

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BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: October 1, 2020

POLICY NUMBER: 619109 012

ELIGIBLE GROUP(S):

All Full-Time Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 17.5 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before October 1, 2020: None

For employees entering an eligible group after October 1, 2020: None

REHIRE:

If your employment ends and you are rehired within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

Your Employer allows you to elect to have the cost of your Employer-paid coverage included in your taxable income.

ELIMINATION PERIOD:

90 days

Accumulation Period: 180 days

Benefits begin the day after the elimination period is completed.

MONTHLY BENEFIT:

60% of monthly earnings to a maximum benefit of $15,500 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

MAXIMUM PERIOD OF PAYMENT:

Age at Disability	Maximum Period of Payment
Less than Age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months

Age 68	18 months
Age 69 or older	12 months

Year of Birth	Social Security Normal Retirement Age
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

No premium payments are required for your coverage while you are receiving payments under this plan.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $1,000 per month.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

DEPENDENT CARE EXPENSE BENEFIT:

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, you may receive payments to cover certain dependent care expenses limited to the following amounts:

Dependent Care Expense Benefit Amount: $350 per month, per dependent

Dependent Care Expense Maximum Benefit Amount: $1,000 per month for all eligible dependent care expenses combined

TOTAL BENEFIT CAP:

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings, unless the excess amount is payable as a Cost of Living Adjustment. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings, unless the excess amount is payable as a Cost of Living Adjustment.

OTHER FEATURES:

Continuity of Coverage

Cost of Living Adjustment

Disability Plus

Minimum Benefit

Pre-Existing: 3/12

Recovery Income Protection

Survivor Benefit

Work Life Assistance Program

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

CLAIM INFORMATION

LONG TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim should be sent within 30 days after the date your disability begins. However, you must send Unum written proof of your claim no later than 90 days after your elimination period. If it is not possible to give proof within 90 days, it must be given as soon as is reasonably possible.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE PROOF OF CLAIM?

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

The form to use to submit your proof of claim is available from your Employer, or you can request the form from us. If you do not receive the form from Unum or your Employer within 15 days of your request, send Unum proof of claim without waiting for the form.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation;
- that you are under the **regular care** of a **physician**;
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians; and
- the appropriate documentation of your monthly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. We may also require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request by us. If it is not possible to give proof within 45 days, it must be given as soon as reasonably possible. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require

you to meet with and be interviewed by an authorized Unum Representative. Unum will deny your claim, or stop sending you payments, if you fail to comply with our requests.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim;
- disability earnings; or
- deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made which may include reducing or withholding future payments including the minimum monthly payment.

Unum will not recover more money than the amount we paid you.

Any unpaid premium due for your coverage under the policy may be recovered by us by offsetting against amounts otherwise payable to you under the policy, or by other legally permitted means.

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage to which you are entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

Unum will provide your Employer with a certificate of coverage for delivery to each insured.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

WHEN DOES YOUR COVERAGE BEGIN?

When your Employer pays 100% of the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the date you are eligible for coverage.

When you and your Employer share the cost of your coverage under a plan or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you apply for insurance on or before that date;
- the date you apply for insurance, if you apply within 31 days after your eligibility date; or
- the date Unum approves your application, if **evidence of insurability** is required.

Evidence of insurability is required if you:

- are a late applicant, which means you apply for coverage more than 31 days after the date you are eligible for coverage; or
- voluntarily cancelled your coverage and are reapplying.

An evidence of insurability form can be obtained from your Employer.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary **layoff**, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your temporary layoff begins.

If you are on a **leave of absence**, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage will take effect immediately if you are in active employment or if you are on a covered layoff or leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment except as provided under the covered layoff or leave of absence provision.

If your coverage ends, Unum will continue to provide coverage for a payable claim which occurs while the policy or plan was inforce.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application as a basis for doing this.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

LONG TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period**. Unum will treat your disability as continuous if your disability stops for 30 days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.

You must be continuously disabled through your **elimination period**. The days that you are not disabled will not count toward your elimination period.

Your elimination period is 90 days.

In addition, if you return to work while satisfying your elimination period, and are no longer disabled, you may satisfy your elimination period within the **accumulation period**. You do not need to be continuously disabled through your elimination period if you are satisfying your elimination period under this provision. If you do not satisfy the elimination period within the accumulation period, a new period of disability will begin.

Your accumulation period is 180 days.

You are not required to have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness to be considered disabled during the elimination period.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes. If you are working while you are disabled, the days you are disabled will count toward your elimination period.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment monthly for any period for which Unum is liable.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

1. Multiply your monthly earnings by 60%.
2. The maximum **monthly benefit** is $15,500.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **monthly payment**.

Your monthly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 month, we will send you 1/30 of your monthly payment for each day of disability and 1/30 of any additional benefits for each day of disability.

WILL UNUM EVER PAY MORE THAN 100% OF MONTHLY EARNINGS?

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings, unless the excess amount is payable as a Cost of Living Adjustment. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings, unless the excess amount is payable as a Cost of Living Adjustment.

WHAT ARE YOUR MONTHLY EARNINGS?

"Monthly Earnings" means your gross monthly income from your Employer in effect as of the October 1st just prior to your date of disability or your date of hire if later than October 1st. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from sources other than your Employer.

WHAT WILL WE USE FOR MONTHLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?

We will send you the monthly payment if you are disabled and your monthly **disability earnings**, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are from 20% through 80% of your indexed monthly earnings, due to the same sickness or injury, Unum will figure your payment as follows:

During the first 24 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.
2. Compare the answer in Item 1 to your indexed monthly earnings.

If the answer from Item 1 is less than or equal to 100% of your indexed monthly earnings, Unum will not further reduce your monthly payment.

If the answer from Item 1 is more than 100% of your indexed monthly earnings, Unum will subtract the amount over 100% from your monthly payment.

After 24 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

1. Subtract your disability earnings from your indexed monthly earnings.
2. Divide the answer in Item 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in Item 2.

This is the amount Unum will pay you each month.

As part of your proof of disability earnings, we can require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income.

After the elimination period, if you are disabled for less than 1 month, we will send you 1/30 of your payment for each day of disability.

WILL YOUR PAYMENT BE ADJUSTED BY A COST OF LIVING INCREASE?

Unum will make a cost of living adjustment (COLA) after you have received 5 full years of payments for your disability.

Your payment will increase by 3% beginning on the fifth anniversary of payments and each following anniversary while you continue to receive payments for your disability.

Each month Unum will add the cost of living adjustment to your monthly payment. When Unum adds the adjustment to your payment, the increase may cause your payment to exceed the maximum monthly benefit.

HOW DO WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings have fluctuated from month to month, Unum may determine your benefit eligibility based on the average of your disability earnings over the most recent 3 months.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive under:

   - a workers' compensation law.
   - an occupational disease law.
   - any other **act** or **law** with similar intent.

2. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:

   - state compulsory benefit **act** or **law**.
   - other group insurance plans that are provided by or sponsored by your Employer.
   - other group insurance with a different employer as a result of your return to work in rehabilitative employment following a period of disability.
   - **governmental retirement system**.

3. The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:

   - the United States Social Security Act.
   - the Canada Pension **Plan**.
   - the Quebec Pension Plan.
   - any similar plan or act.

   We will only subtract payments your spouse and children receive if they live with you, or if you have a legal obligation to provide financial support for them.

4. The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under:

   - the United States Social Security Act.
   - the Canada Pension Plan.
   - the Quebec Pension Plan.
   - any similar plan or act.

5. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

   Regardless of how retirement payments are distributed, Unum will consider

payments attributable to your post tax contributions to be distributed throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

6. The amount that you:

   - receive as disability payments under your Employer's **retirement plan**.
   - voluntarily elect to receive as retirement payments under your Employer's retirement plan.
   - receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

   Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

   Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

   Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

7. The amount that you receive under Title 46, United States Code Section 688 (The Jones Act).

With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable as a result of the same disability.

We will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation

- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- no fault motor vehicle plans
- **salary continuation** or **accumulated sick leave** plans

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum monthly payment is the greater of:

- $100; or
- 10% of your gross disability payment.

Unum may apply this amount toward an outstanding overpayment.

WHAT HAPPENS WHEN YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME?

Once Unum has subtracted any deductible source of income from your gross disability payment, Unum will not further reduce your payment due to a cost of living increase from that source.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1, 2 and 3 in the deductible sources of income section, we will estimate your entitlement to these benefits and reduce your payment by the estimated amount if you agree to reduce your benefit.

We will also estimate your entitlement to these benefits and reduce your payment by the estimated amount if:

- you do not apply for these benefits within a reasonable period of time;
- you do not file a request for reconsideration of these benefits within a reasonable period of time; or
- you do not request a hearing before an Administrative Law Judge when appropriate even though we have agreed to pay for the costs incurred by you in making an appearance at the hearing and for legal representation that is not paid for or reimbursed by the Social Security Administration.

If your benefits are reduced because you did not take the steps as outlined directly above, Unum will restore estimated benefit reductions when you begin or resume these steps.

If benefits are reduced, then when a final denial of benefits is received, Unum will reimburse all reductions, if any, in a lump sum with interest at the rate the Federal plan pays on amounts it owes.

If you receive a final denial of these benefits, we will refund our estimated reductions to you in a lump sum payment.

If you receive an award for these benefits, you are obligated to repay us at the time these benefits are granted, for any overpayment that we made to you. If you do not repay us, we will apply your monthly payment toward the outstanding overpayment until it is paid in full.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be prorated on a monthly basis over the time period for which the sum was given. If no time period is stated, the sum will be prorated on a monthly basis over the earlier of:

- the end of the maximum period of payment; or
- your expected lifetime.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each month up to the **maximum period of payment**. Your maximum period of payment is based on your age at disability as follows:

Age at Disability	Maximum Period of Payment
Less than Age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

Year of Birth	Social Security Normal Retirement Age
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- when you are able to work in your regular occupation on a **part-time basis** and you do not;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die.

WHAT DISABILITIES HAVE A LIMITED PAY PERIOD UNDER YOUR PLAN?

The lifetime cumulative maximum benefit period for all disabilities due to **mental illness** is 24 months. Only 24 months of benefits will be paid even if the disabilities:

- are not continuous; and/or
- are not related.

However, Unum will send you payments beyond the 24 month period if you meet one of these conditions:

1. If you are confined to a **hospital or institution** at the end of the 24 month period, Unum will continue to send you payments during your confinement.

   If you are still disabled when you are discharged, Unum will send you payments for a recovery period of up to 90 days.

   If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Unum will send payments during that additional confinement and for one additional recovery period up to 90 more days.

2. If you are not confined to a hospital or institution but become confined for a period of at least 14 days within 90 days after the 24 month period for which you have received payments, Unum will send payments during the length of the confinement.

Under no circumstances will Unum pay beyond the maximum period of payment as indicated in the **BENEFITS AT A GLANCE** section of your policy.

Unum will not apply the mental illness limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a felony for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

WHAT IS A PRE-EXISTING CONDITION?

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

WHEN CAN THE PRE-EXISTING CONDITION EXCLUSION BE WAIVED?

Unum may send a payment if your disability results from a pre-existing condition if:

- immediately preceding the date you became insured under the plan, you were insured under another group long term disability policy issued by Unum; and
- we made a payment to you for the same disabling condition under that group long term disability policy.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME WITH THE POLICYHOLDER AND YOUR DISABILITY OCCURS AGAIN?

If you have a **recurrent disability**, Unum will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- you were continuously insured under the plan for the period between the end of your prior claim and your recurrent disability; and
- your recurrent disability occurs within 6 months from the end of your prior claim.

Your recurrent disability will be subject to the same terms of the plan as your prior claim and will be treated as a continuation of that disability.

Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the elimination period.

LONG TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT RECOVERY INCOME PROTECTION DO YOU HAVE IF YOU RETURN TO WORK?

We will send you the monthly payment if you have been disabled and you satisfy each of the following:

- you have satisfied the elimination period for that disability;
- you return to your regular occupation full time with the Employer on the earlier of the date your disability ends or the date your benefits cease; and
- you have a 20% or more loss in your indexed monthly earnings due to the same disability.

Recovery income protection benefit payments will end on the earliest of the following:

- the date 12 months recovery income protection benefits have been paid; or
- the date your current earnings exceed 80% of your indexed monthly earnings.

WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)

When Unum receives proof that you have died, we will pay your **eligible survivor** a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your 3 month survivor benefit prior to your death if you have been diagnosed as terminally ill.

We will pay you a lump sum amount equal to 3 months of your gross disability payment if:

- you have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to less than 12 months; and
- you are receiving monthly payments.

Your right to exercise this option and receive payment is subject to the following:

- you must make this election in writing to Unum; and
- your physician must certify in writing that you have a terminal illness or condition and your life expectancy has been reduced to less than 12 months.

This benefit is available to you on a voluntary basis and will only be payable once.

If you elect to receive this benefit prior to your death, no 3 month survivor benefit will be payable upon your death.

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

When the plan becomes effective, Unum will provide coverage for you if:

- you are not in active employment because of a sickness or injury; and
- you were covered by the prior policy.

Your coverage is subject to payment of premium.

Your payment will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount payable by the prior carrier.

WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

Unum may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

Credit will be given for the satisfaction or partial satisfaction of the pre-existing condition under the prior carrier's plan.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

a. the monthly benefit that would have been payable under the terms of the prior plan if it had remained inforce; or
b. the monthly payment under the Unum plan.

Your benefits will end on the date benefits would have ended under the prior plan if it had remained in force.

HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. However, the Total Benefit Cap will apply.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which monthly payments would stop in accordance with this plan.

WHAT ADDITIONAL BENEFIT IS AVAILABLE FOR DEPENDENT CARE EXPENSES TO ENABLE YOU TO PARTICIPATE IN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, we will pay a Dependent Care Expense Benefit when you are disabled and you:

1. are incurring expenses to provide care for a child under the age of 15; and/or
2. start incurring expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.

The payment of the Dependent Care Expense Benefit will begin immediately after you start Unum's Rehabilitation and Return to Work Assistance program.

Our payment of the Dependent Care Expense Benefit will:

1. be $350 per month, per **dependent**; and
2. not exceed $1,000 per month for all dependent care expenses combined.

To receive this benefit, you must provide satisfactory proof that you are incurring expenses that entitle you to the Dependent Care Expense Benefit.

Dependent Care Expense Benefits will end on the earlier of the following:

1. the date you are no longer incurring expenses for your dependent;
2. the date you no longer participate in Unum's Rehabilitation and Return to Work Assistance program; or
3. any other date payments would stop in accordance with this plan.

DISABILITY PLUS RIDER

WHO IS ELIGIBLE FOR DISABILITY PLUS COVERAGE?

You must be insured under the Unum Long Term Disability (LTD) plan to be eligible for the additional disability coverage described in this Rider. All of the policy definitions apply to the coverage as well as policy provisions specified in this Rider.

WHEN WILL THIS COVERAGE BECOME EFFECTIVE?

You will become insured for Disability Plus coverage on the later of:

- the effective date of this Rider; or
- your effective date under the LTD plan.

However, the Disability Plus coverage will be delayed if on your effective date you cannot safely and completely perform 1 or more **activities of daily living** without another person's assistance or verbal cueing or you have a deterioration or loss in intellectual capacity and need another person's assistance or verbal cueing for your protection or for the protection of others. Coverage will begin on the date you can safely and completely perform all of the activities of daily living without another person's assistance or verbal cueing or no longer have a deterioration or loss in intellectual capacity and do not need another person's assistance or verbal cueing for your protection or for the protection of others.

Disability Plus coverage will continue as long as the Rider is in effect and you are insured under the LTD plan.

WHEN WILL YOU BE ELIGIBLE TO RECEIVE DISABILITY PLUS BENEFITS?

We will pay a monthly Disability Plus benefit to you when we receive proof that you are disabled under this rider and are receiving monthly payments under the LTD plan. Disability Plus benefits will begin at the end of the elimination period shown in the LTD plan.

You are disabled under this rider when Unum determines that due to sickness or injury:

- you lose the ability to safely and completely perform 2 activities of daily living without another person's assistance or verbal cueing; or
- you have a deterioration or loss in intellectual capacity and need another person's assistance or verbal cueing for your protection or for the protection of others.

HOW MUCH WILL UNUM PAY IF YOU ARE DISABLED?

The Disability Plus benefit is 20% of monthly earnings to a maximum monthly benefit of the lesser of the LTD plan maximum monthly benefit or $5,000.

This benefit is not subject to policy provisions, except for the Total Benefit Cap, which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.

WHAT EXCLUSIONS AND LIMITATIONS APPLY TO DISABILITY PLUS?

All of the policy provisions that exclude or limit coverage will apply to this Disability Plus Rider.

WHAT CLAIMS INFORMATION IS NEEDED FOR DISABILITY PLUS?

The LTD claim information section under the policy applies to Disability Plus coverage. We may ask you to be examined, at our expense, by a physician and/or other medical practitioner of our choice. We may also require an interview with you.

WHEN WILL DISABILITY PLUS BENEFIT PAYMENTS END?

Benefit payments will end on the earliest of the following dates:

- the date you are no longer disabled under the Rider;
- the date you become ineligible for monthly payments under the LTD plan;
- the end of the maximum period of payment shown in the LTD plan; or
- the date you die.

No survivor benefits are payable for the Disability Plus coverage.

WHAT IS THE WAIVER OF PREMIUM FOR DISABILITY PLUS?

Premium for the Disability Plus coverage is not required while you are receiving monthly payments under the LTD plan.

OTHER SERVICES

These services are also available from us as part of your Unum Long Term Disability plan.

IS THERE A WORK LIFE ASSISTANCE PROGRAM AVAILABLE WITH THE PLAN?

We do provide you and your dependents access to a work life assistance program designed to assist you with problems of daily living.

You can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a child, to helping to deal with the stress of the workplace. This work life program is available for everyday issues as well as crisis support.

This service is also available to your Employer.

This program can be accessed by a 1-800 telephone number available 24 hours a day, 7 days a week or online through a website.

Information about this program can be obtained through your plan administrator.

HOW CAN UNUM HELP YOUR EMPLOYER IDENTIFY AND PROVIDE WORKSITE MODIFICATION?

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with your Employer. One of our designated professionals will assist you and your Employer to identify a modification we agree is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, your Employer and Unum.

When this occurs, Unum will reimburse your Employer for the cost of the modification, up to the greater of:

- $1,000; or
- the equivalent of 2 months of your monthly benefit.

This benefit is available to you on a one time only basis.

HOW CAN UNUM'S SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM ASSIST YOU WITH OBTAINING SOCIAL SECURITY DISABILITY BENEFITS?

In order to be eligible for assistance from Unum's Social Security claimant advocacy program, you must be receiving monthly payments from us. Unum can provide expert advice regarding your claim and assist you with your application or appeal.

Receiving Social Security benefits may enable:

- you to receive Medicare after 24 months of disability payments;
- you to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist you in obtaining Social Security disability benefits by:

- helping you find appropriate legal representation;
- obtaining medical and vocational evidence; and
- reimbursing pre-approved case management expenses.

GLOSSARY

ACCUMULATION PERIOD means the period of time from the date disability begins during which you must satisfy the elimination period.

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Temporary and seasonal workers are excluded from coverage.

ACTIVITIES OF DAILY LIVING mean:

- Bathing - the ability to wash yourself either in the tub or shower or by sponge bath with or without equipment or adaptive devices.
- Dressing - the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn.
- Toileting - the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing.
- Transferring - the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
- Continence - the ability to either:
  - voluntarily control bowel and bladder function; or
  - if incontinent, be able to maintain a reasonable level of personal hygiene.
- Eating - the ability to get nourishment into the body.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DEPENDENT means:

- your child(ren) under the age of 15; and
- your child(ren) age 15 or over or a family member who requires personal care assistance.

DISABILITY EARNINGS means the earnings which you receive from your Employer while you are disabled and working, and the earnings from other employment that you receive for work which you begin after you become disabled. It also includes the earnings you could receive if you were working to your **maximum capacity**.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

GOVERNMENTAL RETIREMENT SYSTEM means a plan which is part of any federal, state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INDEXED MONTHLY EARNINGS means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while you are disabled and working.

INJURY means a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

LAW, PLAN OR ACT means the original enactments of the law, plan or act and all amendments.

LAYOFF or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LIMITED means what you cannot or are unable to do.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

MAXIMUM CAPACITY means, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.

MAXIMUM PERIOD OF PAYMENT means the longest period of time Unum will make payments to you for any one period of disability.

MENTAL ILLNESS means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders relatable to stress or to substance abuse or dependency. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.

MONTHLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

MONTHLY EARNINGS means your gross monthly income from your Employer as defined in the plan.

MONTHLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your indexed monthly earnings.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a physician for a claim that you send to us.

PLAN means a line of coverage under the policy.

PRE-EXISTING CONDITION means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

RECURRENT DISABILITY means a disability which is:

- caused by a worsening in your condition; and
- due to the same cause(s) as your prior disability for which Unum made a disability payment.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

REGULAR OCCUPATION means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan does not include any plan which is part of any governmental retirement system.

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by your Employer of all or part of your monthly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your monthly payment.

SICKNESS means an illness or disease. Disability must begin while you are covered under the plan.

SURVIVOR, ELIGIBLE means your spouse, if living; otherwise your children under age 25 equally.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

WE, **US** and **OUR** means Unum Life Insurance Company of America.

YOU means an employee who is eligible for Unum coverage.

LONG TERM DISABILITY/SHORT TERM DISABILITY

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY CERTAIN STATES. PLEASE READ CAREFULLY.

State variations apply and are subject to change. Consult your employer or plan administrator for the most current state provisions that may apply to you.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

The states of **Florida and Maryland** require us to advise residents of those states that if your Certificate was issued in a jurisdiction other than the state in which you reside, it may not provide all of the benefits required by the laws of your residence state.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

For residents of Colorado:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The **WHAT *DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **BENEFIT INFORMATION** section of the policy and in the **SPOUSE DISABILITY BENEFIT** provision in the **OTHER BENEFIT FEATURES** section of the policy is amended to provide that any exclusion for disabilities caused by, contributed to by, or resulting from your intentionally self-inflicted injuries will be applied only if you were sane when the injury was inflicted.

For residents of Louisiana:

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 3 years.

For residents of Minnesota:

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

The ***WHAT ARE DEDUCTIBLE SOURCES OF INCOME?*** provision in the **BENEFIT INFORMATION** section of the policy is amended so that deductible sources of income will not include any amounts you receive as mandatory portions of any "no fault" motor vehicle plan or any amounts received from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise, until after you have been fully compensated from this other source.

The **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy will be applied by deleting the phrase "or you had symptoms for which an ordinarily prudent person would have consulted a health care provider."

If your coverage includes the **Spouse Disability Rider** benefit the exclusions for mental illness and alcoholism applicable to the rider are removed.

For residents of Montana:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The definition of pre-existing condition found in the provisions ***WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?*** and ***WHAT DISABILITIES ARE NOT COVERED FOR A COST OF LIVING INCREASE?*** in the **BENEFIT INFORMATION** section of the policy, is amended to limit a pre-existing condition to "a sickness or injury for which you received medical advice or treatment from a provider of health care services or medical advice or treatment was recommended by a provider of health care services" during the time period specified in the policy.

For residents of New Hampshire:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

For residents of North Carolina:

The definition of pre-existing condition found in the provisions ***WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?*** and ***WHAT DISABILITIES ARE NOT COVERED FOR A COST OF LIVING INCREASE?*** in the **BENEFIT INFORMATION** section of the policy, is amended by removing any reference to "symptoms arising from the sickness or injury, whether diagnosed or not."

For residents of South Carolina:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The ***WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM?*** provision in the **BENEFIT INFORMATION** section of the policy, is amended to provide that Unum will credit the pre-existing condition period you satisfied under another similar group disability policy if you were covered under the prior policy within 30 days of being effective under this policy and you applied for this coverage when you first became eligible.

For residents of South Dakota:

The **Pre-existing Condition** limitation in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** limitation in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

For residents of Texas:

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

The **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy will be applied by deleting the phrase "or you had symptoms for which an ordinarily prudent person would have consulted a health care provider."

For residents of Utah:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it

will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

For residents of Vermont:

If the policy is marketed in Vermont, the policyholder has a principal office or is organized in Vermont, or there are more than 25 Vermont residents insured under the policy:

The limitation specifying the number of months payments will be made for a disability caused by a mental and nervous condition is removed.

The **MINIMUM HOURS REQUIREMENT** stated in the **BENEFITS AT A GLANCE** section of the policy is reduced to 17.5 hours per week.

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

For residents of West Virginia:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

For residents of Wisconsin:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

ERISA

Additional Summary Plan Description Information

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document.

Name of Plan:
National Basketball Association Referees Insurance Plan

Name and Address of Employer:
NBA Services Corp.
100 Plaza Drive
Secaucus, New Jersey
07094

Plan Identification Number:
a. Employer IRS Identification #: 26-2863272
b. Plan #: 501

Type of Welfare Plan:
Disability Income

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:
September 30

Plan Administrator, Name, Address, and Telephone Number:
NBA Services Corp.
100 Plaza Drive
Secaucus, New Jersey
07094
(201) 974-6202

NBA Services Corp. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
NBA Services Corp.
100 Plaza Drive
Secaucus, New Jersey
07094

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions:

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number 619109 012. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE

The Employer can request a policy change. Only an officer of Unum can approve a change. The change must be in writing and endorsed on or attached to the policy.

MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY

The policy or a plan under the policy can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the policy or a plan if:

- there is less than 75% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for an Employer paid plan;
- the Employer does not promptly provide Unum with information that is reasonably required;
- the Employer fails to perform any of its obligations that relate to the policy;
- fewer than 10 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of the policy that specify whether the Employer, the employee, or both, pay(s) the premiums;
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or
- the Employer fails to pay any portion of the premium within the 31 day grace period.

If Unum cancels or modifies the policy or a plan for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer

at least 31 days prior to the cancellation date or modification date. The Employer may cancel the policy or a plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the policy or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the policy or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. 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".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of disability earnings or deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

Addendum to the "Additional Summary Plan Description Information" included with your certificate of coverage or policy and effective for claims filed on or after April 1, 2018.

The regulations governing ERISA disability claims and appeals have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description Information included with your certificate of coverage or policy conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

For any adverse benefit determination, you will be provided with an explanation of the basis for disagreeing or not following the views of: (1) health care professionals who have treated you or vocational professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (3) any disability determination made by the Social Security Administration regarding you and presented to the plan by you.

For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.

Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.

If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.

Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in section 503-1(l).

NOTICE
NEW JERSEY LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center, 9th Floor
Newark, New Jersey 07102

State of New Jersey Department of Banking & Insurance
20 West State Street
CN-325
Trenton, New Jersey 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Guaranty Association Act, N.J.S.A.17B:32A-1,et seq. (the "Act").

COVERAGE

The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association;

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than $100,000 in cash surrender values for life insurance, $100,000 in cash surrender values for annuity benefits, $500,000 in life insurance death benefits, or $500,000 in present value of annuities--again no matter how many policies and contracts that were with the same company, and no matter how many different types of coverages.

The Association will not pay more than $2,000,000 in benefits to any one contractholder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.

NBA Services Corp.

CIGNA DENTAL PREFERRED
PROVIDER INSURANCE

EFFECTIVE DATE: October 1, 2020

CN003
3341189

This document printed in August, 2020 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: NBA Services Corp.

GROUP POLICY(S) — COVERAGE
3341189 - DPPO CIGNA DENTAL PREFERRED PROVIDER INSURANCE

EFFECTIVE DATE: October 1, 2020

CERTIFICATE SUBJECT TO THE LAWS OF THE STATE OF NEW JERSEY.

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

Anna Krishtul

Anna Krishtul, Corporate Secretary

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Important Notices

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HC-NOT96 07-17

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY : اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki

dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese –
注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711را شمارگیری کنید).

HC-NOT97 07-17

Important Notice

Your health plan provides that you will not be held financially liable for payments to health care providers for any sums, other than required copayments, coinsurance or deductibles, owed for covered expenses, if Cigna fails to pay for the covered expenses for any reason.

Subsequent changes in your coverage shall be evidenced in a separate benefit rider issued to you or your dependent(s).

If you or your dependent(s) are in need of emergency care, whether or not you use a participating provider in the network, your covered expenses will be reimbursed to you as if you or your dependent(s) had been treated by a preferred provider.

HC-IMP46 04/10
V1

How To File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by calling Member Services using the toll-free number on your identification card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service. If claims are not submitted within one year, the claim will not be considered valid and will be denied.

WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

HC-CLM14 04-10
V1

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 30 hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

None.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

HC-ELG1 04-10
V6

Cigna Dental Preferred Provider Insurance

The Schedule

For You and Your Dependents

The Dental Benefits Plan offered by your Employer includes Participating and non-Participating Providers. If you select a Participating Provider, your cost will be less than if you select a non-Participating Provider.

Emergency Services

The Benefit Percentage payable for Emergency Services charges made by a non-Participating Provider is the same Benefit Percentage as for Participating Provider Charges. Dental Emergency Services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

Deductibles

Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that year.

Participating Provider Payment

Participating Provider services are paid based on the Contracted Fee that is agreed to by the provider and Cigna. Based on the provider's Contracted Fee, a higher level of plan payment may be made to a Participating Provider resulting in a lower payment responsibility for you. To determine how your Participating Provider compares refer to your provider directory.
Provider information may change annually; refer to your provider directory prior to receiving a service. You have access to a list of all providers who participate in the network by visiting www.mycigna.com.

Non-Participating Provider Payment

Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 90th percentile of all provider charges in the geographic area.

Simultaneous Accumulation of Amounts

Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

Expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule.

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Classes I, II, III, IX Combined Calendar Year Maximum	$2,000	
Class IV Lifetime Maximum	$2,000	$2,000

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Calendar Year Deductible		
Individual	$50 per person Not Applicable to Class I	
Family Maximum	$150 per family Not Applicable to Class I	
Class I		
Preventive Care	100%	100%
Class II		
Basic Restorative	90% after plan deductible	90% after plan deductible
Class III		
Major Restorative	60% after plan deductible	60% after plan deductible
Class IV		
Orthodontia	50%	50%
Class IV Orthodontia applies only to a Dependent Child less than 19 years of age.		
Class IX		
Implants	60% after plan deductible	60% after plan deductible

Missing Teeth Limitation

The amount payable for the replacement of teeth that are missing when a person first becomes insured is 50% of the amount payable for the replacement of teeth that are extracted after a person has dental coverage.

This payment limitation no longer applies after 12 months of continuous coverage.

HC-MTL7 04-10
V1

Covered Dental Expense

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule has been met;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment.

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, Cigna will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $200.

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Covered Services

The following section lists covered dental services. Cigna may agree to cover expenses for a service not listed. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

HC-DEN1 04-10
V1

Dental PPO – Participating and Non-Participating Providers

Participating Providers

Plan payment for a covered service delivered by a Participating Provider is the Contracted Fee for that procedure, times the benefit percentage that applies to the class of service, as specified in The Schedule.

The covered person is responsible for the balance of the Participating Provider's Contracted Fee minus what the plan pays.

Non-Participating Providers

Plan payment for a covered service delivered by a non-Participating Provider is the Maximum Reimbursable Charge for that procedure, times the benefit percentage that applies to the class of service, as specified in The Schedule.

The covered person is responsible for the non-Participating Provider's actual charge minus what the plan pays.

HC-DEN194 11-15
V1

Class I Services – Diagnostic and Preventive

Clinical oral examination – Only 2 per person per calendar year.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are

performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 36 consecutive months.

Bitewing x-rays – Only 2 charges per person per calendar year.

Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) – Only 2 per person per calendar year.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Only 1 per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old - Only 1 treatment per tooth in any 3 calendar years.

HC-DEN3 04-10
V5

Class II Services – Basic Restorations, Periodontics, Endodontics, Oral Surgery, Prosthodontic Maintenance

Amalgam Filling

Composite/Resin Filling

Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.

Periodontal Scaling and Root Planing – Entire Mouth

Adjustments – Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recement Bridge

Routine Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.

General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I.V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

HC-DEN163 04-10
V1

Class III Services - Major Restorations, Dentures and Bridgework

Crowns

Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

Bridge Pontics - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Retainer Crowns - Resin with High Noble Metal

Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable

if the existing prosthesis is at least 60 consecutive months old, is not serviceable and cannot be repaired.

HC-DEN172 07-14
V1

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

Continued active treatment after the first month.

Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

Periodic observation of patient dentition to determine when orthodontic treatment should begin, at intervals established by the dentist, up to four times per calendar year.

The total amount payable for all expenses incurred for orthodontics during a Dependent child's lifetime will not be more than the orthodontia maximum shown in the Schedule.

Payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first payment is due when the appliance is installed. Later payments are due at the end of each 3-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while such child is insured. If insurance coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

HC-DEN6 04-10
V3

Class IX Services – Implants

Covered Dental Expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired.

Implant coverage may have a separate deductible amount, yearly maximum and/or lifetime maximum as shown in The Schedule.

HC-DEN8 04-10
V1

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance). However, for newborn children benefits will include coverage of an injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities;
- 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 made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- any replacement of a bridge, crown or denture which 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 periodontally 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;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- localized delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth. Allowable only on teeth with both periodontal pocket depths of 5 mm or greater and a prior history of Periodontal Therapy. Not allowable when more than eight (8) of these procedures are reported on the same date of service;
- services for which benefits are not payable according to the "General Limitations" section.

Personal Injury Protection (PIP) or Out-of-State Automobile Insurance Coverage (OSAIC)

When expenses are incurred as the result of an Automobile Related Injury, and the injured person has coverage under Personal Injury Protection (PIP) or Out-of-State Automobile Insurance Coverage (OSAIC), this section will be used to

determine whether this certificate provides coverage that is primary to such coverage or secondary to such coverage. It will also be used to determine the amount payable if this certificate provides primary or secondary coverage.

This certificate provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the person covered under this policy. This election is made by the named insured under a PIP policy and affects that person's family members who are not themselves named insureds under another automobile certificate. This certificate may be primary for one covered person, but not for another if the persons have separate automobile insurance policies and have made different selections regarding primacy of health coverage.

This certificate is secondary to OSAIC. However, if the OSAIC contains provisions which make it secondary or excess to the policyholder's Plan, then the policyholder's Plan is primary.

HC-DEX88 04-10

General Limitations

Dental Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- charges for or in connection with an injury or illness which is covered under any workers' compensation or similar law. This exclusion does not apply to self-employed persons, limited liability partnerships, limited liability companies and partnerships that do not obtain workers' compensation coverage;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- covered services to the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicare or Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

HC-DEX13 04-10
V2

Coordination of Benefits

PLEASE NOTE: If you are covered by more than one health benefit plan, you should file all your claims with each plan and provide each plan with information regarding the other plans under which you are covered.

Purpose of This Provision

A covered person may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows Cigna to coordinate what Cigna pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the primary plan and which is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the covered person is covered.

Definitions

The words shown below have special meanings when used in this provision. Please read these definitions carefully. Throughout this provision, these defined terms appear with their initial letter capitalized.

Allowable Expense: The charge for any health care service, supply or other item of expense for which the covered person is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this policy is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

Cigna will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.

When this policy is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, Cigna

will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period: A Calendar Year, or any portion of a Calendar Year, during which a covered person is covered by this policy and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

- Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
- Group hospital indemnity benefit amounts that exceed $150.00 per day;
- Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:

- Individual or family insurance contracts or subscriber contracts;
- Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
- Group or group-type coverage where the cost of coverage is paid solely by the covered person except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
- Group hospital indemnity benefit amounts of $150.00 per day or less;
- School accident-type coverage;
- A State plan under Medicaid.

Primary Plan: A Plan whose benefits for a covered person's health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either item below exists:

- The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
- All Plans which cover the covered person use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply as determined by Cigna, based on a standard which is most often charged for a given service by a Provider within the same geographic area.

Secondary Plan: A Plan which is not a Primary Plan. If a covered person is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

Primary and Secondary Plan

Cigna considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each claim determination period the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "Procedures to be Followed by the Secondary Plan to Calculate Benefits" section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Rules for the Order of Benefit Determination

The benefits of the Plan that covers the covered person as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the covered person as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the covered person as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the covered person as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the covered person as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the covered person under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

- The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
- If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the plan which covered the other parent for a shorter period of time.
- "Birthday," as used above, refers only to month and day in a Calendar Year, not the year in which the parent was born.
- If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

- The benefits of the Plan of the parent with custody of the child shall be determined first.
- The benefits of the Plan of the spouse of the parent with custody shall be determined second.
- The benefits of the Plan of the parent without custody shall be determined last.
- If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:

- The basis on which the Primary Plan and the Secondary Plan pay benefits; and
- Whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R & C), or some similar term. This means that the provider bills a charge and the covered person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R & C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the covered person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the covered person uses the services of a non-network provider, the plan will be treated as an R & C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation." This means that the HMO or other plan pays the provider a fixed amount per covered person. The covered person is liable only for the applicable deductible, coinsurance or copayment. If the covered person uses the services of a non-network provider, the HMO or other plan will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is R & C Plan and Secondary Plan is R & C Plan

The Secondary Plan shall pay the lesser of:

- The difference between the amount of the billed charges and the amount paid by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and the covered person shall not exceed the fee schedule of the Primary Plan. In no event shall the covered person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is R & C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

- The difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

The covered person shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the covered person has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall the covered person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R & C Plan

If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R & C Plan or Fee Schedule Plan

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the covered person receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R & C Plan

If the covered person receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

- The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R & C Plan and Secondary Plan is Capitation Plan

If the covered person receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The covered person shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

Primary Plan is an HMO and Secondary Plan is an HMO

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the covered person receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan, except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

Payment of Benefits

To Whom Payable

Dental Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient’s payment on the charge, it is the provider’s responsibility to reimburse the

patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by Cigna within 30 days after it receives a proper claim by electronic means and within 40 days after it receives a proper claim by other than electronic means. A claim will be considered to be properly submitted if it is an eligible claim for a health care service provided by a Physician to an insured; the claim has no material defect such as missing substantiating documentation or incorrect coding; there is no dispute regarding the amount of the claim; Cigna has no reason to believe the claim is fraudulent; and the claim requires no special treatment that prevents timely payment. If the claim is in whole or in part denied, ineligible, incomplete of substantiating documentation, miscoded or contains misinformation, the amount is in dispute, or requires special treatment, Cigna will in writing or by electronic means as appropriate, give an explanation of: denial, what documentation is needed to perfect a claim, a disputed claim amount, or a claim requiring extra time to process. Cigna will give notice of receipt of a claim by electronic means no later than two working days following receipt of the transmission of the claim. An overdue payment shall bear simple interest at the rate of 10% per annum.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

HC-POB4 04-10
V3

Miscellaneous

Clinical research has established an association between dental disease and complication of some medical conditions, such as the conditions noted below.

If you are a Cigna Dental plan member and you have one or more of the conditions listed below, you may apply for 100% reimbursement of your copayment or coinsurance for certain periodontal or caries-protection procedures (up to the applicable plan maximum reimbursement levels and annual plan maximums.)

For members with diabetes, cerebrovascular or cardiovascular disease:

- periodontal scaling and root planing (sometimes referred to as "deep cleaning")
- periodontal maintenance

For members who are pregnant:

- periodic, limited and comprehensive oral evaluation.
- periodontal evaluation
- periodontal maintenance
- periodontal scaling and root planing (sometimes referred to as "deep cleaning")
- treatment of inflamed gums around wisdom teeth.
- an additional cleaning during pregnancy.
- palliative (emergency) treatment – minor procedure

For members with chronic kidney disease or going to or having undergone an organ transplant or undergoing head and neck Cancer Radiation:

- topical application of fluoride
- topical fluoride varnish
- application of sealant
- periodontal scaling and root planing (sometimes referred to as "deep cleaning")
- periodontal maintenance

Please refer to the plan enrollment materials for further details.

HC-POB8 04-10
V1

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: stops paying premium for you; or otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels your insurance.

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM62 04-10
V1

Continuation

Special Continuation of Dental Insurance

If your insurance would otherwise cease due to total disability, and if you have been insured for at least three consecutive months under the policy, and if you pay your Employer the required premium, your Dental Insurance will be continued until the earliest of:

- the last day for which you have paid the required premium;
- the date you become employed and eligible for similar insurance under another group policy for dental benefits;
- the date the policy is canceled.

Within 31 days after the date the insurance would otherwise cease, you may elect such continuation by completing a continuation notification and by paying the required premium to your Employer.

If your insurance is being continued as outlined above, the Dental Insurance for any of your Dependents insured on the date your insurance would otherwise cease may be continued, subject to the above provisions. The Dependent Dental Insurance will be continued until the earlier of:

- the date your insurance ceases; or
- with respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent.

This option will not operate to reduce any continuation of insurance otherwise provided.

HC-TRM61 04-10
V1

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the final impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted within 3 calendar months after his insurance ceases.

- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.
- for a dental condition which causes an insured to be Totally Disabled on the day insurance ends, in the event the group policy cancels, and the expenses are incurred within 90 days after his insurance cancels.

Totally Disabled

A person is considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to perform the basic duties of his occupation; and
- he is not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

There is no extension for any Dental Service not shown above.

HC-BEX24 04-10
V1

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

HC-FED1 10-10

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of dental practitioners, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

HC-FED78 10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

HC-FED4 10-10

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed:

- if your Employer agrees, and you meet the criteria shown in the following Sections B through F and enroll for or change coverage within the time period established by your Employer.

B. Change of status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid eligibility/entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in cost of coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in coverage of spouse or Dependent under another employer's plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

HC-FED95 04-17

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and

effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67V1 09-14

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13 10-10

Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

HC-FED93 10-17

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

HC-FED18 10-10

Claim Determination Procedures under ERISA

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.

You or your authorized representative (typically, your health care professional) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents as applicable, and in the determination notices.

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

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: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; 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, if applicable; 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 for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

HC-FED83 03-13

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline

COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.

- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled "Disability Extension" for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

HC-FED66 07-14

ERISA Required Information

The name of the Plan is:

NBA Services Corp.

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

NBA Services Corp.
100 Plaza Drive
Secaucus, NJ 07094
(201) 974-6290

Employer Identification Number (EIN):	Plan Number:
263863272	See Plan Administrator

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

The cost of the Plan is paid by the Employer.

The Plan's fiscal year ends on 09/30.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective

bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan

and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HC-FED72 05-15

Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

HC-SPP4 04-10
V1

When You Have a Concern or Complaint

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted and a "Dentist reviewer" is a licensed Dentist, depending on the care, treatment or service under review who is also a Medical Director or his or her designee who rendered the initial adverse determination.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Complaints and Administrative Appeals Regarding Contractual Benefits, Quality of Care and Services

Start with Member Services

We are here to listen and help. If you have a specific concern or complaint regarding a person, a service, the quality of care, choice of or access to providers, provider network adequacy or contractual benefits, you or your designated representative (including your treating Provider) can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

> Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 calendar days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Administrative Appeals Procedure

Cigna has a two step appeals procedure for coverage decisions. To initiate an Administrative appeal, you must submit a request for an appeal in writing within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by calling the toll-free number on your Benefit Identification card. If you choose to designate a representative to appeal on your behalf, including your provider, all correspondence related to your appeal will be sent to your designated representative and you. If you do not want such representative to pursue the appeal on your behalf, you must notify Cigna that you do not want this representative appealing this issue on your behalf.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision.

For level one appeals, we will acknowledge in writing that we have received your request within 10 business days and respond in writing with a decision within 30 calendar days after we receive an appeal for a post-service coverage determination or within 15 calendar days for a pre-service coverage determination. If more time or information is needed to make the determination, we 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.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal, except that such a request must be submitted within 60 days from your receipt of a Level One Appeal decision.

Requests for a second review will be acknowledged in writing that we have received your request within 10 business days. Post-service requests will be completed within 30 calendar days, while most pre-service requests will be completed within 15 calendar days. If more time or information is needed to make the determination, we 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 will be notified in writing of the decision.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Dentist would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Dentist reviewer, in consultation with the treating Dentist will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond with a decision within 72 hours.

Appeal to the State of New Jersey

For appeals regarding a person, a service, the quality of care, choice of or access to providers, provider network adequacy, or the contractual benefits, if you remain dissatisfied after exhausting Cigna's Complaint and Appeal procedure, you may appeal to the State of New Jersey Department of Banking and Insurance at the following address and telephone number:

Consumer Protection Services
New Jersey Department of Banking and Insurance
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
(609) 292-5316

You may also wish to access an online New Jersey complaint form at: www.state.nj.us/dobi/enfcon.htm.

Appeals Regarding Required Medical Necessity and Utilization Review Determinations

Initial Determination

Cigna is responsible for making decisions about the appropriateness, medical necessity and efficiency of health care services provided to Members under this Certificate. All decisions to deny or limit coverage for an inpatient admission, a service, a procedure or an extension of inpatient stay, are made by a New Jersey-licensed Dentist.

The health care determinations made by Cigna are directly communicated to the treating or requesting Provider (including a Provider acting on your behalf with your consent, if such Provider is the requesting Provider) on a timely basis appropriate to the Member's medical needs. Cigna will not reverse its initial determination of medical necessity or appropriateness unless misrepresented or fraudulent information was submitted to Cigna as part of the request for health care services.

You or your designated representative (including a provider acting on your behalf with your consent) may request a written notice of an initial determination made by Cigna, including an explanation of the Medical Necessity Appeal process.

Medical Necessity Appeals Procedure

Cigna has a two step procedure for coverage decisions. To initiate a Medical Necessity appeal, you must submit a request for an appeal in writing to the address that appears on your Benefit Identification card, explanation of benefits or claim form within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by calling the toll-free number on your Benefit Identification card. If you choose to designate a representative to appeal on your behalf, including your provider, all correspondence related to your appeal will be sent to your designated representative and you. If you do not want such representative to pursue the appeal on your behalf, you must notify Cigna that you do not want this representative appealing this issue on your behalf.

Level One Appeal

You have the opportunity to speak with, and may request appeal review by, Cigna's Dentist reviewer.

For level one appeals, we will respond in writing with a decision within five business days after we receive an appeal.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal, except

that such a request must be submitted within 60 days from your receipt of a Level One Appeal decision.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least one Dentist reviewer and two other Dentists/health care professionals. Anyone involved in the prior decision may not participate on the Appeal Committee. The committee will consult with at least one Dentist in the same or similar specialty as the care under consideration, as determined by Cigna's Dentist reviewer. You may request that the same or similar specialist be a participant on the committee. You may present your situation to the committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request within 10 business days and schedule a committee review. The committee review will be completed within 15 calendar days for pre-service appeals and 20 business days for post-service appeals. If more time or information is needed to make the determination, we will notify the Department of Banking and Insurance and you in writing to request an extension of up to 15 calendar days for pre-service appeals and 20 business days for post-service appeals and to specify any additional information needed by the Appeals Committee to complete the review. You will be notified in writing of the Appeals Committee's decision.

External Appeals of Utilization Management Determinations

After exhausting Cigna's Medical Necessity Appeal procedure, if you remain dissatisfied with Cigna's health care determination, you may initiate a review by an Independent Utilization Review Organization (IURO) within 60 calendar days from the receipt of Cigna's final written decision. To initiate a review, you or your Provider, on your behalf, should complete the State of New Jersey IURO forms provided by Cigna and mail the completed forms to:

Consumer Protection Services
New Jersey Department of Banking and Insurance
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
(609) 292-5316

along with a check or money order for $25 payable to the "New Jersey Department of Banking and Insurance" (this fee may be reduced to $2 in cases of financial hardship). If a Provider is appealing to the IURO on your behalf, the Provider is responsible for paying your portion of the cost of the IURO appeal (e.g. $25, or $2 if financial hardship). Cigna will bear the remaining costs of the review.

You or your Provider, on your behalf, may also request review of your appeal by the IURO if Cigna has missed any timeframes associated with the processing of your medical necessity appeal. If this is the case, you must certify to the IURO that you or your Provider, on your behalf, did not hinder Cigna from making a timely determination by failing to provide the information required for Cigna to make its decision.

Once the IURO communicates its decision, Cigna will respond within 10 business days to you (or the Provider, on your behalf) the IURO and the Department of Banking and Insurance with a written report describing how Cigna will implement the IURO's decision.

The External Appeals Program is a voluntary program. The decision of the IURO is binding on Cigna.

Appeal to the State of New Jersey

You have the right to contact the New Jersey Department of Banking and Insurance for assistance at any time. The New Jersey Department of Banking and Insurance may be contacted at the following address and telephone number:

Consumer Protection Services
New Jersey Department of Banking and Insurance
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
(609) 292-5316

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: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; 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 as defined; a statement describing: the procedure to initiate the next level of appeal; any voluntary appeal procedures offered by the plan; and the claimant's right to bring an action under ERISA section 502(a); 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 for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the Level Two Appeal decision (or with the Level One Appeal decision if expedited). You or your plan may have other voluntary alternative dispute resolution options such as Mediation. 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.

Relevant Information

Relevant Information is any document, record, or other information which: was relied upon in making the benefit determination; 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; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action Following Appeals

If your plan is governed by ERISA, you have the right to bring a civil action in federal court under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action in federal court.

If your plan is governed by New Jersey P.L.2001, c.187 (2A:53A-30 et seq), you have the right to bring action in state court accordance with that statute. You must exhaust the Independent Health Care Appeals Program procedures created pursuant to section 11 of P.L.1997, c.192 (C26:2S-11), before filing an action in state court, unless serious or significant harm to the covered person has occurred or will imminently occur, before filing an action in state court for economic and non-economic loss that occurs as a result of Cigna's negligence with respect to the denial of or delay in approving or providing medically necessary covered services, which denial or delay is the proximate cause of a covered person's: death; serious and protracted or permanent impairment of a bodily function or system; loss of a body organ necessary for normal bodily function; loss of a body member; exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment; a physical condition resulting in chronic and significant pain; or substantial physical or mental harm which resulted in further substantial medical treatment made medically necessary by the denial or delay of care.

HC-APL49 04-10
V1

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1 04-10
V1

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

HC-DFS122 04-10
V1

Contracted Fee

The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on an Employee or Dependent, according to the Employee's dental benefit plan.

HC-DFS123 04-10
V1

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a provider operating within the scope of his license when he performs any of the Dental Services described in the policy.

HC-DFS125 04-10
V3

Dependent

Dependents are:

- your lawful spouse, including civil union partners; or
- your Domestic Partner; and

- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild, a grandchild who lives with you, or a child for whom you are the legal guardian, and any child acquired through a civil union. If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

The rights of married persons under federal law may not be available to parties to a civil union.

HC-DFS311 04-10
V1

Domestic Partner

A Domestic Partner is party to a domestic partnership, which is established when all of the following requirements are met:

- Both persons have a common residence and are otherwise jointly responsible for each other's common welfare as evidenced by joint financial arrangements or joint ownership of real or personal property, demonstrated by at least one of the following:
  - a joint deed, mortgage agreement or lease;
  - a joint bank account;
  - designation of one of the persons as a primary beneficiary in the other person's will;
  - designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or
  - joint ownership of a motor vehicle.
- Both persons agree to be jointly responsible for each other's basic living expenses during the domestic partnership.
- Neither person is in a marriage or civil union partnership recognized by New Jersey law, or a member of another domestic partnership.
- Neither person is related to the other by blood or affinity, up to and including the fourth degree of consanguinity.
- Both persons have chosen to share each other's lives in a committed relationship of mutual caring.
- Both persons are at least 18 years of age.
- Both persons file jointly an Affidavit of Domestic Partnership.
- Neither person has been a partner in a domestic partnership that was terminated less than 180 days prior to the filing of the current Affidavit of Domestic Partnership, except that this prohibition will not apply if one of the partners dies.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

HC-DFS120 04-10
V1

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

HC-DFS7 04-10
V3

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

Maximum Reimbursable Charge - Dental

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS752 07-14
V5

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

HC-DFS16 04-10
V1

Medicare

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

HC-DFS17 04-10
V1

Participating Provider

The term Participating Provider means: a dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a contract with Cigna to provide dental services at predetermined fees.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by your Employer.

HC-DFS136 04-10
V1



NBA Services Corp.

Your Group Life and Accidental Death and Dismemberment Plan

Identification No. 619109 011

Underwritten by Unum Life Insurance Company of America

10/13/2020

CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the Summary of Benefits (issued to the Employer), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

The Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at the Employer's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

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BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: October 1, 2020

IDENTIFICATION NUMBER: 619109 011

ELIGIBLE GROUP(S):

All Eligible Full-Time Active Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 17.5 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before October 1, 2020: None

For employees entering an eligible group after October 1, 2020: None

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

$500,000

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

If you have reached age 75, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to age 75; or
- 50% of the amount of life insurance shown above if you become insured on or after age 75.

There will be no further increases in your amount of life insurance.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

Continuity of Coverage

Premium Waiver

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

BENEFITS AT A GLANCE

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss. The amount you or your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death or any other covered loss according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: October 1, 2020

IDENTIFICATION NUMBER: 619109 011

ELIGIBLE GROUP(S):

All Eligible Full-Time Active Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 17.5 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before October 1, 2020: None

For employees entering an eligible group after October 1, 2020: None

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU (FULL AMOUNT)

$500,000

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

If you have reached age 75, your amount of AD&D insurance will be:
- 50% of the amount of AD&D insurance you had prior to age 75; or
- 50% of the amount of AD&D insurance shown above if you become insured on or after age 75.

There will be no further increases in your amount of AD&D insurance.

REPATRIATION BENEFIT FOR YOU

Maximum Benefit Amount:

Up to $5,000

The Repatriation Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your accidental death benefit must be paid first.

SEATBELT(S) AND AIR BAG BENEFIT FOR YOU

Benefit Amount:

Seatbelt(s): 10% of the Full Amount of your accidental death and dismemberment insurance benefit.

Air Bag: 5% of the Full Amount of your accidental death and dismemberment insurance benefit.

Maximum Benefit Payment:

Seatbelt(s): $25,000

Air bag: $5,000

The Seatbelt(s) and Air Bag Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Seatbelt(s) and Air Bag Benefit, your accidental death benefit must be paid first.

EDUCATION BENEFIT

Each Qualified Child

Benefit Amount per Academic Year for which a Qualified Child is enrolled:

6% of the Full Amount of the employee's accidental death and dismemberment insurance to a maximum of $6,000.

Maximum Benefit Payments:

4 per lifetime

Maximum Benefit Amount:

$24,000

Maximum Benefit Period:

6 years from the date the first benefit payment has been made.

The Education Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Education Benefit, your accidental death benefit must be paid first.

COMMON CARRIER BENEFIT

Maximum Benefit: The Full Amount

The Common Carrier Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Common Carrier benefit your accidental death benefit must be paid first.

EXPOSURE AND DISAPPEARANCE BENEFIT FOR YOU

Maximum Benefit Amount: The Full Amount

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

Continuity of Coverage is available under this plan - refer to the **ACCIDENTAL DEATH AND DISMEMBERMENT OTHER BENEFIT FEATURES** for further details.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

CLAIM INFORMATION

LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on your disability, written notice and proof of claim must be sent no later than 90 days after the date your disability begins.

If a claim is based on death, written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

If you have a disability, you must notify us immediately when you return to work in any capacity, regardless of whether you are working for your Employer.

HOW DO YOU FILE A CLAIM FOR A DISABILITY?

You or your authorized representative, and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

If your claim is based on your disability, your proof of claim, provided at your expense, must show:

- that you are under the **regular care** of a **physician**;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation; and
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

If claim is based on death, proof of claim, provided at your or your authorized representative's expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim or proof of continuing disability. Unum will deny your claim if the appropriate information is not submitted.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

HOW WILL UNUM MAKE PAYMENTS?

If your life claim is at least $10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to your beneficiary.

Also, your beneficiary may request the life claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

CLAIM INFORMATION

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on death or other covered loss, written notice and proof of claim must be sent no later than 90 days after the date of death or the date of any other covered loss.

If a claim is based on the Education Benefit, written notice and proof of claim must be sent no later than 60 days after the date of your death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the time proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

HOW DO YOU FILE A CLAIM FOR A COVERED LOSS?

You or your authorized representative and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF CLAIM?

If claim is based on death or other covered loss, proof of claim for death or covered loss, provided at your or your authorized representative's expense, must show:

- the cause of death or covered loss;
- the extent of the covered loss;
- the date of covered loss; and
- the name and address of any **hospital or institution** where treatment was received, including all attending **physicians**.

Also, in case of death, a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim. Unum will deny your claim if the appropriate information is not submitted.

If a claim is based on the Education Benefit, proof of claim, provided at your authorized representative's expense, must show:

- the date of enrollment of your qualified child in an accredited post-secondary institution of higher learning;
- the name of the institution;
- a list of courses for the current academic term; and
- the number of credit hours for the current academic term.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your accidental death and dismemberment insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

HOW WILL UNUM MAKE PAYMENTS?

If your accidental death or dismemberment claim is at least $10,000 Unum will make available to you or your beneficiary a **retained asset account** (the Unum Security Account).

Payment for the accidental death or dismemberment claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the accidental death or dismemberment claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, your beneficiary may request the accidental death claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

The Education Benefit will be paid to your qualified child or the qualified child's legal representative.

All other benefits will be paid to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS? (Assignability Rights)

The rights provided to you by the plan(s) for accidental death insurance benefits are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

WHEN DOES YOUR COVERAGE BEGIN?

When your Employer pays 100% of the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the later of:

- the date you are eligible for coverage; or
- the date Unum approves your evidence of insurability form, if **evidence of insurability** is required.

When you and your Employer share the cost of your coverage under a plan or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you apply for insurance on or before that date;
- the date you apply for insurance, if you apply within 31 days after your eligibility date; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

Evidence of insurability is required if you:

- are a late applicant, which means you apply for coverage more than 31 days after the date you are eligible for coverage; or
- voluntarily cancelled your coverage and are reapplying.

An evidence of insurability form can be obtained from your Employer.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE NOT WORKING DUE TO INJURY OR SICKNESS?

If you are not working due to injury or sickness, and if premium is paid, you may continue to be covered up to your retirement date.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary **layoff**, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your temporary layoff begins.

If you are on a **leave of absence**, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage due to a change in your annual earnings or due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your evidence of insurability form, if evidence of insurability is required. You must be in active employment or on a covered layoff or leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional coverage due to a change in your annual earnings or due to a plan change will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage or an evidence of insurability form a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application or an evidence of insurability form as a basis for doing this.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE SUMMARY OF BENEFITS REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The Summary of Benefits does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For the purposes of the Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

LIFE INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer in effect as of the October 1st just prior to the date of loss or your date of hire if later than October 1st. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, shift differential, overtime pay or any other extra compensation, or income received from sources other than your Employer.

WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT HAPPENS TO YOUR LIFE INSURANCE COVERAGE IF YOU BECOME DISABLED?

Your life insurance coverage may be continued for a specific time and your life insurance premium will be waived if you qualify as described below.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?

Your life insurance premium waiver will begin when we approve your claim, if you meet the following conditions. Your Employer may continue premium payments until Unum notifies your Employer of the date your life insurance premium waiver begins.

Your life insurance premium will be waived if you meet these conditions:

- you are less than 70 and insured under the plan.
- you become disabled and remain disabled .
- you meet the notice and proof of claim requirements for disability while your life insurance is in effect or within three months after it ends.

- your claim is approved by Unum.

After we approve your claim, Unum does not require further premium payments for you while you remain disabled according to the terms and provisions of the plan.

Your life insurance amount will not increase while your life insurance premiums are being waived. Your life insurance amount will reduce or cease at any time it would reduce or cease if you had not been disabled.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER END?

The life insurance premium waiver will automatically end if:

- you recover and you no longer are disabled;
- you fail to give us proper proof that you remain disabled;
- you refuse to have an examination by a physician chosen by Unum;
- you reach age 65; or
- premium has been waived for 12 months and you are considered to reside outside the United States or Canada. You will be considered to reside outside the United States or Canada when you have been outside these countries for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are not working in any occupation due to your **injury** or **sickness**; and
- due to the same injury or sickness, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by training, education or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

APPLYING FOR LIFE INSURANCE PREMIUM WAIVER

Ask your Employer for a life insurance premium waiver claim form.

The form has instructions on how to complete and where to send the claim.

WHAT INSURANCE IS AVAILABLE WHILE YOU ARE SATISFYING THE DISABILITY REQUIREMENTS? (See Conversion Privilege)

You may use this life conversion privilege when your life insurance terminates while you are satisfying the disability requirements. Please refer to the conversion

privilege below. You are not eligible to apply for this life conversion if you return to work and, again, become covered under the plan.

If an individual life insurance policy is issued to you, any benefit for your death under this plan will be paid only if the individual policy is returned for surrender to Unum. Unum will refund all premiums paid for the individual policy.

The amount of your death benefit will be paid to your named beneficiary for the plan. If, however, you named a different beneficiary for the individual policy and the policy is returned to Unum for surrender, that different beneficiary will not be paid.

If you want to name a different beneficiary for this group plan, you must change your beneficiary as described in the Beneficiary Designation page of this group plan.

WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)

When coverage ends under the plan, you can convert your coverage to an individual life policy, without evidence of insurability. The maximum amount that you can convert is the amount you are insured for under the plan. You may convert a lower amount of life insurance.

You must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- your employment terminates; or
- you no longer are eligible to participate in the coverage of the plan.

If you convert to an individual life policy, then return to work, and, again, become insured under the plan, you are not eligible to convert to an individual life policy again. However, you do not need to surrender that individual life policy when you return to work.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. You may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)

You may convert a limited amount of life insurance if you have been insured under your Employer's group plan with Unum for at least five (5) years and the Summary of Benefits or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum will be the lesser of:

- $10,000; or
- your coverage amount under the plan less any amount that becomes available under any other group life plan offered by your Employer within 31 days after the date the Summary of Benefits or the plan is cancelled.

PREMIUMS

Premiums for the converted insurance will be based on:

- your then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum's customary rates in use at that time; and
- the class of risk to which you belong.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

DEATH DURING THE THIRTY-ONE DAY CONVERSION APPLICATION PERIOD

If you die within the 31 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

APPLYING FOR CONVERSION

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

WILL UNUM ACCELERATE YOUR DEATH BENEFIT FOR THE PLAN IF YOU BECOME TERMINALLY ILL? (Accelerated Benefit)

If you become terminally ill while you are insured by the plan, Unum will pay you a portion of your life insurance benefit one time. The payment will be based on 75% of your life insurance amount. However, the one-time benefit paid will not be greater than $500,000.

Your right to exercise this option and to receive payment is subject to the following:

- you request this election, in writing, on a form acceptable to Unum;
- you must be terminally ill at the time of payment of the Accelerated Benefit;
- your physician must certify, in writing, that you are terminally ill and your life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to Unum.

The Accelerated Benefit is available on a voluntary basis. Therefore, you are not eligible for benefits if:

- you are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or

- you are required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the full amount of life insurance unless you qualify to have your life premium waived.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that would be continued under a disability continuation provision or that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Summary of Benefits subject to any reduction and termination provisions.

Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 24 months after your initial effective date of insurance; and
- suicide occurring within 24 months after the date any increases or additional insurance becomes effective for you.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you applied for at that time.

LIFE INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you if you were covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick under this Summary of Benefits,
- you return to active employment, or
- when your period for disability extension of benefits or accrued liability, including premium waiver, under the prior policy ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you is subject to payment of required premium and all other terms of this Summary of Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT IN THE EVENT OF YOUR DEATH IF YOUR DEATH IS THE DIRECT RESULT OF AN ACCIDENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim providing you meet certain conditions.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF ACCIDENTAL DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

WHEN WILL YOU RECEIVE PAYMENT IN THE EVENT OF CERTAIN OTHER COVERED LOSSES IF THE LOSS IS THE DIRECT RESULT OF AN ACCIDENT?

You will receive payment when Unum approves the claim.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR CERTAIN OTHER COVERED LOSSES?

If Unum approves the claim, Unum will determine the payment according to the Covered Losses and Benefits List below. The benefit Unum will pay is listed opposite the corresponding covered loss.

The benefit will be paid only if an **accidental bodily injury** results in one or more of the covered losses listed below within 365 days from the date of the accident.

Also, the accident must occur while you are insured under the plan.

Covered Losses	**Benefit Amounts**
Life	The Full Amount
Both Hands or Both Feet or Sight of Both Eyes	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and Sight of One Eye	The Full Amount
One Foot and Sight of One Eye	The Full Amount
Speech and Hearing	The Full Amount
Quadriplegia	The Full Amount
Triplegia	Three Quarters The Full Amount

Paraplegia	Three Quarters The Full Amount
One Hand or One Foot	One Half The Full Amount
Sight of One Eye	One Half The Full Amount
Speech or Hearing	One Half The Full Amount
Hemiplegia	One Half The Full Amount
Thumb and Index Finger of Same Hand	One Quarter The Full Amount
Uniplegia	One Quarter The Full Amount

The most Unum will pay for any combination of Covered Losses from any one accident is the full amount.

The Full Amount is the amount shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

"Annual Earnings" means your gross annual income from your Employer in effect as of the October 1st just prior to the date of loss or your date of hire if later than October 1st. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, shift differential, overtime pay or any other extra compensation, or income received from sources other than your Employer.

WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you have an accidental bodily injury that results in one or more of the covered losses while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT REPATRIATION BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit for the preparation and transportation of your body to a mortuary chosen by you or your authorized representative. Payment will be made if, as the result of a covered accident, you suffer loss of life at least 100 miles away from your principal place of residence.

However, when combined with two or more Unum accidental death and dismemberment insurance plans, the combined overall maximum for these plans together cannot exceed the actual expenses for the preparation and transportation of your body to a mortuary.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT SEATBELT(S) AND AIR BAG BENEFIT WILL UNUM PROVIDE?

Unum will pay you or your authorized representative an additional benefit if you sustain an accidental bodily injury which causes your death while you are driving or riding in a **Private Passenger Car**, provided:

For Seatbelt(s):

- the Private Passenger Car is equipped with seatbelt(s); and
- the seatbelt(s) were in actual use and properly fastened at the time of the covered accident; and
- the position of the seatbelt(s) are certified in the official report of the covered accident, or by the investigating officer. A copy of the police accident report must be submitted with the claim.

Also, if such certification is not available, and it is clear that you were properly wearing seatbelt(s), then we will pay the additional seatbelt benefit.

However, if such certification is not available, and it is unclear whether you were properly wearing seatbelt(s), then we will pay a fixed benefit of $1,000.

An automatic harness seatbelt will not be considered properly fastened unless a lap belt is also used.

For Air Bag:

- the Private Passenger Car is equipped with an air bag for the seat in which you are seated; and
- the seatbelt(s) must be in actual use and properly fastened at the time of the covered accident.

No benefit will be paid if you are the driver of the Private Passenger Car and do not hold a current and valid driver's license.

No benefit will be paid if Unum is able to verify that the air bag(s) had been disengaged prior to the accident.

The accident causing your death must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT EDUCATION BENEFIT WILL UNUM PROVIDE FOR YOUR QUALIFIED CHILDREN?

Unum will pay your authorized representative on behalf of each of your qualified children a lump sum payment if:

- you lose your life:
  - as a result of an accidental bodily injury; and
  - within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your accidental bodily injury occurred while you were insured under the plan;
- proof is furnished to Unum that the child is a **qualified child**; and

- the qualified child continues to be enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level.

The benefit amount per academic year, maximum benefit payments, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN WILL THE EDUCATION BENEFIT END FOR EACH QUALIFIED CHILD?

The education benefit will terminate for each qualified child on the earliest of the following dates:

- the date your qualified child fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

WHAT COVERAGE FOR EXPOSURE AND DISAPPEARANCE BENEFIT WILL UNUM PROVIDE?

Unum will pay a benefit if you sustain an accidental bodily injury and are unavoidably exposed to the elements and suffer a loss.

We will presume you suffered loss of life due to an accident if:
- you are riding in a common public passenger carrier that is involved in an accident covered under the Summary of Benefits; and
- as a result of the accident, the common public passenger carrier is wrecked, sinks, is stranded, or disappears; and
- your body is not found within 1 year of the accident.

Also, the accident must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT COMMON CARRIER BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit if you die from an accidental bodily injury received in an accident which is not an **occupational injury** and occurs while you are riding as a passenger in a common public passenger carrier.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any accidental losses caused by, contributed to by, or resulting from:

- suicide, self destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane.
- active participation in a riot.
- an attempt to commit or commission of a crime.

- the use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your physician. This exclusion will not apply to you if the chemical substance is ethanol.
- disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.
- being **intoxicated**.
- war, declared or undeclared, or any act of war.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you if you were covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick under this Summary of Benefits,
- you return to active employment, or
- when your period for disability extension of benefits or accrued liability, including premium waiver, under the prior policy ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you is subject to payment of required premium and all other terms of this Summary of Benefits.

GLOSSARY

ACCIDENTAL BODILY INJURY means bodily harm caused solely by external, violent and accidental means and not contributed to by any other cause.

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Temporary and seasonal workers are excluded from coverage.

ANNUAL EARNINGS means your annual income received from your Employer as defined in the plan.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Employer/Applicant named in the Application For Participation in the Select Group Insurance Trust, on the first page of the Summary of Benefits and in all amendments. It includes any division, subsidiary or affiliated company named in the Summary of Benefits.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that within 12 months of your return to work is or can be expected to provide you with an income that is at least equal to 60% of your annual earnings in effect just prior to the date your disability began.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

HEMIPLEGIA means total and irreversible paralysis of both limbs on either side of the body (i.e. the right arm and right leg or the left arm and left leg).

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INJURY means a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

INTOXICATED means that your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state where the accident occurred.

LAYOFF or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LOSS OF A FOOT means that all of the foot is cut off at or above the ankle joint.

LOSS OF A HAND means that all four fingers are cut off at or above the knuckles joining each to the hand.

LOSS OF HEARING means the total and irrecoverable loss of hearing in both ears.

LOSS OF SIGHT means the eye is totally blind and that no sight can be restored in that eye.

LOSS OF SPEECH means the total and irrecoverable loss of speech.

LOSS OF THUMB AND INDEX FINGER means that all of the thumb and index finger are cut off at or above the joint closest to the wrist.

OCCUPATIONAL INJURY means an injury that was caused by or aggravated by any employment for pay or profit or otherwise occurring within the course of employment.

PARAPLEGIA means total and irreversible paralysis of both lower limbs.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the Summary of Benefits.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the Summary of Benefits.

PRIVATE PASSENGER CAR means a validly registered four-wheel private passenger car (including Employer-owned cars), station wagons, jeeps, pick-up trucks, and vans that are used only as private passenger cars.

QUADRIPLEGIA means total and irreversible paralysis of all four limbs.

QUALIFIED CHILD is any of your unmarried dependent children under age 25 who, on the date of your death as a result of an accidental bodily injury, was either:

- enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level; or
- at the 12th grade level and enrolls as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level within 365 days following the date of your death.

Children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

RETAINED ASSET ACCOUNT:

- **for Life Insurance**, is an interest bearing account established through an intermediary bank in the name of your beneficiary, as owner.
- **for Accidental Death and Dismemberment Insurance**, is an interest bearing account established through an intermediary bank in the name of you or your beneficiary, as owner.

SICKNESS means an illness or disease. Disability must begin while you are covered under the plan.

TRIPLEGIA means total and irreversible paralysis of three limbs.

TRUST means the policyholder trust named on the first page of the Summary of Benefits and all amendments to the policy.

UNIPLEGIA means total and irreversible paralysis of one limb.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

WE, **US** and **OUR** means Unum Life Insurance Company of America.

YOU means an employee who is eligible for Unum coverage.

GROUP LIFE

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY CERTAIN STATES. PLEASE READ CAREFULLY.

State variations apply and are subject to change. Consult your employer or plan administrator for the most current state provisions that may apply to you.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

If you had group life coverage in place with your employer through another carrier when your employer changed carriers to Unum, your prior coverage may be continued under the Unum plan to the extent the laws of your resident state require such right to continue.

The states of **Florida and Maryland** require us to advise residents of those states that if your Certificate was issued in a jurisdiction other than the state in which you reside, it may not provide all of the benefits required by the laws of your residence state.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

For residents of Colorado:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

For residents of Connecticut:

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by deleting the exclusion for use of drugs, poisons, fumes or other chemical substances and amended to restate the crime or felony exclusion to read, "an attempt to commit or commission of a felony."

For residents of Illinois:

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the phrase "contributed to by."

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the phrase "contributed to by" and by limiting the application of the drug and chemical substance exclusion to "voluntary" use of a prescription or non prescription drug, poison, fume or other chemical substance.

For residents of Louisiana:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

The ***WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?*** provision in the **GENERAL PROVISIONS** section of the policy is amended by providing that unmarried dependent children may be covered from live birth until age 21 or such older age as stated in the policy.

For residents of Minnesota:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to include the additional right to continue coverage for up to 18 months at no more than 102% of the cost of your coverage under the group policy if your coverage terminates or you are laid off.

The ***PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE*** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE OTHER BENEFIT FEATURES** section of the policy, if applicable, are amended to provide that you may continue your coverage in the amount you are insured for under the group policy. However, the amount of your ported life insurance must be equal to or greater than the amount of your ported accidental death and dismemberment insurance.

The ***PREMIUM RATE CHANGES FOR PORTABLE COVERAGE*** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **AD&D INSURANCE OTHER BENEFIT FEATURES** section of the policy, are amended to provide that Unum may not change rates until your or your dependents' ported coverage has been in effect for 18 months.

The ***WHAT HAPPENS IF Unum OVERPAYS YOUR CLAIM?*** in the **LIFE INSURANCE CLAIM INFORMATION** section of the policy and the ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** in the **GENERAL PROVISIONS** section of the policy are amended by deleting all references to fraud and the provision ***HOW WILL Unum HANDLE INSURANCE FRAUD?*** in the **GENERAL PROVISIONS** section of the policy is removed.

For residents of Montana:

The ***WHAT LIMITED CONVERSION IS AVAILABLE IF THE POLICY OR THE PLAN IS CANCELLED? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended so that the period of time you must be insured under the plan is 3 years.

For residents of New Hampshire:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage.

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

For residents of New York:

The ***APPLYING FOR PORTABLE COVERAGE*** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE OTHER BENEFIT FEATURES** section of the policy is amended by removing the prohibition on porting coverage if you, your spouse or your dependent are injured or sick.

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy and ***APPLYING FOR PORTABLE COVERAGE*** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **AD&D INSURANCE OTHER BENEFIT FEATURES** section of the policy, are amended to provide you have 90 days to convert or port your coverage from the date your life insurance terminates, or if the employer notifies you of your conversion or port rights within 90 days, 45 days from the date of that notice.

The ***WHAT SEATBELT(S) AND AIRBAG BENEFIT WILL UNUM PROVIDE?*** provision in the **AD&D INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the requirement that the driver must have a valid driver's license.

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **AD&D INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the exclusion for being intoxicated.

For residents of North Carolina:

The ***APPLYING FOR PORTABLE COVERAGE*** provision in **the LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE OTHER BENEFIT FEATURES** section of the policy is amended by removing the prohibition on porting coverage if you, your spouse or your dependent are injured or sick.

For residents of North Dakota:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to limit the suicide exclusion to 12 months after the effective date of coverage.

The **SICKNESS** definition in the **GLOSSARY** section of the policy is amended to mean an illness or disease.

For residents of Oklahoma:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended to limit the suicide and self inflicted injury exclusion to suicide while sane or insane.

For residents of Oregon:

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that in the event of death by suicide during the suicide exclusion period, a refund of premiums will be made.

For residents of Pennsylvania:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage. In no event will the time allowed for you to exercise the life conversion privilege be extended beyond 90 days from the date your life insurance terminates.

The ***HOW MUCH WILL Unum PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR YOUR DEPENDENT'S ACCIDENTAL DEATH OR FOR CERTAIN OTHER COVERED LOSSES?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the requirement that for a claim to be payable, a death that results from an accidental bodily injury must occur within 365 days from the date of the accident.

For residents of South Carolina:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage.

The ***WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to allow up to 6 years from the date proof of claim is required to start a legal action regarding your claim.

The war exclusion in the ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended to read, "participation in a war, declared or undeclared, or any act of war."

For residents of South Dakota:

The ***WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the $10,000 limitation on the individual life policy maximum available.

The definition of **PHYSICIAN** in the **GLOSSARY** section of the policy is amended so that the limitation on the provision of physician services by family members reads as follows:

> Unum will not recognize as a physician the claimant or any member of the claimant's family residing in the claimant's household.

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by deleting the exclusions for intoxication, operating a vehicle while intoxicated and use of a chemical substance.

For residents of Texas:

The ***WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?*** provision in the **GENERAL PROVISIONS** section of the policy is amended by providing that unmarried dependent children may be covered until age 26 or such older age as stated in the policy regardless of student status.

For residents of Vermont:

If the policy is marketed in Vermont, the policyholder has a principal office or is organized in Vermont, or there are more than 25 Vermont residents insured under the policy:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage. In addition, in no event will the time allowed for you to exercise the life conversion privilege be extended beyond 90 days from the date your life insurance terminates.

For residents of Washington:

The **ACTIVE EMPLOYMENT** definition in the **GLOSSARY** section of the policy is amended to include the following:

> A period of up to 6 months during which you are not working due to a strike, lockout or other labor dispute is considered active employment. Your employer may require you to pay premium during this period of time.

The ***WILL Unum ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL? (Accelerated Benefit)*** in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended by changing the life expectancy requirement to 24 months or less, or such longer period as stated in the policy.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to remove any exclusion for death caused by suicide.

For residents of West Virginia:

The ***WHAT LIMITED CONVERSION IS AVAILABLE IF THE POLICY OR THE PLAN IS CANCELLED? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended so that the period of time you must be insured under the plan is 3 years.

For residents of Wisconsin:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

The ***WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that once your waiver claim is approved, premium waiver is retroactive to the end of the elimination period.

ERISA

Additional Summary Plan Description Information

If the Summary of Benefits provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the Summary of Benefits constitute the Plan. Benefit determinations are controlled exclusively by the Summary of Benefits, your certificate of coverage and the information contained in this document.

Name of Plan:
National Basketball Association Referees Insurance Plan

Name and Address of Employer:
NBA Services Corp.
100 Plaza Drive
Secaucus, New Jersey
07094

Plan Identification Number:
a. Employer IRS Identification #: 26-2863272
b. Plan #: 501

Type of Welfare Plan:
Life and Accidental Death and Dismemberment

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance Summary of Benefits issued to the Plan.

ERISA Plan Year Ends:
September 30

Plan Administrator, Name, Address, and Telephone Number:
NBA Services Corp.
100 Plaza Drive
Secaucus, New Jersey
07094
(201) 974-6202

NBA Services Corp. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
NBA Services Corp.
100 Plaza Drive
Secaucus, New Jersey
07094

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions:

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under identification number 619109 011. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

EMPLOYER'S RIGHT TO REQUEST SUMMARY OF BENEFITS CHANGE

The Employer can request a Summary of Benefits change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the Summary of Benefits.

MODIFYING OR CANCELLING THE SUMMARY OF BENEFITS OR A PLAN UNDER THE SUMMARY OF BENEFITS

The Summary of Benefits or a plan under the Summary of Benefits can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the Summary of Benefits or a plan if:

- there is less than 100% participation of those eligible employees for an Employer paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a plan; or
- the Employer does not promptly provide Unum with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to the Summary of Benefits; or
- fewer than 10 employees are insured under a plan; or
- the premium is not paid in accordance with the provisions of the Summary of Benefits that specify whether the Employer, the employee, or both, pay the premiums; or
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or

- the Employer fails to pay any premium within the 31 day grace period.

If Unum cancels or modifies the Summary of Benefits or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the Summary of Benefits or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the Summary of Benefits or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the Summary of Benefits or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the Summary of Benefits or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the Summary of Benefits or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the Summary of Benefits or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

If a claim is based on death, a covered loss not based on disability or for the Education Benefit

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

If a claim is based on your disability

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

If an appeal is based on death, a covered loss not based on disability or for the Education Benefit

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and

- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

If an appeal is based on your disability

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. 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".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Addendum to the "Additional Summary Plan Description Information" included with your certificate of coverage or summary of benefits and effective for claims filed on or after April 1, 2018.

The regulations governing ERISA disability claims and appeals have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description Information included with your certificate of coverage or summary of benefits conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

For any adverse benefit determination, you will be provided with an explanation of the basis for disagreeing or not following the views of: (1) health care professionals who have treated you or vocational professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (3) any disability determination made by the Social Security Administration regarding you and presented to the plan by you.

For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.

Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.

If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.

Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in section 503-1(l).

NOTICE
NEW JERSEY LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center, 9th Floor
Newark, New Jersey 07102

State of New Jersey Department of Banking & Insurance
20 West State Street
CN-325
Trenton, New Jersey 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Guaranty Association Act, N.J.S.A.17B:32A-1,et seq. (the "Act").

COVERAGE

The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association;

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than $100,000 in cash surrender values for life insurance, $100,000 in cash surrender values for annuity benefits, $500,000 in life insurance death benefits, or $500,000 in present value of annuities--again no matter how many policies and contracts that were with the same company, and no matter how many different types of coverages.

The Association will not pay more than $2,000,000 in benefits to any one contractholder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.



NBA Services Corp.

Your Group Life Insurance Plan

Identification No. 619109 021

Underwritten by Unum Life Insurance Company of America

10/13/2020

CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the Summary of Benefits (issued to the Employer), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

The Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at the Employer's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

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BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: October 1, 2020

IDENTIFICATION NUMBER: 619109 021

ELIGIBLE GROUP(S):

Retirees under the age of 65 who retire after 7/15/2010

WHO PAYS FOR THE COVERAGE:

You pay the cost of your coverage.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

$500,000

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

CLAIM INFORMATION

LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

Written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within this time limit, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Proof of claim, provided at your or your authorized representative's expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim. Unum will deny your claim if the appropriate information is not submitted.

WHEN CAN UNUM REQUEST AN AUTOPSY?

Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

HOW WILL UNUM MAKE PAYMENTS?

If your life claim is at least $10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to your beneficiary.

Also, your beneficiary may request the life claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

The date you are eligible for coverage is the later of:

- the plan effective date; or
- the date you retire.

WHEN DOES YOUR COVERAGE BEGIN?

You pay 100% of the cost of your coverage. You will be covered at 12:01 a.m. on the later of:

- the date you are eligible for coverage, if you apply for coverage on or before that date; or
- the date you apply for coverage if you apply within 31 days after your eligibility date.

WHEN DOES YOUR COVERAGE END?

Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered; or
- the last day of the period for which any required contributions are made.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage or an evidence of insurability form a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application or an evidence of insurability form as a basis for doing this.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE SUMMARY OF BENEFITS REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The Summary of Benefits does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For the purposes of the Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

LIFE INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer in effect as of the October 1st just prior to the date of loss or your date of hire if later than October 1st. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, shift differential, overtime pay or any other extra compensation, or income received from sources other than your Employer.

WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)

When coverage ends under the plan, you can convert your coverage to an individual life policy, without evidence of insurability. The maximum amount that you can convert is the amount you are insured for under the plan. You may convert a lower amount of life insurance.

You must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- your coverage terminates; or
- you no longer are eligible to participate in the coverage of the plan.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. You may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)

You may convert a limited amount of life insurance if you have been insured under your Employer's group plan with Unum for at least five (5) years and the Summary of Benefits or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum will be the lesser of:

- $10,000; or
- your coverage amount under the plan less any amount that becomes available under any other group life plan offered by your Employer within 31 days after the date the Summary of Benefits or the plan is cancelled.

PREMIUMS

Premiums for the converted insurance will be based on:

- your then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum's customary rates in use at that time; and
- the class of risk to which you belong.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

DEATH DURING THE THIRTY-ONE DAY CONVERSION APPLICATION PERIOD

If you die within the 31 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

APPLYING FOR CONVERSION

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

WILL UNUM ACCELERATE YOUR DEATH BENEFIT FOR THE PLAN IF YOU BECOME TERMINALLY ILL? (Accelerated Benefit)

If you become terminally ill while you are insured by the plan, Unum will pay you a portion of your life insurance benefit one time. The payment will be based on 75% of your life insurance amount. However, the one-time benefit paid will not be greater than $500,000.

Your right to exercise this option and to receive payment is subject to the following:

- you request this election, in writing, on a form acceptable to Unum;
- you must be terminally ill at the time of payment of the Accelerated Benefit;

- your physician must certify, in writing, that you are terminally ill and your life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to Unum.

The Accelerated Benefit is available on a voluntary basis. Therefore, you are not eligible for benefits if:

- you are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- you are required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the full amount of life insurance.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Summary of Benefits subject to any reduction and termination provisions.

Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 24 months after your initial effective date of insurance; and
- suicide occurring within 24 months after the date any increases or additional insurance becomes effective for you.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you applied for at that time.

GLOSSARY

ANNUAL EARNINGS means your annual income received from your Employer as defined in the plan.

EMPLOYER means the Employer/Applicant named in the Application For Participation in the Select Group Insurance Trust, on the first page of the Summary of Benefits and in all amendments. It includes any division, subsidiary or affiliated company named in the Summary of Benefits.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

INSURED means any person covered under a plan.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the Summary of Benefits.

PLAN means a line of coverage under the Summary of Benefits.

RETAINED ASSET ACCOUNT is an interest bearing account established through an intermediary bank in the name of your beneficiary, as owner.

RETIREE means a person who was in active employment in the United States with the Employer just prior to their date of retirement.

TRUST means the policyholder trust named on the first page of the Summary of Benefits and all amendments to the policy.

WE, **US** and **OUR** means Unum Life Insurance Company of America.

YOU means a person who is eligible for retiree coverage under this plan.

GROUP LIFE

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY CERTAIN STATES. PLEASE READ CAREFULLY.

State variations apply and are subject to change. Consult your employer or plan administrator for the most current state provisions that may apply to you.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

If you had group life coverage in place with your employer through another carrier when your employer changed carriers to Unum, your prior coverage may be continued under the Unum plan to the extent the laws of your resident state require such right to continue.

The states of **Florida and Maryland** require us to advise residents of those states that if your Certificate was issued in a jurisdiction other than the state in which you reside, it may not provide all of the benefits required by the laws of your residence state.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

For residents of Colorado:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

For residents of Connecticut:

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by deleting the exclusion for use of drugs, poisons, fumes or other chemical substances and amended to restate the crime or felony exclusion to read, "an attempt to commit or commission of a felony."

For residents of Illinois:

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the phrase "contributed to by."

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the phrase "contributed to by" and by limiting the application of the drug and chemical substance exclusion to "voluntary" use of a prescription or non prescription drug, poison, fume or other chemical substance.

For residents of Louisiana:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

The ***WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?*** provision in the **GENERAL PROVISIONS** section of the policy is amended by providing that unmarried dependent children may be covered from live birth until age 21 or such older age as stated in the policy.

For residents of Minnesota:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to include the additional right to continue coverage for up to 18 months at no more than 102% of the cost of your coverage under the group policy if your coverage terminates or you are laid off.

The ***PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE*** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE OTHER BENEFIT FEATURES** section of the policy, if applicable, are amended to provide that you may continue your coverage in the amount you are insured for under the group policy. However, the amount of your ported life insurance must be equal to or greater than the amount of your ported accidental death and dismemberment insurance.

The ***PREMIUM RATE CHANGES FOR PORTABLE COVERAGE*** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **AD&D INSURANCE OTHER BENEFIT FEATURES** section of the policy, are amended to provide that Unum may not change rates until your or your dependents' ported coverage has been in effect for 18 months.

The ***WHAT HAPPENS IF Unum OVERPAYS YOUR CLAIM?*** in the **LIFE INSURANCE CLAIM INFORMATION** section of the policy and the ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** in the **GENERAL PROVISIONS** section of the policy are amended by deleting all references to fraud and the provision ***HOW WILL Unum HANDLE INSURANCE FRAUD?*** in the **GENERAL PROVISIONS** section of the policy is removed.

For residents of Montana:

The ***WHAT LIMITED CONVERSION IS AVAILABLE IF THE POLICY OR THE PLAN IS CANCELLED? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended so that the period of time you must be insured under the plan is 3 years.

For residents of New Hampshire:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage.

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

For residents of New York:

The ***APPLYING FOR PORTABLE COVERAGE*** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE OTHER BENEFIT FEATURES** section of the policy is amended by removing the prohibition on porting coverage if you, your spouse or your dependent are injured or sick.

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy and ***APPLYING FOR PORTABLE COVERAGE*** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **AD&D INSURANCE OTHER BENEFIT FEATURES** section of the policy, are amended to provide you have 90 days to convert or port your coverage from the date your life insurance terminates, or if the employer notifies you of your conversion or port rights within 90 days, 45 days from the date of that notice.

The ***WHAT SEATBELT(S) AND AIRBAG BENEFIT WILL UNUM PROVIDE?*** provision in the **AD&D INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the requirement that the driver must have a valid driver's license.

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **AD&D INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the exclusion for being intoxicated.

For residents of North Carolina:

The ***APPLYING FOR PORTABLE COVERAGE*** provision in **the LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE OTHER BENEFIT FEATURES** section of the policy is amended by removing the prohibition on porting coverage if you, your spouse or your dependent are injured or sick.

For residents of North Dakota:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to limit the suicide exclusion to 12 months after the effective date of coverage.

The **SICKNESS** definition in the **GLOSSARY** section of the policy is amended to mean an illness or disease.

For residents of Oklahoma:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended to limit the suicide and self inflicted injury exclusion to suicide while sane or insane.

For residents of Oregon:

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that in the event of death by suicide during the suicide exclusion period, a refund of premiums will be made.

For residents of Pennsylvania:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage. In no event will the time allowed for you to exercise the life conversion privilege be extended beyond 90 days from the date your life insurance terminates.

The ***HOW MUCH WILL Unum PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR YOUR DEPENDENT'S ACCIDENTAL DEATH OR FOR CERTAIN OTHER COVERED LOSSES?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the requirement that for a claim to be payable, a death that results from an accidental bodily injury must occur within 365 days from the date of the accident.

For residents of South Carolina:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage.

The ***WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to allow up to 6 years from the date proof of claim is required to start a legal action regarding your claim.

The war exclusion in the ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended to read, "participation in a war, declared or undeclared, or any act of war."

For residents of South Dakota:

The ***WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the $10,000 limitation on the individual life policy maximum available.

The definition of **PHYSICIAN** in the **GLOSSARY** section of the policy is amended so that the limitation on the provision of physician services by family members reads as follows:

> Unum will not recognize as a physician the claimant or any member of the claimant's family residing in the claimant's household.

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by deleting the exclusions for intoxication, operating a vehicle while intoxicated and use of a chemical substance.

For residents of Texas:

The ***WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?*** provision in the **GENERAL PROVISIONS** section of the policy is amended by providing that unmarried dependent children may be covered until age 26 or such older age as stated in the policy regardless of student status.

For residents of Vermont:

If the policy is marketed in Vermont, the policyholder has a principal office or is organized in Vermont, or there are more than 25 Vermont residents insured under the policy:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage. In addition, in no event will the time allowed for you to exercise the life conversion privilege be extended beyond 90 days from the date your life insurance terminates.

For residents of Washington:

The **ACTIVE EMPLOYMENT** definition in the **GLOSSARY** section of the policy is amended to include the following:

> A period of up to 6 months during which you are not working due to a strike, lockout or other labor dispute is considered active employment. Your employer may require you to pay premium during this period of time.

The ***WILL Unum ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL? (Accelerated Benefit)*** in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended by changing the life expectancy requirement to 24 months or less, or such longer period as stated in the policy.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to remove any exclusion for death caused by suicide.

For residents of West Virginia:

The ***WHAT LIMITED CONVERSION IS AVAILABLE IF THE POLICY OR THE PLAN IS CANCELLED? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended so that the period of time you must be insured under the plan is 3 years.

For residents of Wisconsin:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

The ***WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that once your waiver claim is approved, premium waiver is retroactive to the end of the elimination period.

ERISA

Additional Summary Plan Description Information

If the Summary of Benefits provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the Summary of Benefits constitute the Plan. Benefit determinations are controlled exclusively by the Summary of Benefits, your certificate of coverage and the information contained in this document.

Name of Plan:
National Basketball Association Referees Insurance Plan

Name and Address of Employer:
NBA Services Corp.
100 Plaza Drive
Secaucus, New Jersey
07094

Plan Identification Number:
a. Employer IRS Identification #: 26-2863272
b. Plan #: 501

Type of Welfare Plan:
Life

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance Summary of Benefits issued to the Plan.

ERISA Plan Year Ends:
September 30

Plan Administrator, Name, Address, and Telephone Number:
NBA Services Corp.
100 Plaza Drive
Secaucus, New Jersey
07094
(201) 974-6202

NBA Services Corp. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
NBA Services Corp.
100 Plaza Drive
Secaucus, New Jersey
07094

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions:

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under identification number 619109 021. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

EMPLOYER'S RIGHT TO REQUEST SUMMARY OF BENEFITS CHANGE

The Employer can request a Summary of Benefits change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the Summary of Benefits.

MODIFYING OR CANCELLING THE SUMMARY OF BENEFITS OR A PLAN UNDER THE SUMMARY OF BENEFITS

The Summary of Benefits or a plan under the Summary of Benefits can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the Summary of Benefits or a plan if:

- there is less than 100% participation of those eligible employees for an Employer paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a plan; or
- the Employer does not promptly provide Unum with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to the Summary of Benefits; or
- fewer than 10 employees are insured under a plan; or
- the premium is not paid in accordance with the provisions of the Summary of Benefits that specify whether the Employer, the employee, or both, pay the premiums; or
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or

- the Employer fails to pay any premium within the 31 day grace period.

If Unum cancels or modifies the Summary of Benefits or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the Summary of Benefits or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the Summary of Benefits or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the Summary of Benefits or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the Summary of Benefits or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the Summary of Benefits or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the Summary of Benefits or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

NOTICE
NEW JERSEY LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center, 9th Floor
Newark, New Jersey 07102

State of New Jersey Department of Banking & Insurance
20 West State Street
CN-325
Trenton, New Jersey 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Guaranty Association Act, N.J.S.A.17B:32A-1,et seq. (the "Act").

COVERAGE

The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association;

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than $100,000 in cash surrender values for life insurance, $100,000 in cash surrender values for annuity benefits, $500,000 in life insurance death benefits, or $500,000 in present value of annuities--again no matter how many policies and contracts that were with the same company, and no matter how many different types of coverages.

The Association will not pay more than $2,000,000 in benefits to any one contractholder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.



NBA Services Corp.

Your Group Life Insurance Plan

Identification No. 619109 031

Underwritten by Unum Life Insurance Company of America

10/13/2020

CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the Summary of Benefits (issued to the Employer), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

The Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at the Employer's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

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BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: October 1, 2020

IDENTIFICATION NUMBER: 619109 031

ELIGIBLE GROUP(S):

Retirees under the age of 65 who retire before 7/15/2010 (Closed Group)

WHO PAYS FOR THE COVERAGE:

You pay the cost of your coverage.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

$50,000

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

CLAIM INFORMATION

LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

Written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within this time limit, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Proof of claim, provided at your or your authorized representative's expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim. Unum will deny your claim if the appropriate information is not submitted.

WHEN CAN UNUM REQUEST AN AUTOPSY?

Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

HOW WILL UNUM MAKE PAYMENTS?

If your life claim is at least $10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to your beneficiary.

Also, your beneficiary may request the life claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

The date you are eligible for coverage is the plan effective date.

WHEN DOES YOUR COVERAGE BEGIN?

You pay 100% of the cost of your coverage. You will be covered at 12:01 a.m. on the date you are eligible for coverage.

WHEN DOES YOUR COVERAGE END?

Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered; or
- the last day of the period for which any required contributions are made.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage or an evidence of insurability form a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application or an evidence of insurability form as a basis for doing this.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE SUMMARY OF BENEFITS REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The Summary of Benefits does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For the purposes of the Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

LIFE INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer in effect as of the October 1st just prior to the date of loss or your date of hire if later than October 1st. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, shift differential, overtime pay or any other extra compensation, or income received from sources other than your Employer.

WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)

When coverage ends under the plan, you can convert your coverage to an individual life policy, without evidence of insurability. The maximum amount that you can convert is the amount you are insured for under the plan. You may convert a lower amount of life insurance.

You must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- your coverage terminates; or
- you no longer are eligible to participate in the coverage of the plan.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. You may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)

You may convert a limited amount of life insurance if you have been insured under your Employer's group plan with Unum for at least five (5) years and the Summary of Benefits or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum will be the lesser of:

- $10,000; or
- your coverage amount under the plan less any amount that becomes available under any other group life plan offered by your Employer within 31 days after the date the Summary of Benefits or the plan is cancelled.

PREMIUMS

Premiums for the converted insurance will be based on:

- your then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum's customary rates in use at that time; and
- the class of risk to which you belong.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

DEATH DURING THE THIRTY-ONE DAY CONVERSION APPLICATION PERIOD

If you die within the 31 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

APPLYING FOR CONVERSION

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

WILL UNUM ACCELERATE YOUR DEATH BENEFIT FOR THE PLAN IF YOU BECOME TERMINALLY ILL? (Accelerated Benefit)

If you become terminally ill while you are insured by the plan, Unum will pay you a portion of your life insurance benefit one time. The payment will be based on 75% of your life insurance amount. However, the one-time benefit paid will not be greater than $500,000.

Your right to exercise this option and to receive payment is subject to the following:

- you request this election, in writing, on a form acceptable to Unum;
- you must be terminally ill at the time of payment of the Accelerated Benefit;

- your physician must certify, in writing, that you are terminally ill and your life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to Unum.

The Accelerated Benefit is available on a voluntary basis. Therefore, you are not eligible for benefits if:

- you are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- you are required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the full amount of life insurance.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Summary of Benefits subject to any reduction and termination provisions.

Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 24 months after your initial effective date of insurance; and
- suicide occurring within 24 months after the date any increases or additional insurance becomes effective for you.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you applied for at that time.

GLOSSARY

ANNUAL EARNINGS means your annual income received from your Employer as defined in the plan.

EMPLOYER means the Employer/Applicant named in the Application For Participation in the Select Group Insurance Trust, on the first page of the Summary of Benefits and in all amendments. It includes any division, subsidiary or affiliated company named in the Summary of Benefits.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

INSURED means any person covered under a plan.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the Summary of Benefits.

PLAN means a line of coverage under the Summary of Benefits.

RETAINED ASSET ACCOUNT is an interest bearing account established through an intermediary bank in the name of your beneficiary, as owner.

RETIREE means a person who was in active employment in the United States with the Employer just prior to their date of retirement.

TRUST means the policyholder trust named on the first page of the Summary of Benefits and all amendments to the policy.

WE, **US** and **OUR** means Unum Life Insurance Company of America.

YOU means a person who is eligible for retiree coverage under this plan.

GROUP LIFE

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY CERTAIN STATES. PLEASE READ CAREFULLY.

State variations apply and are subject to change. Consult your employer or plan administrator for the most current state provisions that may apply to you.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

If you had group life coverage in place with your employer through another carrier when your employer changed carriers to Unum, your prior coverage may be continued under the Unum plan to the extent the laws of your resident state require such right to continue.

The states of **Florida and Maryland** require us to advise residents of those states that if your Certificate was issued in a jurisdiction other than the state in which you reside, it may not provide all of the benefits required by the laws of your residence state.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

For residents of Colorado:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

For residents of Connecticut:

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by deleting the exclusion for use of drugs, poisons, fumes or other chemical substances and amended to restate the crime or felony exclusion to read, "an attempt to commit or commission of a felony."

For residents of Illinois:

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the phrase "contributed to by."

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the phrase "contributed to by" and by limiting the application of the drug and chemical substance exclusion to "voluntary" use of a prescription or non prescription drug, poison, fume or other chemical substance.

For residents of Louisiana:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

The ***WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?*** provision in the **GENERAL PROVISIONS** section of the policy is amended by providing that unmarried dependent children may be covered from live birth until age 21 or such older age as stated in the policy.

For residents of Minnesota:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to include the additional right to continue coverage for up to 18 months at no more than 102% of the cost of your coverage under the group policy if your coverage terminates or you are laid off.

The ***PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE*** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE OTHER BENEFIT FEATURES** section of the policy, if applicable, are amended to provide that you may continue your coverage in the amount you are insured for under the group policy. However, the amount of your ported life insurance must be equal to or greater than the amount of your ported accidental death and dismemberment insurance.

The ***PREMIUM RATE CHANGES FOR PORTABLE COVERAGE*** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **AD&D INSURANCE OTHER BENEFIT FEATURES** section of the policy, are amended to provide that Unum may not change rates until your or your dependents' ported coverage has been in effect for 18 months.

The ***WHAT HAPPENS IF Unum OVERPAYS YOUR CLAIM?*** in the **LIFE INSURANCE CLAIM INFORMATION** section of the policy and the ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** in the **GENERAL PROVISIONS** section of the policy are amended by deleting all references to fraud and the provision ***HOW WILL Unum HANDLE INSURANCE FRAUD?*** in the **GENERAL PROVISIONS** section of the policy is removed.

For residents of Montana:

The ***WHAT LIMITED CONVERSION IS AVAILABLE IF THE POLICY OR THE PLAN IS CANCELLED? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended so that the period of time you must be insured under the plan is 3 years.

For residents of New Hampshire:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage.

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

For residents of New York:

The ***APPLYING FOR PORTABLE COVERAGE*** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE OTHER BENEFIT FEATURES** section of the policy is amended by removing the prohibition on porting coverage if you, your spouse or your dependent are injured or sick.

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy and ***APPLYING FOR PORTABLE COVERAGE*** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **AD&D INSURANCE OTHER BENEFIT FEATURES** section of the policy, are amended to provide you have 90 days to convert or port your coverage from the date your life insurance terminates, or if the employer notifies you of your conversion or port rights within 90 days, 45 days from the date of that notice.

The ***WHAT SEATBELT(S) AND AIRBAG BENEFIT WILL UNUM PROVIDE?*** provision in the **AD&D INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the requirement that the driver must have a valid driver's license.

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **AD&D INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the exclusion for being intoxicated.

For residents of North Carolina:

The ***APPLYING FOR PORTABLE COVERAGE*** provision in **the LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE OTHER BENEFIT FEATURES** section of the policy is amended by removing the prohibition on porting coverage if you, your spouse or your dependent are injured or sick.

For residents of North Dakota:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to limit the suicide exclusion to 12 months after the effective date of coverage.

The **SICKNESS** definition in the **GLOSSARY** section of the policy is amended to mean an illness or disease.

For residents of Oklahoma:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended to limit the suicide and self inflicted injury exclusion to suicide while sane or insane.

For residents of Oregon:

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that in the event of death by suicide during the suicide exclusion period, a refund of premiums will be made.

For residents of Pennsylvania:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage. In no event will the time allowed for you to exercise the life conversion privilege be extended beyond 90 days from the date your life insurance terminates.

The ***HOW MUCH WILL Unum PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR YOUR DEPENDENT'S ACCIDENTAL DEATH OR FOR CERTAIN OTHER COVERED LOSSES?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the requirement that for a claim to be payable, a death that results from an accidental bodily injury must occur within 365 days from the date of the accident.

For residents of South Carolina:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage.

The ***WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to allow up to 6 years from the date proof of claim is required to start a legal action regarding your claim.

The war exclusion in the ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended to read, "participation in a war, declared or undeclared, or any act of war."

For residents of South Dakota:

The ***WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the $10,000 limitation on the individual life policy maximum available.

The definition of **PHYSICIAN** in the **GLOSSARY** section of the policy is amended so that the limitation on the provision of physician services by family members reads as follows:

> Unum will not recognize as a physician the claimant or any member of the claimant's family residing in the claimant's household.

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by deleting the exclusions for intoxication, operating a vehicle while intoxicated and use of a chemical substance.

For residents of Texas:

The ***WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?*** provision in the **GENERAL PROVISIONS** section of the policy is amended by providing that unmarried dependent children may be covered until age 26 or such older age as stated in the policy regardless of student status.

For residents of Vermont:

If the policy is marketed in Vermont, the policyholder has a principal office or is organized in Vermont, or there are more than 25 Vermont residents insured under the policy:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage. In addition, in no event will the time allowed for you to exercise the life conversion privilege be extended beyond 90 days from the date your life insurance terminates.

For residents of Washington:

The **ACTIVE EMPLOYMENT** definition in the **GLOSSARY** section of the policy is amended to include the following:

> A period of up to 6 months during which you are not working due to a strike, lockout or other labor dispute is considered active employment. Your employer may require you to pay premium during this period of time.

The ***WILL Unum ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL? (Accelerated Benefit)*** in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended by changing the life expectancy requirement to 24 months or less, or such longer period as stated in the policy.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to remove any exclusion for death caused by suicide.

For residents of West Virginia:

The ***WHAT LIMITED CONVERSION IS AVAILABLE IF THE POLICY OR THE PLAN IS CANCELLED? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended so that the period of time you must be insured under the plan is 3 years.

For residents of Wisconsin:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

The ***WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that once your waiver claim is approved, premium waiver is retroactive to the end of the elimination period.

ERISA

Additional Summary Plan Description Information

If the Summary of Benefits provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the Summary of Benefits constitute the Plan. Benefit determinations are controlled exclusively by the Summary of Benefits, your certificate of coverage and the information contained in this document.

Name of Plan:
National Basketball Association Referees Insurance Plan

Name and Address of Employer:
NBA Services Corp.
100 Plaza Drive
Secaucus, New Jersey
07094

Plan Identification Number:
a. Employer IRS Identification #: 26-2863272
b. Plan #: 501

Type of Welfare Plan:
Life

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance Summary of Benefits issued to the Plan.

ERISA Plan Year Ends:
September 30

Plan Administrator, Name, Address, and Telephone Number:
NBA Services Corp.
100 Plaza Drive
Secaucus, New Jersey
07094
(201) 974-6202

NBA Services Corp. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
NBA Services Corp.
100 Plaza Drive
Secaucus, New Jersey
07094

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions:

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under identification number 619109 031. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

EMPLOYER'S RIGHT TO REQUEST SUMMARY OF BENEFITS CHANGE

The Employer can request a Summary of Benefits change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the Summary of Benefits.

MODIFYING OR CANCELLING THE SUMMARY OF BENEFITS OR A PLAN UNDER THE SUMMARY OF BENEFITS

The Summary of Benefits or a plan under the Summary of Benefits can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the Summary of Benefits or a plan if:

- there is less than 100% participation of those eligible employees for an Employer paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a plan; or
- the Employer does not promptly provide Unum with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to the Summary of Benefits; or
- fewer than 10 employees are insured under a plan; or
- the premium is not paid in accordance with the provisions of the Summary of Benefits that specify whether the Employer, the employee, or both, pay the premiums; or
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or

- the Employer fails to pay any premium within the 31 day grace period.

If Unum cancels or modifies the Summary of Benefits or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the Summary of Benefits or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the Summary of Benefits or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the Summary of Benefits or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the Summary of Benefits or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the Summary of Benefits or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the Summary of Benefits or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

NOTICE
NEW JERSEY LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center, 9th Floor
Newark, New Jersey 07102

State of New Jersey Department of Banking & Insurance
20 West State Street
CN-325
Trenton, New Jersey 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Guaranty Association Act, N.J.S.A.17B:32A-1,et seq. (the "Act").

COVERAGE

The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association;

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than $100,000 in cash surrender values for life insurance, $100,000 in cash surrender values for annuity benefits, $500,000 in life insurance death benefits, or $500,000 in present value of annuities--again no matter how many policies and contracts that were with the same company, and no matter how many different types of coverages.

The Association will not pay more than $2,000,000 in benefits to any one contractholder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.

HM Life Insurance Company

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222

HM Life Insurance Company certifies that you will be insured under the Policy Number issued to the Policyholder named below during the time, in the manner, and for the amounts provided in the Policy.



President

POLICYHOLDER:	NBA Services Corp.
POLICY EFFECTIVE DATE:	October 01, 2016
CERTIFICATE EFFECTIVE DATE:	October 01, 2016
STATE OF ISSUE:	New Jersey

Your coverage under the Policy **HM Life Insurance Company** issued to the Policyholder is shown in this Certificate. If your coverage is changed by an amendment to the Policy, we will provide the Policyholder with a revised Certificate or other notice to be given to you.

PLEASE READ THIS CERTIFICATE CAREFULLY

This Certificate of Insurance has a Table of Contents to help you find specific provisions. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Certificate Effective Date shown above, at the Policyholder's address. The laws of the State of New Jersey govern this Certificate.

"You" and "your" refer to the Employee; "we", "us", and "our" refer to **HM Life Insurance Company**. Other defined terms are printed with an initial capital letter.

GROUP VISION POLICY - NON-PARTICIPATING

THE POLICY PROVIDES LIMITED BENEFITS

Questions or Comments

We want to hear from you. If you have any questions about this Certificate, its benefits, the filing of claims, a complaint or a compliment, write to us at the address on the front of this Certificate. We thank you for your loyal patronage.

ADMINISTERED BY

Davis Vision Inc., 175 E. Houston Street, San Antonio, TX 78205
For Customer Service Call: 800-328-4728

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INTRODUCTION

This Certificate is intended to be read in its entirety. In order to understand how benefits are calculated and all the conditions, exclusions and limitations applicable to its benefits, please read all the Certificate provisions carefully.

Subject to the terms and conditions of the Policy, we agree to provide the benefits described in this Certificate in consideration of the Policyholder's remittance of the premium when due, or if you are being billed directly your payment of the required premium when due.

WAITING PERIOD

The Waiting Period is the period of time that must elapse from the date you are hired before you or your Dependents are eligible for a benefit payment under the Policy. This period is determined by the Policyholder's personnel practices. We will not pay for benefits received during the Waiting Period. If your coverage ends you may have to satisfy a new Waiting Period in order to become insured again under the Policy. See Reinstatement for exceptions.

COVERED PERSONS

Member

Dependents

SCHEDULE OF BENEFITS

Subject to the terms of the Policy, benefits are payable per Covered Person as shown in the Schedule of Benefits.

A Covered Person may use the Provider of their choice. There are two types of Providers - those that are part of the Network (In-Network Providers) and those that are not part of the Network (Out-of-Network Providers). The payment of benefits varies depending on the type of Provider chosen.

When services or Materials are received from a Provider who is part of the Network, you are responsible for:

1. The Copayment, if a cash payment is due the Provider; or

2. If an Allowance is provided - the difference between the Allowance and the Allowable Charge. We will pay the dollar amount of the Allowance or the Allowable Charge, if less. If the Allowable Charge is more than the Allowance an In-Network Provider may bill you for the difference.

Benefits for services or Materials received from a Provider outside of the Network are shown in terms of the dollar amount we will pay you for that service or Material. If you use an Out-of-Network Provider your total responsibility is the difference between the Reimbursement and the Provider's Actual Charge -- we will pay the dollar amount of the Reimbursement for that service or Material or the Provider's Actual Charge if less. An Out-of-Network Provider may bill you for the difference.

You will not be paid a separate benefit, charged an additional Copayment or incur any additional cost for any item listed as "Included" or "Included -- no Copayment".

Emergency Care

If a Covered Person requires Emergency Care and the treatment for that care either requires an initial pair of eyeglasses or replacement lenses in an existing pair of eyeglasses we will either provide you with an initial frame and spectacle lenses or replacement spectacle lenses at the In-Network rate shown in the Schedule of Benefits.

For purpose of this provision "Emergency Care" means a service provided by any health care provider for a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in placing the health of the individual in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part.

Benefit	In-Network			Out-of-Network	Benefit Frequency
	Visionworks	Collection Providers	Non-Collection Providers		
VISION EXAMINATION					
Comprehensive Eye Examination	Included	Included	Included	$40 Reimbursement	For each Covered Person Once every 12 months
Contact Lenses Evaluation, Fitting and Follow-Up In lieu of eyeglasses lenses					For each Covered Person Once every 12 months
Standard - Collection	Not Available	Included	Not Available	Not Covered	
Standard - Non-Collection	Included	Included	Included	Not Covered	
Specialty - Non-Collection	$60 Allowance	$60 Allowance	$60 Allowance	Not Covered	
Low Vision					
Comprehensive Evaluation	$300 Allowance per Evaluation	$300 Allowance per Evaluation	$300 Allowance per Evaluation	$300 Allowance per Evaluation	Once every 60 months for each Covered Person
Follow-up Visit	$100 Allowance per Follow-up Visit	$100 Allowance per Follow-up Visit	$100 Allowance per Follow-up Visit	$100 Allowance per Follow-up Visit	Four visits every 60 months for each Covered Person
VISION MATERIALS					
Spectacle Lenses - per pair					For each Covered Person Once every 12 months
Single Vision	Included	Included	Included	$40 Reimbursement	
Bifocal	Included	Included	Included	$60 Reimbursement	
Trifocal	Included	Included	Included	$80 Reimbursement	
Lenticular	Included	Included	Included	$100 Reimbursement	
Frames					For each Covered Person Once every 12 months
Collection Fashion Designer Premier	Not Available	Included Included Included	Not Available	Not Covered	

Benefit	In-Network			Out-of-Network	Benefit Frequency
	Visionworks	Collection Providers	Non-Collection Providers		
Non-Collection	$150 Allowance	$150 Allowance	$150 Allowance	$50 Reimbursement	
Contact Lenses--(only one option available per benefit frequency) In lieu of eyeglasses					For each Covered Person Once every 12 months
Collection Planned Replacement Disposable	Not Available	4 boxes 8 boxes	Not Available	Not Covered	
Non-Collection	$150 Allowance	$150 Allowance	$150 Allowance	$105 Reimbursement	
Visually Required Contact Lenses - with prior approval	Included	Included	Included	$225 Reimbursement	
Lens Options - per pair					For each Covered Person Once every 12 months
Oversize Lenses	Included	Included	Included	Not Covered	
Cataract Lenses	Included	Included	Included	Not Covered	
Tint Solid or Gradient	Included	Included	Included	Not Covered	
Glass-Grey #3 Sunglass Lenses	Included	Included	Included	Not Covered	
Glass Lenses	Included	Included	Included	Not Covered	
Ultraviolet (UV) Coating	Included	Included	Included	Not Covered	
Scratch Resistant Coating	Included	Included	Included	Not Covered	
Scratch Protection Plan (single vision)	$20 Co-payment	$20 Co-payment	$20 Co-payment	Not Covered	
Scratch Protection Plan (multifocal)	$40 Co-payment	$40 Co-payment	$40 Co-payment	Not Covered	
Polycarbonate Lenses	Included	Included	Included	Not Covered	
Polycarbonate Lenses (For covered Children, monocular patients, patients with prescriptions ≥ +/- 6.00 diopters)	Included	Included	Included	Not Covered	
Blended Segment Lenses	$20 Co-payment	$20 Co-payment	$20 Co-payment	Not Covered	
Intermediate Vision Lenses	$30 Co-payment	$30 Co-payment	$30 Co-payment	Not Covered	
Standard Progressive Lenses (add on to Bifocal)	Included	Included	Included	Not Covered	
Premium Progressive Lenses (add on to Bifocal)	$90 Co-payment	$90 Co-payment	$90 Co-payment	Not Covered	
Ultra Progressive Lenses (add on to Bifocal)	$140 Co-payment	$140 Co-payment	$140 Co-payment	Not Covered	
Photochromic Glass Lenses	$20 Co-payment	$20 Co-payment	$20 Co-payment	Not Covered	
Plastic Photosensitive Lenses	$65 Co-payment	$65 Co-payment	$65 Co-payment	Not Covered	

Benefit	In-Network			Out-of-Network	Benefit Frequency
	Visionworks	Collection Providers	Non-Collection Providers		
Polarized Lenses	$75 Co-payment	$75 Co-payment	$75 Co-payment	Not Covered	
Standard Anti-Reflective (AR) Coating	Included	Included	Included	Not Covered	
Premium Anti-Reflective (AR) Coating	$48 Co-payment	$48 Co-payment	$48 Co-payment	Not Covered	
Ultra Anti-Reflective (AR) Coating	$60 Co-payment	$60 Co-payment	$60 Co-payment	Not Covered	
High-Index Lenses	$55 Co-payment	$55 Co-payment	$55 Co-payment	Not Covered	
Low Vision Aids	$600 Maximum Allowance per Aid $1,200 Lifetime Maximum Allowance for all Aids	$600 Maximum Allowance per Aid $1,200 Lifetime Maximum Allowance for all Aids	$600 Maximum Allowance per Aid $1,200 Lifetime Maximum Allowance for all Aids	$600 Maximum Allowance per Aid $1,200 Lifetime Maximum Allowance for all Aids	

Davis Vision Collection

In lieu of the frame Allowance, Covered Persons may choose to select any frame from the Davis Vision's Collection. The Collection is available at most participating independent provider offices and features three levels of frames.

In lieu of the non-Collection contact lens Allowance, Members may be fitted with contact lenses from the Davis Vision Collection. Contact lenses from the Davis Vision Collection include the evaluation, fitting and follow-up care.

Examination

An Exam or Eye examination includes (but is not limited to):

- Case history -- chief complaint, eye and vision history, medical history
- Entrance distance acuities
- External ocular evaluation including slit lamp examination
- Internal ocular examination
- Tonometry
- Distance refraction -- objective and subjective
- Binocular coordination and ocular motility evaluation
- Evaluation of pupillary function
- Biomicroscopy
- Gross visual fields
- Assessment and plan
- Advising on matters pertaining to vision care
- Form completion -- school, motor vehicle, etc.
- Dilated Fundus Examination (DFE) (diagnostic procedure used in the detection and management of diabetes, glaucoma, hypertension and other ocular and/or systemic diseases) when professionally indicated.

Visually Required Contact Lenses

Visually Required contact lenses will only be covered when the treating Provider has determined that a Covered Person has a "chronic visual disturbance." For the purposes of this section, chronic visual disturbance means a physiologic change in a Covered Person's vision either innate or acquired that inhibits the Covered Person's ability to achieve functional vision with spectacles such that a Visually Required contact lens is required to achieve the minimum functional vision needed to carry out normal daily activities. Chronic visual disturbance may include the following conditions: Keratoconus, Myopia, progressive or malignant, Hyperopia, Anisometropia, Aniseikonia, Aphakia, Aniridia or Irregular Astigmatism.

Visually Required contact lenses are available only if the treating Provider sends a completed request and supporting documentation showing a diagnosis of one of the foregoing conditions to Davis Vision before the lenses are initially ordered. The Visually Required contact lenses are subject to the maximum benefit Allowance per Frequency period. The Covered Person's benefit is paid in full up to the maximum Allowance during each Frequency period. Any amount due over the Allowance for such lenses during the Frequency period is the Covered Person's responsibility.

Visually Required contact lenses are subject to prior approval. If advance approval for the initial Visually Required contact lenses is not obtained, the standard contact lens benefit may be applied if available. This limitation will not apply if it is shown that it was not reasonably possible to submit the request for approval.

Contact lens evaluation, fitting and follow-up care applies to standard daily wear, disposable, planned replacement, specialty and the Visually Necessary contact lens benefit.

Low Vision Program

Low vision is a significant loss of vision, but not total blindness. Ophthalmologists and optometrists specializing in low-vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the Covered Person's remaining useable vision.

A comprehensive low vision evaluation is performed in addition to an eye examination when the eye examination indicates a need for such an evaluation. This supplemental evaluation includes a history of functional difficulties that involves daily activities. The result of this evaluation may include prescription of various treatments options, including low vision aids, as well as assist the Covered Person with identifying other resources for vision and lifestyle rehabilitation.

The Low Vision Program is available both in and out of network and is subject to prior approval. A completed request must be sent to Davis Vision prior to the initial evaluation. Once approved, a Covered Person is eligible for a comprehensive low vision evaluation and follow-up visits up to the maximum for such evaluation and visits shown above. Low vision aids will be provided as prescribed up to the maximum per aid, subject to the lifetime maximum for all aids shown above. Any amount due over the Allowance above for an evaluation, follow-up visits or aids is the Covered Person's responsibility. If the required approval is not obtained, no benefits will be paid for any such evaluation, follow-up visits or aids and the entire charge for such services or supplies will be the Covered Person's responsibility. This limitation will not apply if it is shown that it was not reasonably possible to submit the request for approval.

Eyeglass Warranty

Davis Vision provides a breakage warranty to repair or replace any Collection frame and/or lens(es) for a period of one year from the date of delivery. This warranty applies to eyeglasses (spectacle lenses, frames from the Davis Vision frame Collection and frames obtained from a national retail chain that is part of Davis Vision's Provider Network where the Davis Vision frame Collection is not displayed).

At Wal-Mart, Sam's Club and Costco locations a Covered Person will receive the full Allowance toward the location's everyday low pricing.

DEFINITIONS

Please note that certain words used in this Certificate have specific meanings. Other than references to he, him, his, you, your, yours, we, us or our, the words defined below and capitalized within the text of this Certificate have the meanings set forth below.

Allowable Charge means the amount negotiated between an In-Network Provider and us or our authorized representative as full payment for a Covered Expense shown in the Schedule of Benefits received or purchased by a Covered Person.

Allowance means a flat dollar amount payable under the Policy towards a Covered Expense from an In-Network Provider. Allowances are shown in the Schedule of Benefits. If the Providers charge is less than the Allowance we will only pay up to the Providers charge.

Average Retail Price means the charge made by other Providers rendering or furnishing vision care, treatment or supplies within the same geographic area.

We will base our determination of the retail price within a geographical area on a study or survey done to determine such charges. Consideration will be given to the nature and severity of the condition being treated including any complications which require additional time, skill, treatment or expertise.

Certificate means the document issued for delivery to the Covered Person that lists the benefits, conditions and limits of the Policy.

Child or Children means your or your Partner's unmarried natural or unmarried step Child who:

a. is under age 31; or

b. is unmarried or not in a civil union partnership, under age 31 and attends an accredited educational institution as a full-time student.

If your Child becomes incapable of self-support due to a developmental disability or physical handicap before reaching the limiting age his coverage may be continued. To continue the Child's coverage we must receive proof of incapacity within 31 days after coverage would otherwise terminate.

This Insurance will continue for as long as the Employee's Insurance stays in force and the Child remains incapacitated. Additional proof may be required from time to time but not more often than once a year.

This term includes a Child who:

1. Is living with you or your Partner in a parent Child relationship; or

2. Is adopted by or placed for adoption with, or is party in a suit for adoption by, you or your Partner; or

3. Is required to be provided coverage by you or your Partner under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).

Collection means Davis Vision's frame or contact lens Collection shown in the Schedule of Benefits.

Copayment means the amount a Covered Person is required to pay to the Provider prior to an eye examination or toward the cost of Materials. Copayments are shown in the Schedule of Benefits.

Covered Expense means the benefits listed in the Schedule of Benefits. The term "Covered Expense" or "Covered Expenses" does not include:

1. Any services or Materials that are not listed in the Schedule of Benefits; or

2. Any services or Materials shown as "Not Covered" in the Schedule of Benefits; or

3. An additional exam, frame, pair of spectacle lenses or contact lenses for which you have already received either an "In-Network Benefit" or an "Out-of-Network Benefit" during any one Frequency period; or

4. More than one type of contact lens at a time during any one Frequency period; or

5. The fitting and follow-up care or adjustments to eyeglasses (frames and spectacle lenses - including Additional In-Network Items) or contact lenses (including evaluation, fitting and follow-up care) if vision correction is not recommended by a Provider following an eye examination.

Covered Person or Covered Persons means a person covered by this Policy. The types of Covered Persons insured under the Policy are shown under Covered Persons in the Schedule of Benefits. For example, if "Member' is shown we insure all eligible Members, if 'Partner' is shown we insure the Employee's eligible Partner, and if "Children" is shown we insure all eligible Children.

Dependent or Dependents means an Employee's:

1. Partner; or

2. Child.

Enrollment Period means a period of time agreed upon by the Policyholder and us or our authorized representative during which a Member may apply for Insurance.

Frequency means the time period shown in the Schedule of Benefits during which you are eligible for the Covered Expenses shown in the Schedule of Benefits.

He, him or his means an individual, male or female.

In-Network Provider means a Provider who has entered into a contract with us or our authorized representative to provide eye examinations and/or Materials on an Allowable Charge basis. These Providers are part of our or our authorized representatives Network and will not bill you for more than:

1. The Copayment; or

2. Any difference between the Allowance and the amount he agreed to as total Reimbursement (the Allowable Charge).

Insurance means the group vision care Insurance provided to you and your Dependents, if any, under the Policy.

Life Event means one of the following: (1) your marriage or divorce; (2) the death of your spouse; (3) the birth or adoption of your Child; (4) the death of your Child; (5) a change in the employment status of your spouse; or (6) a change in your employment status.

Materials means frames and lenses provided to a Covered Person for ophthalmic correction under the terms and conditions of the Policy.

Member means a person:

1. Who is employed by the Policyholder as either an associate or employee; and

2. Who works the minimum number of hours to be eligible for the benefits provided by the Policy as determined by the Policyholder.

Network means a group of Providers who have entered into a contract with us or our authorized representative to provide eye examinations and/or Materials on a Scheduled Fee basis. Available Networks are shown in the Schedule of Benefits.

Out-of-Network Provider means Providers of optometric services, including ophthalmologists and opticians, who have not entered into a contract with us or our authorized representative to provide vision care services. An Out-of-Network Provider may bill you for the difference between the Reimbursement and his total charge (the Provider's Actual Charge).

Partner means your spouse, civil union partner or domestic partner:

1. By marriage; or

2. By a union between two adults having the effect of marriage that is recognized by New Jersey law; or

3. By a mutual agreement, recognized by the Policyholder, between two consenting adults who:

    a. are not married or legally separated;

    b. occupy the same residence; and

    c. share household expenses.

A 'domestic partner' includes partners in relationships from other jurisdictions that provide some, but not all, of the rights and benefits of marriage. A 'civil union partner' includes partners in same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage and are valid under the laws of the jurisdiction in which the civil union relationship was entered.

Policyholder means the entity shown on the cover page of this Certificate.

Provider means a practitioner who is a legally qualified professional providing eye examinations, refractive and/or post-refractive services and surgery within the scope of their license. This term includes an ophthalmologist, an optometrist, an optician or a surgeon recognized as such in accordance with the laws of the State in which the services are provided**.** The Policy recognizes two categories of Providers; In-Network Providers and Out-of-Network Providers. Refer to these Definitions for further information.

This term does not include:

1. A person employed or retained by the Policyholder;

2. A person living in the Covered Person's household; or

3. A parent, sibling, spouse, domestic partner or Child of the Covered Person.

Provider's Actual Charge means the total amount charged by a Provider for a Covered Expense.

Reimbursement means a flat dollar amount payable under the Policy towards a Covered Expense from an Out-of-Network Provider. Reimbursement levels are shown in the Schedule of Benefits. If the Providers charge is less than the Reimbursement we will only pay up to the Providers charge.

Visually Required means a service, supply or treatment which is:

1. Ordered by a Provider;

2. Required for treatment or management of a medical condition or symptom;

3. Provided in accordance with approved and generally accepted medical and surgical practice.

ELIGIBILITY REQUIREMENT

You are eligible for coverage under the Policy provided:

1. You meet the applicable definition shown in Definitions; and

2. You have completed the Waiting Period, if any, shown in the Schedule of Benefits.

Your Dependents are eligible for coverage under the Policy provided both you and your Dependents meet the applicable definition shown in Definitions.

No person is eligible for Insurance under this Policy as both a Member and Dependent at the same time. If both Partners are eligible as a Member one but not both may elect Dependent coverage.

EFFECTIVE DATE

You and your eligible Dependent's Insurance becomes effective on the date:

1. A completed and approved enrollment form, if any, is submitted for the person or persons to be insured; and

2. The required contribution for the person or persons to be insured has been submitted by your Employer or the required premium for the person or persons to be insured has been paid by the Policyholder or by some other designated person acting on behalf of the Policyholder.

A newborn Dependent Child is automatically covered from birth provided we receive notification within 31 days after the birth of the newborn. A Child adopted by you or your Partner, or placed for adoption with, or who is a party in a suit for adoption with you or your Partner is covered automatically provided we receive notification:

1. If a newborn within 31 days after the Child's birth; or

2. If not a newborn within 31 days after the date of adoption, date of placement for adoption or the date the Child becomes a party in a suit for adoption by you or your Partner.

A Child required to be provided coverage by you or your Partner under the terms of a Qualified Medical Child Support Order (QMCSO) is covered automatically from the date stipulated in the judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).

APPLYING FOR COVERAGE

You may only apply for coverage on yourself or your Dependents during the following periods:

1. Within 31 days after the date you are or your Dependent is first eligible for coverage;

2. During an Enrollment Period; or

3. Within 31 days of a Life Event.

You cannot apply for coverage on yourself or your Dependents at any other time, unless you have a certificate of creditable coverage from another vision plan, or did not apply when first eligible because of other vision coverage. If you do not enroll yourself or your Dependent when first eligible you and/or your Dependents will be considered a Late Entrant.

LATE ENTRANTS

A person who meets the Eligibility Requirement will be considered a late entrant if the Member:

1. Does not apply for his Insurance or the Dependent's Insurance within 31 days of the first day of the month following the date he or that Dependent is first eligible; or

2. Elects coverage on himself and/or his Dependents within 31 days of the date he or that Dependent is first eligible and subsequently voids such coverage within that time period.

If a Member does not apply for his Insurance or Dependents Insurance when he or his Dependent is first eligible he must wait until the Policyholder's next Enrollment Period or a Change in Family Status to enroll himself or his Dependents.

TERMINATION OF INSURANCE

Please read the Continuation of Insurance section of this Policy for information on continuation after eligibility for coverage would otherwise end.

The Insurance on a Covered Person will end on the earliest date below:

1. The first of the month following the date this Policy or Insurance for a Covered Class is terminated; or

2. The day following the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy; or

3. The last day of the last period for which premium is paid; or

4. The day he reports for active duty in the armed forces of the United States or any other country; or

5. The end of any period of continuation, as provided by the Policyholder's personnel practices; or

6. With respect to a Dependent, the first day of the month following the date of the death of the Member or the first of the month following the date the Dependent is no longer in a Covered Class or satisfies eligibility requirements under this Policy; or

7. The first of the month following the date the Employee retires from active service with the Policyholder.

Termination will not affect a claim for benefits incurred while coverage was in effect.

EXTENSION OF COVERAGE DUE TO DISABILITY

The termination of the Policy during a period of time when the Member is totally disabled or confined to a hospital will have no effect on benefits payable for that disability. In the event the Policy is terminated during a period of time when the Member is totally disabled that Member's coverage will continue for up to an additional 90 days. Continued coverage is subject to all of the provisions and limitations of the Policy.

CONTINUATION

1. Family and Medical Leave

   Your coverage and your Dependents coverage may be continued during absences for family or medical leave. If you are on a family or medical leave of absence, coverage will continue, provided any required premium is paid when due and the Policyholder has approved the leave in writing. Coverage will be continued for up to the greater of the leave period required by the federal Family and Medical Leave Act or the leave period required by applicable state law.

2. Military Leave

   If you or one of your Dependents is called upon to serve in the armed forces of the United States that person's coverage will be continued during such absence until he reports for active duty. Coverage continued during a military leave of absence is subject to notifying your Employer of such leave in writing and continued payment of any required premium when due.

3. COBRA

   In general, the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers, (other than certain church employers) who normally employed at least 20 or more employees in the prior calendar year, to temporarily extend their health care coverage to certain categories of employees and their covered Dependents when, due to certain "qualifying events," they are no longer eligible for group coverage. Contact the Policyholder for more information about COBRA and the events that may allow you or your Dependents to temporarily extend vision coverage.

REINSTATEMENT

If Insurance ends because you become a full time member of the armed forces of the United States you will not have to satisfy any applicable Waiting Period provided you re-enroll yourself and your Dependents and return to Active Service after you leave active military service within the applicable time period specified in the Uniform Services Employment and Reemployment Rights Act (USERRA). If you do not re-enroll yourself and your Dependents within 31 days of the date you return to Active Service from a military leave you must wait until the next Enrollment Period or a Life Event to enroll.

If a Dependent's Insurance ends because he becomes a full time member of the armed forces of the United States that person may be re-enrolled if eligible provided he is re-enrolled within the applicable time period specified in the Uniform Services Employment and Reemployment Rights Act (USERRA). If you do not re-enroll this person within 31 days you must wait until the next Enrollment Period or a Life Event to enroll this person.

EXCLUSIONS

Benefits will not be paid for, and the term "Covered Expenses" will not include charges arising from:

1. Any Covered Expense not shown in the Schedule of Benefits or any expenses shown as "Not Covered" in the Schedule of Benefits.

2. Eye examinations required by an employer as a condition of employment except, as otherwise provided under the Safety Program.

3. Services or Materials provided in connection with special procedures such as orthoptics and visual training (including but not limited to "Corneal Refractive Therapy" ("CRT), or "orthokeratology"), or in connection with medical or surgical treatment except as provided herein.

4. Materials which do not provide vision correction, except as provided herein.

5. Charges for the replacement of lost or stolen lenses or frames within the applicable benefit Frequency period in the Schedule of Benefits.

6. Sickness or injury covered by a workers' compensation act or other similar legislation if application for such benefits has been made.

7. Incurred as a direct or indirect result or war (declared or undeclared).

8. Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.

9. Services or supplies furnished to a Covered Person before the effective date of his Insurance under the Policy or after the date a Covered Person's Insurance ends.

10. Any medical treatment rendered outside the United States or Canada.

11. Services rendered by practitioners who do not meet the definition of Provider.

12. Comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior approval was not obtained from us or our authorized representative.

13. For Visually Required contact lenses prescribed for a Covered Person for which prior approval was not obtained from us or our authorized representative.

14. Refraction-only claims.

CLAIM PROVISIONS

In-Network

A Covered Person must contact an In-Network Provider before receiving services for a Covered Expense. The In-Network Provider will verify his eligibility for Covered Expenses with us or our authorized representative before the examination takes place. The Provider will submit Covered Person's claim directly to us or our authorized representative.

Out-of-Network

When a Covered Person uses an Out-of-Network Provider he must first pay the billed charge and then submit a claim.

1. Notice of Claim - written or authorized electronic/telephonic notice of claim must be given to us within 31 days after a Covered Expense is incurred or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized representative. Notice should include the Policyholder's name and the Covered Person's name, address, Policy and Policy Number.

2. Claim Forms - we will send claim forms for filing proof of loss when we receive notice of a claim. If the person making claim does not receive such forms before the expiration of 15 days after the insurer receives notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy.

3. Proof of Loss - written or authorized electronic proof of loss satisfactory to us must be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized representative within 90 days of the loss for which claim is made.

   If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which we are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible.

   We will remit payment for claims submitted in accordance with the above requirements no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means.

4. Payment of Claims - we will pay benefits due under this Policy for any loss immediately upon receipt of due written or authorized electronic proof of such loss.

   All benefits will be paid in United States currency. All benefits payable under this Policy, unless otherwise stated, will be payable to the Covered Person or to his estate.

   If we are to pay benefits to the Covered Person's estate or to a person who is incapable of giving a valid release, we may pay up to $1,000 to a relative by blood or marriage that we believe is equitably entitled. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment and release us from all liability.

Right to Receive and Release Needed Information

We have the right to obtain or give information needed to coordinate benefit payments with other plans. This can be from or to any other insurance company, organization or person, subject to the consent of the Covered Person. Any Covered Person claiming benefits must furnish us with the necessary information needed to coordinate benefit payments.

Right to Make Payments

We have the right to pay any other organization, as needed, to properly carry out this provision. Any such payments made in good faith are considered benefits paid under the Policy, and fully discharge our liability, to the extent of such payments.

Right to Recovery

We have the right to retrieve any excess amounts that may have been paid out should they exceed the provisions of the Policy. This can be from the Covered Person for whom the payments were made. It can also be from any other insurance company or organization.

Review

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;

2. Reference to specific Certificate provisions, rules or guidelines on which the denial was based;

3. A description of the additional information needed to support your claim;

4. Information concerning your right to request that we review our decision; and

5. A description of our review procedures, time limits and notice of your right to bring civil action.

This request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. As part of this review, you may:

1. Send us written comments;

2. Review any non-privileged information relating to your claim; or

3. Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. We will advise you of the results of our review within 60 days after we receive your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

Claimant Cooperation

Failure of a claimant to cooperate with us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Administration

The Policyholder has given us the authority to review claims for the benefits provided by this Policy and for deciding appeals of denied claims. In this role we shall have the authority, in our discretion, to interpret the terms of the Policy, to decide questions of eligibility for coverage or benefits under the plan, and to make any related findings of fact.

We will have no responsibility with respect to the administration of the benefit provided by this Policy except as described above. It is understood that our sole liability to the Policyholder and Covered Persons under the Policy shall be for the payment of benefits provided under this Policy.

We may contract with another entity to perform this function on our behalf.

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment

If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods within 18 months after the date the first payment on the claim was made:

1. A request for lump sum payment of the overpaid amount.

2. A reduction of any amounts payable under this Certificate.

If there is an overpayment due when the Covered Person dies, we may recover the overpayment from the Covered Person's estate.

We will not attempt to collect from a health care provider for overpayment on or before the 45th calendar day following the submission of the reimbursement request to the health care provider.

ADMINISTRATIVE PROVISIONS

If a premium is not paid when due, we will cancel this Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the Schedule of Benefits. The Policyholder has the sole responsibility to notify Covered Persons of such termination.

Contributions

You may be required to contribute toward all or part of your and your Dependent's Insurance under the Policy. If so you must agree to:

1. Have all or a portion of the cost of both your Insurance and your Dependent's Insurance deducted from your pay; or

2. Remit all or a portion of the cost of both your Insurance and your Dependent's Insurance directly to the Policyholder.

GENERAL PROVISIONS

Assignment

The rights and benefits under this Policy may be assigned under certain circumstances. Any Covered Person that wants to make an assignment of his Insurance should see the Policyholder for the conditions and further information.

We assume no responsibility for the validity, sufficiency, or effect of any assignment of a Covered Person's Insurance (including an assignment on a form furnished by us or by the Policyholder).

Incontestability

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of a claimant's death or incapacity, his applicable representative will be given a copy.

After two years from a Covered Person's effective date of Insurance, or from the effective date of increased benefits, no such statement will cause Insurance or the increased benefits to be contested except for fraud.

Clerical Error

A Covered Person's Insurance will not be affected by clerical error or delay in keeping records of Insurance under the Policy. If such error or delay is found, we will adjust the premium fairly.

Conformity with Statutes

Any provisions in conflict with the requirements of any state or federal law that applies to the Policy are automatically changed to satisfy the minimum requirements of such laws.

Compensation Insurance

The Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation, Occupational Disease or similar law.

ADDITIONAL SERVICES ADMINSTERED BY DAVIS VISION

In addition to the benefits listed in the Certificate, the following Value Added Services are available:

1. Non-Collection Frame - An additional 20% discount is given on any amount over the allowance for frames.

2. Non-Collection Contact Lenses - An additional 15% discount is given on any amount over the allowance for contact lenses.

3. Specialty Non-Collection Contact Lens evaluation fitting services and follow-up care -- An additional 15% discount is given on any amount over the allowance.

4. Laser Vision Correction

Laser Vision Correction Surgery		
	In-Network	**Out-of-Network**
Discount	Up to 25% or receive an additional 5% discount on any advertised specials	Not Covered

Laser Vision Correction Surgery

Laser vision correction is a surgical procedure to correct vision problems such as nearsightedness, farsightedness and astigmatism. Such procedures include Laser Epithelial Keratomileusis (LASEK), Laser in Situ Keratomileusis (LASIK), and Photorefractive Keratectomy (PRK).

Approval must be obtained prior to surgery to receive the Discount. A completed request must be sent to Davis Vision prior to the initial evaluation. If the required approval is not obtained, the entire charge for the services will be the Covered Person's responsibility.

Surgery must be performed within six months of the preoperative examination. If a Covered Person does not obtain the surgery within this time period, another pre-operative examination is necessary at the cost of the Covered Person.

5. Mail Order Replacement Contact Lens Program

Davis Vision's mail order contact lens replacement service is powered by ABB Optical Group. By accessing www.davisvisioncontacts.com, Davis Vision Members can easily order replacement contact lenses at a discount and have them shipped directly to their doorstep.

NBA Services Corp.

THE RESTATED NATIONAL BASKETBALL ASSOCIATION

REFEREES' PENSION PLAN

Restated Effective June 1, 2012

THE RESTATED NATIONAL BASKETBALL ASSOCIATION

REFEREES' PENSION PLAN

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PREAMBLE

THE RESTATED NATIONAL BASKETBALL ASSOCIATION

REFEREES' PENSION PLAN

WHEREAS, the National Basketball Association Referees' Pension Plan (the "Plan") was established on October 1, 1968;

WHEREAS, the Plan was last restated effective June 1, 2006;

WHEREAS, the First Amendment to the Plan was adopted on September 25, 2007 in order for the Internal Revenue Service to issue a favorable determination letter;

WHEREAS, the Second Amendment to the Plan was adopted on May 28, 2009 in order to reflect the assumption of sponsorship of the Plan by NBA Services Corp. and to incorporate changes required by the Pension Protection Act of 2006 and the Final Treasury Regulations under Section 415 of the Internal Revenue Code;

WHEREAS, the Third Amendment to the Plan was adopted on November 16, 2009, in order to provide for certain changes in the Plan pursuant to the Collective Bargaining Agreement between NBA Services Corp. and the National Basketball Referees Association, dated October 27, 2009;

WHEREAS, the Fourth Amendment to the Plan was adopted on May 26, 2010 to provide for the cessation of benefit accruals under the Plan effective June 1, 2010, a change in the Normal Retirement Date under the Plan and a change in the Plan's deferred retirement factors; and

WHEREAS, the Fifth Amendment to the Plan was adopted on May 31, 2011 in order to provide for compliance with the Heroes Earnings Assistance and Relief Tax Act of 2008

and Internal Revenue Service Notice 2010-15.

WHEREAS, in connection with the required on-cycle determination letter submission rules as provided under the IRS determination letter procedures set forth in Rev. Proc. 2007-44, it is necessary to amend and entirely restate the Plan in order to (i) incorporate the amendments that have previously been made to the Plan, (ii) incorporate the applicable statutory and regulatory changes, (iii) provide for the amendments required by the IRS Cumulative List set forth in Notice 2011-97, and (iv) make certain other changes to the Plan.

NOW, THEREFORE, except as otherwise provided in the Plan, effective June 1, 2012, the Plan is hereby amended and restated as set forth herein.

ARTICLE I

DEFINITIONS

1.1 "Accrued Benefit" shall mean a Referee's Normal Retirement Benefit under Section 4.1 and/or Section 4.1A. In no event shall a Referee's Accrued Benefit under the Plan be greater than the amount of his Accrued Benefit under the Plan on May 31, 2010 (determined based on the Referee's Years of Referee Service as of such date).

1.2 "Actuarial Equivalent" shall mean, unless specified otherwise, a benefit of equivalent value based upon the actuarial factors specified in Schedule A to the Plan.

1.3 "Actuarial Value" shall mean the present value of a benefit when computed on the basis of the actuarial factors specified in Schedule A to the Plan.

1.4 "Anniversary Date" shall mean October 1, 1969, June 1, 1970 and each June 1 of each subsequent year.

1.5 "Association" shall mean the National Basketball Association and its successors.

1.6 "Beneficiary" shall mean the person or persons designated by a Referee to receive any benefits under this Plan. Where a Referee fails to designate a Beneficiary or where a Beneficiary fails to survive a Referee, "Beneficiary" shall mean the Referee's surviving spouse, if any, or, if none, his children, if any, in equal shares, or, if none, his personal representative. Any person entitled to receive benefits hereunder after the death of a Referee shall also be deemed a Beneficiary for purposes of the Plan.

1.7 "Championship Game" shall mean any game included in the Association's schedule of Championship Games and shall not include playoff games or exhibition games.

1.8 "Code" shall mean the Internal Revenue Service Code of 1986, as amended.

1.9 "Committee" shall mean the Pension Committee referred to in Article XIV hereof.

1.10 "Contribution Account" shall mean the nominal account established and maintained pursuant to Section 3.1.

1.11 "Early Retirement Date" shall mean the date described in Section 5.1.

1.12 "Early Retirement Benefit" shall mean the benefit payable to a Referee at his Early Retirement Date as described in Section 5.2.

1.13 "Effective Date" shall mean October 1, 1968.

1.14 "Employee Account" shall mean the account established and maintained pursuant to Section 3.2.

1.15 "Employer" shall mean NBA Services Corp. For periods prior to January 1, 2009, "Employer" shall mean the Association.

1.16 "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.17 "Exhibition Game" shall mean any game other than a Championship Game or Playoff Game.

1.18 "Fund" shall mean the assets of the Trust.

1.19 "Named Fiduciary" shall mean the Committee.

1.20 "Normal Retirement Date" shall mean the earlier of (i) the last day of the month in which the Referee attains age 65 or (ii) the last day of the month in which the Referee has both attained age 62 and completed ten (10) Regular Seasons on the Referees' Roster.

1.21 "Normal Retirement Benefit" shall mean the benefit payable to the Referee at his Normal Retirement Date.

1.22 "Plan" shall mean the Restated National Basketball Association Referees' Pension Plan, including Appendix A hereto.

1.23 "Plan Administrator" shall mean the Committee.

1.24 "Plan Year" shall mean the period beginning on the Effective Date and on each succeeding Anniversary Date and ending on the day preceding the next succeeding Anniversary Date.

1.25 "Playoff Game" shall mean any game included in the Association's schedule of Playoff Games and shall not include Championship Games or Exhibition Games.

1.26 "Referee" shall mean, for a Regular Season ending on or before May 31, 1971, any person under contract with the Association for performing officiating services in a Championship Game, or, where the context permits, a person who formerly performed such services. For a Regular Season ending on or after May 31, 1972, "Referee" shall mean any person under contract with the Employer for performing officiating services in a Championship Game or an Exhibition Game, or where the context permits, a person eligible to perform such services or a person who formerly performed such services.

1.27 "Referees' Roster" shall mean, for a Regular Season ending on or before May 31, 1971, a list of all Referees who had been a Referee for 40 or more of the Championship Games played during the Regular Season involved. For a Regular Season ending on or after May 31, 1972, "Referees' Roster" shall mean a list of all Referees who had been a Referee for 40 or more of a combination of Championship Games and Exhibition Games played during the Regular Season involved; provided, however, that for the Regular Season commencing on February 5, 1999 (and only for such Regular Season), "Referees' Roster" shall mean a list of all Referees who had been a Referee for 25 or more of a combination of Championship Games and Exhibition Games played during such Regular Season. For any Regular Season beginning after May 31, 2004, "Referees' Roster" shall mean a list of all Referees who had been a Referee for 30

or more of a combination of Championship and Exhibition Games played during the Regular Season involved; provided, however, for any Regular Season beginning after May 31, 2009, any games officiated by a Referee in a Developmental League under circumstances described in Article IX, Section 2(c) of the Collective Bargaining Agreement between NBA Services Corp. and the National Basketball Referees Association, dated October 27, 2009, shall be included in determining if the Referee shall be considered to be on the Referees' Roster for the Regular Season involved. If and to the extent required by applicable law, "Referees' Roster" shall also include any Referee who (i) terminates his employment to enter the Armed Forces of the United States and (ii) is not otherwise considered to be on the Referees' Roster for the Regular Season involved.

1.28 "Regular Season" shall mean, for Plan Years ending on or before May 31, 1971, the period beginning on the date of the first game of the Association's Schedule of Championship Games during the year involved and ending on the following May 31. For Plan Years ending on or after May 31, 1972, "Regular Season" shall mean the period beginning on the date of the first game of the Association's schedule of Exhibition Games during the year involved and ending on the following May 31.

1.29 "Restatement Effective Date" shall mean, except as otherwise provided herein, June 1, 2012.

1.30 "Total Disability" shall mean the inability of a Referee to engage in his customary activity for the Employer by reason of any physical or mental impairment which can be expected to result in death or be of continuous and indefinite duration, as certified from time to time by a physician selected by the Committee.

1.31 "Trust Agreement" shall mean the Agreement establishing the Trust hereunder entered into between the Employer and the Trustee.

1.32 "Trust" shall mean the funds and assets held and administered by the Trustees at any time under the terms of the Trust Agreement.

1.33 "Trustees" shall mean the Trustees of the Trust under the Trust Agreement, as originally executed and as amended from time to time, and any successor Trustee or Trustees acting thereunder.

1.34 "Years of Referee Service" shall mean the number of Regular Seasons for which a Referee is on the Referees' Roster; provided, however, that except for the purpose of determining a Referee's Years of Referee Service for vesting purposes under Section 7.1(a), effective June 1, 2010, no Referee shall be credited with any Years of Referee Service with respect to any services that such Referee performs on or after June 1, 2010. In determining Years of Referee Service for a "Terminated Referee" (as defined in Section 7.1(a)) for the sole purpose of calculating the Terminated Referee's vested percentage in his Accrued Benefit under Article VII, the Terminated Referee's "Period of Service" with the Employer while employed in a capacity other than that of a Referee ("Non-Referee Employment") shall be taken into account. For purposes of the preceding sentence:

(a) "Period of Service" shall mean a period of time commencing on the date on which the Terminated Referee is employed in Non-Referee Employment ("employment commencement date") and ending on the date that he is no longer employed in that capacity ("severance from service date");

(b) All such Periods of Service shall, if noncontinuous, be aggregated and less than whole year Periods of Service (whether or not consecutive) shall be aggregated on the basis that 12 months of such service equal a Year of Referee Service; and

(c) A Terminated Referee shall be credited with a full month of service for any fractional month which includes his employment commencement date or his severance from service date.

ARTICLE II

ELIGIBILITY AND PARTICIPATION

2.1 Any Referee who participated in the Plan on the Restatement Effective Date shall continue to participate in the Plan subject to the terms hereunder.

2.2 Any Referee who was not eligible to participate in the Plan on the Restatement Effective Date shall become eligible to participate hereunder on the first Anniversary Date following the end of the first Regular Season during which he is on the Referee's Roster; provided, however, that in no event shall any Referee become a participant in the Plan later than six months after the first anniversary of the date on which his employment commenced. Notwithstanding anything to the contrary herein, effective June 1, 2010, any Referee who is not a participant in the Plan on May 31, 2010 shall not become eligible to participate in the Plan.

2.3 A former Referee who had participated in the Plan and who again becomes a Referee after having terminated his employment with the Employer, shall again participate in the Plan as of the first day of the Plan Year in which he resumes employment, provided that he is on the Referee's Roster during the Plan Year in which he resumes employment. Notwithstanding anything to the contrary herein, effective June 1, 2010, any former Referee who had participated in the Plan and who again becomes a Referee on or after June 1, 2010 shall not become eligible to again participate in the Plan.

2.4 Any Referee who receives the full value of his Pension Benefit, as defined in Section 8.1, (or who is deemed to have received a distribution of his Pension Benefit under Section 7.1(b)) shall thereupon cease to participate in the Plan and neither he nor any person on his behalf shall have any further rights to benefits under the Plan.

ARTICLE III

ACCOUNTS

3.1 Contribution Account.

(a) A Contribution Account shall be maintained for each Referee who was eligible to participate in the Plan on or before May 31, 1995. The value of any such Referee's Contribution Account on June 1, 1995, shall be equal to the value of such Referee's Employer Contribution Account (as defined in Section 1.10A of Appendix A to the Plan) maintained under the Plan as of May 31, 1995. The Contribution Account shall be used to determine the amount of the Referee's Normal Retirement Benefit under Section 4.1 and/or Section 4.1A.

(b) As of the last day of each Plan Year, the Trustee shall value each Contribution Account based upon the net increase or net decrease of the value of the Fund for such Plan Year.

3.2 Employee Account.

(a) An Employee Account shall be maintained for each Referee who had an Employee Contribution Account (as defined in Section 1.8A of Appendix A to the Plan) maintained on his behalf under the Plan on May 31, 1995. The value of any such Referee's Employee Account on June 1, 1995 shall be equal to the value of such Referee's Employee Contribution Account on May 31, 1995.

(b) A Referee's Employee Account shall continue to be invested by the Referee in accordance with the provisions of Article IV-A of Appendix A and shall continue to be valued in accordance with the provisions of Article V-A of Appendix A.

(c) A Referee may elect at any time to make a withdrawal from the amount of his Employee Account (other than amounts attributable to rollover contributions) in an amount

not to exceed the lesser of the total of his contributions credited to said Account (less any amount previously withdrawn therefrom) or the balance credited to such Employee Account as of the Valuation Date immediately preceding the day on which the withdrawal is made. Any such withdrawal may be made by advance written application to the Committee and shall, except for withdrawal of the balance of his Employee Account, be in whole $100 multiples.

(d) (i) Effective June 1, 1995, Referees shall no longer be permitted to make voluntary (after-tax) contributions to the Plan.

(ii) Effective June 1, 1995, Referees shall no longer be permitted to make rollover contributions to the Plan.

ARTICLE IV

NORMAL RETIREMENT

4.1 Amount of Normal Retirement Benefit. The Normal Retirement Benefit of a Referee retiring on his Normal Retirement Date, as determined on the basis of a monthly benefit payable for the life of the Referee with one hundred twenty (120) monthly payments guaranteed, shall be the following:

(a) If the Referee did not participate in the Plan on or before May 31, 1995, his Normal Retirement Benefit shall be an annual amount equal to $2,777 multiplied by the Referee's Years of Referee Service.

(b) If the Referee participated in the Plan on or before May 31, 1995 and does not have an Employee Account maintained on his behalf under the Plan, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $2,777 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(c) If the Referee did not participate in the Plan on or before May 31, 1995 and was employed as a Referee on or after June 1, 1996, his Normal Retirement Benefit shall be an annual amount equal to $2,987 multiplied by the Referee's Years of Referee Service.

(d) If the Referee participated in the Plan on or before May 31, 1995, does not have an Employee Account maintained on his behalf under the Plan and was employed as a Referee on or after June 1, 1996, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $2,987 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(e) If the Referee did not participate in the Plan on or before May 31, 1995 and had not yet received payment of his entire benefit under the Plan as of June 1, 1997, his Normal Retirement Benefit shall be an annual amount equal to $3,228 multiplied by the Referee's Years of Referee Service.

(f) If the Referee participated in the Plan on or before May 31, 1995, does not have an Employee Account maintained on his behalf under the Plan and had not yet received payment of his entire benefit under the Plan as of June 1, 1997, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $3,228 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(g) If the Referee did not participate in the Plan on or before May 31, 1995 and had not yet received payment of his entire benefit under the Plan as of June 1, 1998, his Normal Retirement Benefit shall be an annual amount equal to $3,458 multiplied by the Referee's Years of Referee Service.

(h) If the Referee participated in the Plan on or before May 31, 1995, does not have an Employee Account maintained on his behalf under the Plan and had not yet received payment of his entire benefit under the Plan as of June 1, 1998, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $3,458 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(i) If the Referee did not participate in the Plan on or before May 31, 1995 and had not yet received or commenced to receive payment of his benefit under the Plan as of June 1, 1999, his Normal Retirement Benefit shall be an annual amount equal to $3,631 multiplied by the Referee's Years of Referee Service.

(j) If the Referee participated in the Plan on or before May 31, 1995, does not have an Employee Account maintained on his behalf under the Plan and had not yet received or commenced to receive payment of his benefit under the Plan as of June 1, 1999, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $3,631 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(k) If the Referee did not participate in the Plan on or before May 31, 1995 and had not yet received or commenced to receive payment of his benefit under the Plan as of June 1, 2000, his Normal Retirement Benefit shall be an annual amount equal to $3,822 multiplied by the Referee's Years of Referee Service.

(l) If the Referee participated in the Plan on or before May 31, 1995, does not have an Employee Account maintained on his behalf under the Plan and had not yet received or commenced to receive payment of his benefit under the Plan as of June 1, 2000, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $3,822 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(m) If the Referee did not participate in the Plan on or before May 31, 1995 and had not yet received or commenced to receive payment of his benefit under the Plan as of

June 1, 2001, his Normal Retirement Benefit shall be an annual amount equal to $4,032 multiplied by the Referee's Years of Referee Service.

(n) If the Referee participated in the Plan on or before May 31, 1995, does not have an Employee Account maintained on his behalf under the Plan and had not yet received or commenced to receive payment of his benefit under the Plan as of June 1, 2001, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $4,032 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(o) If the Referee did not participate in the Plan on or before May 31, 1995 and had not yet received or commenced to receive payment of his benefit under the Plan as of June 1, 2002, his Normal Retirement Benefit shall be an annual amount equal to $4,262 multiplied by the Referee's Years of Referee Service.

(p) If the Referee participated in the Plan on or before May 31, 1995, does not have an Employee Account maintained on his behalf under the Plan and had not yet received or commenced to receive payment of his benefit under the Plan as of June 1, 2002, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $4,262 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(q) If the Referee did not participate in the Plan on or before May 31, 1995 and had not yet received or commenced to receive payment of his benefit under the Plan as of June 1, 2003, his Normal Retirement Benefit shall be an annual amount equal to $4,516 multiplied by the Referee's Years of Referee Service.

(r) If the Referee participated in the Plan on or before May 31, 1995, does not have an Employee Account maintained on his behalf under the Plan and had not yet received or commenced to receive payment of his benefit under the Plan as of June 1, 2003, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $4,516 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(s) If a former Referee, who, had received payment of his entire benefit under the Plan, again becomes employed as a Referee, the benefit payable to him shall be equal to the excess (if any) of: (i) the applicable Normal Retirement Benefit to be paid to the Referee in accordance with this Section over (ii) the Normal Retirement Benefit reflected in the benefit payment previously paid to such Referee under the Plan.

(t) If the Referee participated in the Plan on or before May 31, 1995 and has an Employee Account maintained on his behalf under the Plan, his Normal Retirement Benefit shall be the sum of (i) the amount that the Referee would be entitled to receive under the applicable paragraph of this Section 4.1 as if an Employee Account were not maintained on his behalf, plus (ii) the Actuarial Equivalent of the value of the Referee's Employee Account, based upon the value of such Employee Account as of the Valuation Date immediately preceding the date on which the Referee commences to receive payment of his Accrued Benefit under the Plan.

(u) The provisions of this Section 4.1 shall supersede any prior provisions of this Section and shall be interpreted in a manner so as to preclude the duplication of any benefits payable to any Referee or former Referee.

(v) The provisions of this Section 4.1 shall apply only for purposes of determining the Normal Retirement Benefit of a Referee who is not credited with a Year of Referee Service with respect to the Regular Season commencing in 2004 or any Regular Season thereafter. The Normal Retirement Benefit of a Referee who is credited with a Year of Referee Service with respect to the Regular Season commencing in 2004 or any Regular Season thereafter shall be determined under the applicable provisions of Section 4.1A.

4.1A Amount of Normal Retirement Benefit. The Normal Retirement Benefit of a Referee retiring on his Normal Retirement Date, who is credited with a Year of Referee Service with respect to any Regular Season that commences in 2004 or any year thereafter, as determined on the basis of a monthly benefit payable for the life of the Referee with one hundred twenty (120) monthly payments guaranteed, shall be the following:

(a) If the Referee did not participate in the Plan on or before May 31, 1995, and the last Year of Referee Service credited to such Referee is with respect to the 2004-2005

Regular Season, his Normal Retirement Benefit shall be an annual amount equal to $4,659 multiplied by the Referee's Years of Referee Service.

(b) If the Referee participated in the Plan on or before May 31, 1995 and does not have an Employee Account maintained on his behalf under the Plan, and the last Year of Referee Service credited to such Referee is with respect to the 2004-2005 Regular Season, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $4,659 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(c) If the Referee did not participate in the Plan on or before May 31, 1995, and the last Year of Referee Service credited to such Referee is with respect to the 2005-2006 Regular Season, his Normal Retirement Benefit shall be an annual amount equal to $4,807 multiplied by the Referee's Years of Referee Service.

(d) If the Referee participated in the Plan on or before May 31, 1995 and does not have an Employee Account maintained on his behalf under the Plan, and the last Year of Referee Service credited to such Referee is with respect to the 2005-2006 Regular Season, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $4,807 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(e) If the Referee did not participate in the Plan on or before May 31, 1995, and the last Year of Referee Service credited to such Referee is with respect to the 2006-2007 Regular Season, his Normal Retirement Benefit shall be an annual amount equal to $4,960 multiplied by the Referee's Years of Referee Service.

(f) If the Referee participated in the Plan on or before May 31, 1995 and does not have an Employee Account maintained on his behalf under the Plan, and the last Year of Referee Service credited to such Referee is with respect to the 2006-2007 Regular Season, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $4,960 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(g) If the Referee did not participate in the Plan on or before May 31, 1995, and the last Year of Referee Service credited to such Referee is with respect to the 2007-2008 Regular Season, his Normal Retirement Benefit shall be an annual amount equal to $5,117 multiplied by the Referee's Years of Referee Service.

(h) If the Referee participated in the Plan on or before May 31, 1995 and does not have an Employee Account maintained on his behalf under the Plan, and the last Year of Referee Service credited to such Referee is with respect to the 2007-2008 Regular Season, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $5,117 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(i) If the Referee did not participate in the Plan on or before May 31, 1995, and the last Year of Referee Service credited to such Referee is with respect to the 2008-2009 Regular Season, his Normal Retirement Benefit shall be an annual amount equal to $5,280 multiplied by the Referee's Years of Referee Service.

(j) If the Referee participated in the Plan on or before May 31, 1995 and does not have an Employee Account maintained on his behalf under the Plan, and the last Year of Referee Service credited to such Referee is with respect to the 2008-2009 Regular Season, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $5,280 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of

the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(k) If the Referee did not participate in the Plan on or before May 31, 1995, and the last Year of Referee Service credited to such Referee is with respect to the 2009-2010 Regular Season, his Normal Retirement Benefit shall be an annual amount equal to $6,336 multiplied by the Referee's Years of Referee Service.

(l) If the Referee participated in the Plan on or before May 31, 1995 and does not have an Employee Account maintained on his behalf under the Plan, and the last Year of Referee Service credited to such Referee is with respect to the 2009-2010 Regular Season, his Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $6,336 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(m) (i) If a former Referee, who, had received payment of his entire benefit under the Plan (as determined under Section 4.1 or Section 4.1A), again becomes employed as a Referee and is credited with a Year of Referee Service with respect to the Regular Season commencing in 2004 or any Regular Season thereafter, the benefit payable to him shall be equal to the excess (if any) of: (A) the applicable Normal Retirement Benefit to be paid to the Referee as determined in accordance with this Section 4.1A over (B) the Normal Retirement

Benefit reflected in the benefit payment previously paid to such Referee under the Plan.

(ii) If a former Referee, who, is receiving payment of his benefits under the Plan (as determined under Section 4.1 or Section 4.1A), again becomes employed as a Referee and is credited with a Year of Referee Service with respect to the Regular Season commencing in 2004 or any Regular Season thereafter, the benefit being paid to such Referee prior to his reemployment shall continue until he is once again no longer employed as a Referee. At such time, the benefit payable to the Referee shall be equal to the excess of: (A) the applicable Normal Retirement Benefit to be paid to the Referee as determined in accordance with this Section 4.1A over (B) the Actuarial Equivalent of the benefit payments previously received by such Referee; provided, however, that in no event shall the benefit payable to such Referee after he is once again no longer employed as a Referee be less than the benefit that the Referee was receiving immediately prior to his reemployment as a Referee.

(n) If the Referee participated in the Plan on or before May 31, 1995 and has an Employee Account maintained on his behalf under the Plan, his Normal Retirement Benefit shall be the sum of (i) the amount that the Referee would be entitled to receive under the applicable paragraph of this Section 4.1A as if an Employee Account were not maintained on his behalf, plus (ii) the Actuarial Equivalent of the value of the Referee's Employee Account based upon the value of such Employee Account as of the Valuation Date immediately preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(o) Notwithstanding any other provision of the Plan, effective June 1, 2010, the Plan shall be frozen and Referees shall cease to accrue any benefits under the Plan on and after such date. The last Year of Referee Service credited to a Referee for purposes of this Section 4.1A shall be the 2009-2010 Regular Season, and the benefit payable to any Referee under the Plan shall be no greater than the Referee's Accrued Benefit as of May 31, 2010 (determined based on the Referee's Years of Referee Service as of such date).

(p) The provisions of this Section 4.1A shall be interpreted in a manner so as to preclude the duplication of any benefits payable to any Referee or former Referee.

4.2 Deferred Retirement. A Referee who attains his Normal Retirement Date and who remains on the Referees' Roster after his Normal Retirement Date may defer his retirement until the first day of any month after his Normal Retirement Date, which day of actual retirement from the employ of the Employer shall be his Deferred Retirement Date; provided, however, that payment of benefits to such Referee shall be subject to the provisions of Section 8.2(b). The "Deferred Retirement Benefit" payable to a Referee who retires on his Deferred Retirement Date shall be determined in accordance with Section 4.1 and/or Section 4.1A; provided, however, that effective June 1, 2010, with respect to Deferred Retirement Benefits that first commence or are paid on or after June 1, 2010, the applicable benefit described in Section 4.1 or 4.1A shall be actuarially increased for each complete month following the Referee's Normal Retirement Date until such time as the Referee (or his Beneficiary) receives or commences to receive payment of a benefit under the Plan, based upon (a) or (b) below, whichever produces the greatest benefit:

(a) An annual interest rate of 5.0% and mortality assumptions provided under the RP-2000 male mortality table.

(b) A monthly increase of .41667%.

Notwithstanding the foregoing, in the case of a Referee who, on June 1, 2010, has either (i) both attained age 62 and completed ten (10) Regular Seasons on the Referees' Roster or (ii) has attained age 65, the actuarial increase described above shall be calculated using the age of the Referee on May 31, 2010 and the amount of the Referee's Accrued Benefit on May 31, 2010, after taking into account any increases under the provisions of this Section 4.2 as in effect prior to June 1, 2010.

The termination of a Referee's employment after his Normal Retirement Date for any reason other than death shall not affect his rights to, or the amount of, his Deferred Retirement Benefit. If a Referee dies after his Normal Retirement Date while on the Referees' Roster, the only benefit payable under this Plan shall be the benefit provided under Article IX.

4.3 Nonforfeitability of Normal Retirement Benefit. A Referee's right to his Normal Retirement Benefit shall be nonforfeitable upon and after his attainment of his Normal Retirement Date.

4.4 Payment of Normal and Deferred Retirement Benefits. The Normal Retirement Benefit or the Deferred Retirement Benefit (or the Actuarial Equivalent thereof) shall be payable at the time and in the manner provided by Article VIII.

4.5 Effective Date. The provisions of this Article IV shall apply only to those Referees who are under contract on or after June 1, 1995 with the Employer for performing officiating services in Championship and Exhibition Games. The benefit under the Plan of a Referee not described in the preceding sentence shall be determined in accordance with the provisions of Appendix A.

ARTICLE V

EARLY RETIREMENT

5.1 Eligibility for Early Retirement Benefit. A Referee who has both attained age 45 and completed three (3) or more Years of Referee Service may retire on the first day of any month prior to his Normal Retirement Date, which day shall be his Early Retirement Date.

5.2 Amount of Early Retirement Benefit. The Early Retirement Benefit of a Referee who retires on his Early Retirement Date, as determined on the basis of a monthly benefit payable for the life of the Referee with one hundred twenty (120) monthly payments guaranteed, shall be his Normal Retirement Benefit as determined under Section 4.1 or Section 4.1A reduced in accordance with the factors described in Schedule A to the Plan.

5.3 Payment of Early Retirement Benefit. The Early Retirement Benefit (or its Actuarial Equivalent), shall be payable at the time and in the manner provided by Article VIII.

ARTICLE VI

DISABILITY

6.1 A Referee who incurs a Total Disability on or before his Early Retirement Date shall be fully vested in his Accrued Benefit as of the date on which he incurs a Total Disability irrespective of the number of Years of Referee Service completed as of the date on which he incurs the Total Disability.

6.2 The Accrued Benefit of a Referee who incurs a Total Disability (or its Actuarial Equivalent) (a) shall be payable at the time and manner provided by Article VIII commencing not earlier than the first month following the Referee's attainment of age 45 and (b) shall, if applicable, be reduced in accordance with the factors described in Schedule A to the Plan.

ARTICLE VII

TERMINATION OF EMPLOYMENT

7.1 Amount and Payment of Benefit after Termination of Employment.

(a) If the employment of a Referee is terminated before his Normal Retirement Date or Early Retirement Date for reasons other than death or incurring a Total Disability, he shall become a "Terminated Referee" and shall, except as otherwise provided in this Section, be vested in a percentage of his Accrued Benefit based on his completed Years of Referee Service to his date of termination:

Years of Referee Service	Vested Percentage
Less than 3	0%
3 or more	100%

(b) The benefit to which a Terminated Referee is entitled under the Plan shall be his vested Accrued Benefit under paragraph (a) of this Section. Such benefit, or its Actuarial Equivalent (i) shall be payable at the time and manner provided by Article VIII commencing not earlier than the first month following the Referee's attainment of age 45 and (ii) shall, if applicable, be reduced in accordance with the factors described in Schedule A to the Plan. If a Terminated Referee does not have any vested Accrued Benefit and does not have an Employee Account, such Terminated Referee shall be deemed to have received a distribution of his Accrued Benefit under this paragraph (b).

(c) Notwithstanding any other provision of this Section 7.1 to the contrary, a Terminated Referee who has an Employee Account under the Plan shall be fully vested in his Employee Account irrespective of the number of Years of Referee Service which he has completed as of the date of his termination.

(d) Notwithstanding any other provision of this Section 7.1 to the contrary, if a Terminated Referee who is not vested in his Accrued Benefit under this Section resumes employment as a Referee, his Years of Referee Service prior to becoming a Terminated Referee shall be taken into account in determining such Referee's Years of Referee Service under Section 7.1.

7.2 Application of Forfeitures. Any amounts not vested in a Terminated Referee pursuant to this Article shall be forfeited and shall not be applied to increase any benefits which any Referee would otherwise receive under the Plan, but shall be used to reduce the contributions to the Plan of the Employer.

ARTICLE VIII

FORM AND PAYMENT OF BENEFITS

8.1 Definitions. For purposes of this Article and Article IX, the following definitions shall apply:

(a) "Pension Benefit" shall mean a Referee's Normal Retirement Benefit, Early Retirement Benefit, Deferred Retirement Benefit, the benefit to which he is entitled under Section 6.1 upon incurring a Total Disability or the benefit to which he is entitled under Section 7.1 upon termination of employment with three Years of Referee Service, whichever is applicable.

(b) (i) "Annuity Starting Date" shall mean:

(A) Subject to subparagraph (ii), Normal Retirement Date, in the case of a Referee who retires from employment with the Employer on his Normal Retirement Date;

(B) Subject to subparagraph (ii), Deferred Retirement Date, in the case of a Referee who retires from employment with the Employer on his Deferred Retirement Date;

(C) Early Retirement Date, in the case of a Referee who retires from employment with the Employer on his Early Retirement Date provided that, as of the date that payment of his Pension Benefit is to be made or commence, such Referee is neither employed by, nor has agreed to be employed by, the Employer or an affiliate of the Employer or by the Association;

(D) The first day of the month (commencing with the first month following the Referee's attainment of age 45) that a Referee who has

incurred a Total Disability, or who has terminated employment with the Employer, elects to have the payment of his Pension Benefit be made or commence, provided that, as of the date that payment of his Pension Benefit is to be made or commence, such Referee is neither employed by, nor has agreed to be employed by, the Employer or an affiliate of the Employer or by the Association; and

(E) The first day of the month (commencing with the first month following the Referee's Normal Retirement Date) that a Referee who is employed by the Employer, an affiliate of the Employer or by the Association, but who no longer performs or is eligible to perform services as a Referee, elects to have payment of his Pension Benefit be made or commence.

(ii) Except as otherwise provided in Section 8.5, a Referee who retires on his Normal Retirement Date or Deferred Retirement Date may elect to defer his Annuity Starting Date until he elects to receive or commence receiving payment of his Pension Benefit in which case, such Referee's Annuity Starting Date shall be the date in which the Referee receives or commences to receive payment of his Pension Benefit; provided, however, that such payment must be made or commence not later than April 1 of the calendar year following the calendar year in which such Referee attains age 70-1/2.

(iii) Except as otherwise provided in Section 8.5, a Referee who retires on his Early Retirement Date, incurs a Total Disability or terminates employment may elect to defer his Annuity Starting Date until he elects to receive or commence receiving payment of his Pension Benefit, in which case such

Referee's Annuity Starting Date shall be the date in which the Referee receives or commences to receive payment of his Pension Benefit; provided, however, that such payment must be made or commence not later than the first day of the first month following the Referee's attainment of age 65.

(c) "Qualified Joint and Survivor Annuity" shall mean a benefit payable for the life of a Referee and continued upon his death for the life of the Referee's surviving spouse, if any, with the surviving spouse's periodic benefit to be at a level of 50 percent of the actuarially reduced benefit paid or payable for each such period to the Referee during his lifetime.

(d) "Single Life Annuity" shall mean an annuity payable solely for the life of the Referee with one hundred twenty (120) monthly payments guaranteed.

8.2 Time When Pension Benefit Payments are Paid.

(a) The payment of a Referee's Pension Benefit shall, except as provided in paragraphs (b) and (c) below, commence as soon as practicable after his Annuity Starting Date and after he has filed his written election on forms provided by the Committee. However, in all events, such payment shall commence no later than sixty (60) days after the close of the Plan Year in which the latest of the following events occurs:

(i) the attainment by such Referee of age sixty-five (65);

(ii) the tenth anniversary of the date on which such Referee was first eligible to participate in the Plan under Section 2.1;

(iii) subject to Section 4.2, such Referee's retirement or termination of employment.

(b) Notwithstanding the foregoing, any Referee who attains age 70-1/2 after 1995 may elect by April 1 of the calendar year following the year in which the Referee attains

age 70-1/2 to either defer payment of his benefit until the April 1 of the calendar year following the calendar year in which the Referee retires or to begin to receive payment of his benefit by April 1 of the calendar year following the year in which the Referee attains age 70-1/2.

(c) At the election of the Referee and subject to the spousal consent requirements of Section 8.4, the Referee's Pension Benefit shall either be distributed in its entirety to the Referee in accordance with Code Section 401(a)(9)(A)(i) and the Treasury Regulations thereunder, or distributed to the Referee in monthly payments over a period not extending beyond the life expectancy of the Referee or the life expectancy of such Referee and his Beneficiary in accordance with Code Section 401(a)(9)(A)(ii) and the Treasury Regulations thereunder. With respect to distributions under the Plan made in calendar years 2001 and 2002, the Plan shall apply the minimum distribution requirements of Section 401(a)(9) of the Code in accordance with the regulations under Section 401(a)(9) that were proposed on January 17, 2001, notwithstanding any provision of the Plan to the contrary. With respect to distributions made under the Plan in calendar years beginning on or after January 1, 2003, the Plan shall apply the minimum distribution requirements in accordance with the Final and Temporary Regulations under Section 401(a)(9) of the Code. Life expectancy shall be determined under the Plan by reference to the Single Life Table contained in Final Regulation Section 1.401(a)(9)-9.

(d) Notwithstanding any other provisions of the Plan, any distribution required under the incidental benefit requirements of Section 401(a)(9)(G) of the Code shall be treated as a distribution required under Section 401(a)(9) of the Code.

8.3 Forms of Pension Benefit Payment.

(a) If a Referee is not married on the Annuity Starting Date, his Pension Benefit shall be payable in the form of a Single Life Annuity which shall be payable monthly,

commencing as soon as practicable after his Annuity Starting Date, unless he has specifically elected pursuant to Section 8.4 not to receive his Pension Benefit in such form and to receive his Pension Benefit in one of the optional forms described in paragraph (d) of this Section 8.3.

(b) If a Referee is married on the Annuity Starting Date, his Pension Benefit shall be payable monthly commencing as soon as practicable after his Annuity Starting Date in the form of a Qualified Joint and Survivor Annuity which is the Actuarial Equivalent of such Referee's Pension Benefit (even if a Referee shall die after his Annuity Starting Date and before he commences to receive any Pension Benefit), unless he has specifically elected pursuant to Section 8.4 (with the required spousal consent) not to receive his Pension Benefit in such form and to receive his Pension Benefit in one of the optional forms described in paragraph (d) of this Section 8.3.

(c) If the spouse of a Referee dies before the Referee commences to receive his Pension Benefit, the Pension Benefit will automatically become payable in the form described in paragraph (a) of this Section 8.3, unless the Referee subsequently makes an election under Section 8.4. If the spouse of a Referee predeceases the Referee after the Referee commences to receive his Pension Benefit in the form of a Qualified Joint and Survivor Annuity, the Pension Benefit payments will cease on the Referee's death.

(d) If an election has been made under Section 8.4, the Pension Benefit shall be paid to a Referee in the form selected by him from among the alternative forms listed below. Each such form shall be the Actuarial Equivalent of the Referee's Pension Benefit.

(i) For Referees who are married on their Annuity Starting Date, a non-increasing/non-decreasing annuity payable monthly for the life of the Referee, with one hundred twenty (120) monthly payments guaranteed. Any of

such guaranteed monthly payments due and payable after such Referee's death shall be paid to his designated beneficiary, even if the Referee dies before any part of his Pension Benefit is paid to him.

(ii) A lump-sum payment equal to the Actuarial Value of the Referee's Pension Benefit.

(iii) A non-increasing/non-decreasing annuity payable monthly solely for the life of the Referee ("Straight Life Annuity").

(iv) Periodic payments over a period of time (which may not change once payments commence) not exceeding the life expectancy of the Referee.

(v) A non-increasing/non-decreasing joint and survivor annuity payable monthly for the life of a Referee and continued upon his death for the life of the Referee's surviving spouse, if any, with the surviving spouse's periodic benefit to be at a level of 100 percent of the actuarially reduced benefit paid or payable for each such period to the Referee during his lifetime.

(vi) A non-increasing/non-decreasing joint and survivor annuity payable monthly for the life of the Referee and continued upon his death for the life of the Referee's surviving spouse, if any, with the surviving spouse's periodic benefit to be at a level of 75 percent of the actuarially reduced benefit paid or payable each such period to the Referee during his lifetime (the "Qualified Optional Survivor Annuity").

8.4 Notice and Waiver Procedures.

(a) Qualified Joint and Survivor Annuity and Single Life Annuity.

(i) No more than 180 days and no less than 30 days before the Referee's Annuity Starting Date, the Committee shall supply the Referee with an explanation of the terms and conditions of the Qualified Joint and Survivor Annuity, Qualified Optional Survivor Annuity or Single Life Annuity, whichever is applicable, and the relative values of the optional forms of benefit payments available under the Plan.

(ii) A Referee may waive the Qualified Joint and Survivor Annuity or the Single Life Annuity, whichever is applicable, within the 180 day period prior to the Annuity Starting Date, subject to the consent of the spouse as set forth in paragraph (b) below (if applicable). A Referee who has waived the Qualified Joint and Survivor Annuity or the Single Life Annuity may subsequently cancel his waiver of the Qualified Joint and Survivor Annuity or the Single Life Annuity at any time prior to the date his payments commence, by filing a proper waiver or cancellation of waiver with the Committee.

(iii) Notwithstanding anything in the Plan to the contrary, a Referee may elect (with any applicable spousal consent) to waive any requirement that the explanation of rights be provided at least 30 days before the Annuity Starting Date provided that the distribution commences more than 7 days after such explanation is provided.

(iv) Notwithstanding anything in the Plan to the contrary, a Referee may elect (with any applicable spousal consent) to waive any requirement that the explanation of rights be provided at least 30 days before the Annuity

Starting Date (or to waive the 30-day requirement under subparagraph (iii)) if the distribution commences more than 7 days after such explanation is provided.

(b) Spouse's Consent.

(i) The spouse of the Referee who waives the benefits under paragraph (a) above, must consent to the waiver, when initially made. Such consent shall be in writing, shall be irrevocable, shall acknowledge the effect of such consent, and shall be witnessed by a notary public; provided, however, that if it is established to the satisfaction of the Committee that the spouse of the Referee cannot be located, such consent will not be required. Any such consent shall be effective only with respect to the spouse who gives the consent.

(ii) The consent of the spouse as set forth in subparagraph (i) above shall also be required to the designation of any beneficiary other than the spouse, and to any change in such designation.

(iii) If the Secretary of the Treasury issues regulations which set forth special circumstances under which the consent of the spouse to a waiver will not be required pursuant to Section 417 of the Code, then no consent of a spouse will be required under those circumstances under this Plan with respect to a waiver of the Qualified Joint and Survivor Annuity.

(c) Explanation of Rights. The information provided under paragraph (a) above shall contain:

(i) the terms and conditions of the Qualified Joint and Survivor Annuity, Single Life Annuity, Qualified Optional Survivor Annuity and other optional forms of benefit payments available under the Plan;

(ii) an explanation of the relative values of the forms of payments available under the Plan;

(iii) the Referee's right to make, and the effect of, an election to waive the Qualified Joint and Survivor Annuity or Single Life Annuity;

(iv) the rights of the Referee's spouse under paragraph (b) above (if applicable); and

(v) the right to make, and the effect of, a revocation of an election to waive the Qualified Joint and Survivor Annuity or the Single Life Annuity.

8.5 Small Benefit Payments.

If a Referee's employment with the Employer terminates and the Actuarial Value of his vested Accrued Benefit (without taking into account the value of the Referee's Employee Account) is not in excess of $1,000, the Committee shall pay the Referee (or if the payment is on account of the death of the Referee, to his spouse or Beneficiary) such amount in a lump sum payment at such time as the Committee shall determine.

8.6 Reemployment of a Former Referee. If a Referee who is receiving benefit payments is reemployed by the Employer as a Referee, his Pension Benefit payments shall cease with the last payment due immediately prior to his reemployment. Pension Benefit payments shall recommence on the first day of the month coincident with or next following his subsequent retirement date. The Pension Benefit payable to said Referee on his subsequent retirement date shall be equal to (a) plus (b) minus (c):

(a) the Pension Benefit he had accrued prior to his reemployment;

(b) the Pension Benefit accrued between his date of reemployment and his subsequent retirement date;

(c) the Actuarial Value of the Pension Benefit payments, if any, which he received during a prior retirement and before his Normal Retirement Date.

In no event shall the benefits payable to such Referee exceed the amount which would have been payable if he had not previously retired or terminated his employment.

8.7 Payment in the Case of Legal Incompetency or Incapacity. If any person entitled to receive any benefits hereunder has been determined by the appropriate judicial or administrative authority to be legally incompetent or incapable of personally receiving and receipting for any distribution, the Trustees may direct such benefits to be paid to such other person, persons, or institutions as, under the determination of such judicial or administrative authority, then represent such distributee.

8.8 Special Distribution Rules.

(a) Where an optional method of distribution described in Section 8.3 (other than Section 8.3(d)(ii)) is selected hereunder, the periods over which installments are payable to the Referee and his designated Beneficiary shall not exceed the joint life expectancy of the Referee and such Beneficiary, determined as of the time at which the distribution of benefits commence, and in accordance with Section 401(a)(9)(A)(ii) of the Code and the Treasury Regulations thereunder.

(b) If a Referee should die before the distribution of any benefits under this Article has begun, and if the benefit upon the death of the Referee shall be payable over greater than a five (5) year period, such benefit shall be distributed by the end of the calendar year which contains the fifth anniversary of the date of the Referee's death in an amount equal to the

Actuarial Equivalent (as of the date of death) of the payments to be made. The preceding sentence shall not apply if, pursuant to the election made by the surviving spouse under Section 9.1(b) or any other Beneficiary under Section 9.1(c), (i) the payments to be made to the Referee's Beneficiary will be made over the life of such Beneficiary (or over a period not exceeding the life expectancy of the Beneficiary) and (ii) the payments commence not later than the end of the calendar year immediately following the calendar year in which the Referee died (or if the Referee's designated Beneficiary is his spouse, the payments commence no later than (x) the end of the calendar year immediately following the calendar year in which the Referee died, and (y) the end of the calendar year in which the Referee would have attained age 70-1/2 had he survived). If the Referee's designated Beneficiary is his spouse, and if such spouse should die before the distribution of any benefits has begun, the rules of this paragraph (b) shall apply as if the spouse were the Referee.

(c) Notwithstanding anything to the contrary contained herein, if the distribution of benefits has commenced to a Referee and if the Referee dies before his entire interest has been distributed to him, any distributions made after the death of the Referee shall be made at least as rapidly as under the method of distribution in effect as of the date of the Referee's death.

8.9 Special May 1 Retroactive Annuity Starting Date Election.

(a) For each Plan Year, any Referee who would have been eligible to receive or commence to receive payment of his Pension Benefit on May 1 of such Plan Year had he made a timely election under Section 8.4 prior to May 1 of such Plan Year, may elect during the time period and in accordance with procedures specified by the Committee, to receive or commence to receive payment of his Pension Benefit on July 31

of the immediately following Plan Year with such Pension Benefit to be determined based upon a retroactive annuity starting date of the May 1 immediately proceeding such July 31 (the "Retroactive Annuity Starting Date").

(b) Any Referee who wishes to make the Retroactive Annuity Starting Date election described in paragraph (a) shall receive from the Committee an explanation of rights with respect to the Qualified Joint and Survivor Annuity or the Single Life Annuity, whichever is applicable, and a general explanation of the financial effect on the Referee's benefit if he decides to accept the Qualified Joint and Survivor Annuity or the Single Life Annuity, at least 30 days prior to the July 31 on which he would receive or commence to receive payment of his Pension Benefit pursuant to such Referee's election; provided, however, that the Referee may elect (with any applicable spousal consent) to waive any requirement that the explanation of rights be provided at least 30 days prior to the applicable July 31, provided that the distribution commences more than 7 days after such explanation is provided.

(c) Any election made by a Referee under paragraph (a) to receive or commence to receive payment of his Pension Benefit based upon a Retroactive Annuity Starting Date of May 1 of any Plan Year, must be made no later than July 15 of the immediately following Plan Year.

(d) Any Referee who makes a Retroactive Annuity Starting Date election described in paragraph (a) shall not receive any actuarial increase of his Pension Benefit, but shall receive a payment (or, if applicable, payments) which shall include an adjustment for interest from the applicable Retroactive Annuity Starting Date to the July 31 following such Retroactive Annuity Starting Date based upon a reasonable interest

rate determined by the Committee.

(e) Except as otherwise provided in this Section 8.9, the applicable requirements of this Article VIII shall apply to a Referee's election under paragraph (a) to receive payment of his Pension Benefit based upon a Retroactive Annuity Starting Date.

8.10 Rollovers to Other Plans or IRAs.

(a) Notwithstanding any provision of the Plan to the contrary that would otherwise limit a Referee's election under the Plan, a Referee may elect, at the time and in the manner prescribed by the Committee, to have any portion of an Eligible Rollover Distribution paid directly to an Eligible Retirement Plan specified by the Referee in a Direct Rollover.

(b) Definitions:

For purposes of this Section 8.9, the following definitions will apply:

(i) "Eligible Rollover Distribution" shall mean any distribution of all or any portion of the Referee's Pension Benefit under the Plan, except that an Eligible Rollover Distribution does not include:

(A) any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the Referee or the joint lives (or joint life expectancies) of the Referee and the Referee's designated beneficiary, or for a specified period of ten years or more; and

(B) the portion of any distribution that is not includible in gross income.

(ii) "Eligible Retirement Plan" shall mean a plan of one of the following types, provided that such plan accepts the Referee's Eligible Rollover

Distribution: an individual retirement account described in Section 408(a) of the Code; an individual retirement annuity described in Section 408(b) of the Code; an individual retirement plan described in Section 408A of the Code; an annuity plan described in Section 403(a) of the Code; a qualified trust described in Section 401(a) of the Code; an annuity contract described in Section 403(b) of the Code; and an eligible plan under Section 457(b) of the Code which is maintained by a state, political subdivision of a state, or any agency or instrumentality of a state or political subdivision of a state and which agrees to separately account for amounts transferred into such plan from this Plan. This definition of "Eligible Retirement Plan" shall also apply in the case of a distribution to a surviving spouse or to a spouse or former spouse who is an alternate payee under a qualified domestic relations order, as defined in Code Section 414(p). In the case of a Non-spouse Beneficiary, an "Eligible Retirement Plan" shall mean only an individual retirement account or annuity to which a Direct Rollover may be made, provided that such account or annuity is treated as an inherited individual retirement account or annuity under Section 402(c)(11) of the Code.

(iii) "Referee" shall mean a Referee within the meaning of Section 1.26 of the Plan who is entitled to receive a benefit under the Plan. In addition, the Referee's surviving spouse and the Referee's spouse or former spouse who is the alternate payee under a qualified domestic relations order as defined in Section 414(p) of the Code, shall be considered as Referees with regard to the interest of the spouse or former spouse. Furthermore, the Referee's Non-

spouse Beneficiary shall be considered a Referee with regard to the interest of the Non-spouse Beneficiary.

(iv) "Direct Rollover" shall mean a payment by the Plan to the Eligible Retirement Plan specified by the Referee.

(v) "Non-spouse Beneficiary" shall mean a non-spouse beneficiary who is a designated beneficiary within the meaning of Section 401(a)(9)(E) of the Code.

ARTICLE IX

DEATH BENEFITS

9.1 (a) (i) If a married Referee who did not participate in the Plan on or before May 31, 1995 dies prior to the date as of which the Referee receives or commences to receive payment of his Pension Benefit, such Referee's surviving spouse or non-spouse Beneficiary (designated pursuant to paragraph (f) of this Section) shall be entitled to a benefit in an amount equal to ten times the annual amount of the Referee's Accrued Benefit on the date of the Referee's death based upon the Years of Referee Service completed by the Referee to the date of his death.

(ii) If a married Referee who participated in the Plan on or before May 31, 1995 dies prior to the date as of which the Referee receives or commences to receive payment of his Pension Benefit, such Referee's surviving spouse or non-spouse Beneficiary (designated pursuant to paragraph (f) of this Section) shall be entitled to a benefit in an amount equal to: (A) the greater of (x) ten times the annual amount of the Referee's Accrued Benefit on the date of the Referee's death based upon the Years of Referee Service completed by the Referee to the date of his death, or (y) the value of the Referee's Contribution Account as of the last day of the Plan Year preceding the Referee's death; plus, if applicable (B) the value of the Referee's Employee Account as of the Valuation Date immediately preceding the day on which the Referee's surviving spouse or Beneficiary receives or commences to receive payment of her benefit under the Plan.

(iii) For purposes of Sections 9.1(a)(i) and 9.1(a)(ii), a Referee's Years of Referee Service shall include only Years of Referee Service relating to services performed prior to June 1, 2010.

(b) (i) The benefit described in paragraph (a) of this Section that is paid to a Referee's surviving spouse shall be paid to such surviving spouse in the form of a monthly benefit payable as an annuity for her life (the "Preretirement Survivor Annuity"); provided, however, that a Referee's surviving spouse may elect to receive the benefit described in paragraph (a) of this Section in any form of payment provided in Section 8.3(d). Such election shall be in writing and shall be filed with the Committee within a reasonable time prior to the commencement of benefits under this Section.

(ii) The Preretirement Survivor Annuity or any other form of payment (other than the form described in Section 8.3(d)(ii)) shall be the Actuarial Equivalent of the benefit described in paragraph (a) of this Section.

(c) A married Referee's non-spouse Beneficiary shall be entitled to receive the applicable benefit described in paragraph (a) of this Section in any form of payment provided in Section 8.3(d). Such form of payment (other than the form described in Section 8.3(d)(ii)) shall be the Actuarial Equivalent of the applicable benefit described in Section 9.1(a).

(d) The payment of the death benefit available hereunder to the Referee's surviving spouse or other Beneficiary shall commence or be made as soon as practicable after the Committee is notified of the Referee's death. However, except as provided in Section 8.5, if the Referee's death occurs prior to his attainment of his Normal Retirement Date, the Referee's surviving spouse may elect in writing to defer the commencement of the benefit until the first

day of the first month following the date that the Referee would have attained his Normal Retirement Date had he survived.

(e) Notwithstanding paragraph (a) of this Section, in no event shall the monthly benefit payable to a Referee's surviving spouse be less than 50% of the benefit that the Referee would have received had such Referee begun to receive his benefit under the Plan (as adjusted by the factors described in Schedule A to the Plan) on the day before his death in the form of a Qualified Joint and Survivor Annuity.

(f) Waiver by Referee of Surviving Spouse's Preretirement Survivor Annuity.

(i) Notwithstanding Section 9.1(a)(i) and (ii), unless a married Referee makes a Qualified Waiver Election within a reasonable period after receiving a written explanation of the Preretirement Survivor Annuity, upon the death of such Referee, the benefits described in Section 9.1(a)(i) and (ii) shall be paid to the Referee's surviving spouse. An unmarried Referee who marries shall make such Qualified Waiver Election within a reasonable period after receiving a written explanation of the Preretirement Survivor Annuity.

(ii) (A) For purposes of this Section, a "Qualified Waiver Election" is an election by a Referee to waive the right of the Referee's surviving spouse to receive a Preretirement Survivor Annuity.

(B) If a Referee makes a Qualified Waiver Election prior to the first day of the Plan Year in which he attains age 35, such Qualified Waiver Election shall become invalid as of the first day of the Plan Year in which the Referee attains age 35; provided, however, that the Referee may make a new Qualified Waiver Election at any time after the

beginning of the Plan Year in which the Referee attains age 35, or if the Referee terminated employment prior to such Plan Year, at any time after such termination.

(C) A Referee's Qualified Waiver Election shall not be valid unless the Referee's spouse consents to such Qualified Waiver Election in accordance with the rules prescribed in Section 8.4(b) of the Plan with respect to the waiver by a spouse of a Qualified Joint and Survivor Annuity.

(iii) (A) In the case of a Preretirement Survivor Annuity, the Committee shall provide each Referee with a written explanation of the Preretirement Survivor Annuity and other information comparable to that provided with respect to a Qualified Joint and Survivor Annuity under Section 8.4(c).

(B) Such written information shall be provided by the Committee within a reasonable period after an individual becomes a Referee, or in the case of an unmarried Referee who subsequently marries, within a reasonable period after the date of such marriage.

(C) If a Referee has made a Qualified Waiver Election prior to attaining age 35, the Committee shall also provide the written information to the Referee within a reasonable time prior to the Plan Year in which the Referee attains 35, or if the Referee terminated employment prior to attaining age 35, within a reasonable period after such termination.

9.2 (a) Each unmarried Referee, upon becoming eligible to participate under the Plan, may designate a Beneficiary to receive any benefits payable under the Plan in the event of his death. In the absence of any such designation, the provisions of Section 1.6 shall govern with regard to the payment of benefits to a Beneficiary after the death of the Referee. Any designation under this Section shall be in writing on the beneficiary designation form provided by the Committee, and such form shall be filed with the Committee. A Referee may change his Beneficiary at any time prior to the commencement of his benefits by filing a new beneficiary designation form with the Committee. The most recent beneficiary designation form on file with the Committee at the time of a Referee's death shall be conclusive as to the identity of the proper Beneficiary of such Referee and the amount properly payable. Payment made in accordance with such form shall constitute a complete discharge of any and all obligations hereunder.

(b) (i) If an unmarried Referee who did not participate in the Plan on or before May 31, 1995 dies prior to the date as of which the payment of such Referee's Pension Benefit becomes effective, such Referee's Beneficiary shall be entitled to receive the benefit described in Section 9.1(a)(i).

(ii) If an unmarried Referee who participated in the Plan on or before May 31, 1995 dies prior to the date as of which the payment of such Referee's Pension Benefit becomes effective, such Referee's Beneficiary shall be entitled to receive the benefit described in Section 9.1(a)(ii).

(c) An unmarried Referee's Beneficiary shall be entitled to receive the applicable benefit described in paragraph (b) in any form of payment provided in Section 8.3(d). Such form of payment (other than the form described in Section 8.3(d)(ii)) shall be the Actuarial Equivalent of the applicable benefit described in Section 9.1(a).

(d) Payment of a benefit to an unmarried Referee's Beneficiary under this Section shall be made or commence as soon as practicable after the Committee is notified of such Referee's death.

9.3 Upon the death of a Referee after the date as of which the payment of his Pension Benefit becomes effective, no further payments shall be made other than those, if any, specified in the benefit to which the Referee is entitled.

ARTICLE X

FUNDING

10.1 Employers' Contributions. The Employer shall contribute to the Trust each year an amount which the Trustees determine to be necessary to comply with the minimum funding requirements of Title I, Part 3 of ERISA.

10.2 Time of Payment of Contributions. The Employer shall pay to the Trust its contribution for each Plan Year not later than the time prescribed by law for filing the Employer's federal income tax return, including authorized extensions thereof, for the Employer's taxable year which ends with or within the Plan Year for which the contribution is made.

10.3 Funding Policy and Method. The Trustees shall implement the funding policy and method established by the Committee pursuant to Section 14.5 of the Plan.

10.4 Irrevocable Divestiture by the Employer.

(a) Except as provided in this Section and in Section 18.3 and notwithstanding any other provision of the Plan, the Employer irrevocably divests itself of any interest or reversion whatsoever in any sums contributed by it to the Trust, and it shall be impossible for any portion of the Trust to be used for, or diverted to, any purpose other than the exclusive benefit of Referees or their Beneficiaries.

(b) If a contribution made by the Employer is based upon a mistake of fact, the contribution shall be returned to the Employer within one year after the payment of the contribution.

(c) All contributions by the Employer are conditioned upon their deductibility under Section 404 of the Code, and if part or all of the deduction for any contribution is

disallowed, the contribution, to the extent disallowed, shall be returned to the Employer within one year after the disallowance of the deduction.

ARTICLE XI

LIMITATIONS ON BENEFITS FOR LIMITATION YEARS COMMENCING ON OR PRIOR TO JUNE 1, 2000

11.1 (a) In no event shall the annual retirement pension payable to any Referee under this Plan exceed for any Limitation Year, the lesser of:

(i) $90,000, as increased by cost-of-living adjustments prescribed by the Secretary of the Treasury under Section 415(d) of the Code (the "Dollar Amount"); or

(ii) 100 percent of the Referee's average Compensation for the period of three consecutive calendar years yielding the highest such average during which he was a Referee.

(b) In determining the maximum allowable benefit otherwise payable under this Section, if a Referee's annual retirement pension commences or is paid prior to the Referee's Social Security Retirement Age, the Dollar Amount shall be adjusted as follows:

(i) if the Referee's annual retirement pension commences after the Referee attains age 62, the Dollar Amount shall be computed by using a reduction factor that is consistent with the reduction for old-age social security benefits commencing before the Referee's Social Security Retirement Age; or

(ii) if the Referee's annual retirement pension commences prior to the Referee's attaining age 62, the Dollar Amount shall be the Actuarial Equivalent of the Dollar Amount computed as if the Referee's annual retirement pension commenced at age 62, reduced for each month by which benefits commence before the month in which the Referee attains age 62. For purposes of

this paragraph (b), the Actuarial Equivalent of the Dollar Amount shall be based upon the lesser of the benefit determined using (x) the early retirement reduction factors specified in Schedule A of the Plan or (y) an interest rate assumption of 5% per annum, and the mortality table specified in Schedule A of the Plan.

(c) (i) In determining the maximum allowable benefit otherwise payable under this Section, if a Referee's annual retirement pension commences or is paid after the Referee's Social Security Retirement Age, the Dollar Amount shall be adjusted so that it is the Actuarial Equivalent of the Dollar Amount computed as if the Referee's annual retirement pension commenced at the Referee's Social Security Retirement Age.

(ii) For purposes of this paragraph (c), the Actuarial Equivalent of the Dollar Amount shall be based upon the lesser of the benefit determined using (x) the adjustment factor for Deferred Retirement described in Section 4.2 or (y) an interest rate assumption of 5% per annum, and the mortality table specified in Schedule A of the Plan.

(d) For purposes of this Article XI:

(i) In accordance with Treasury Regulation § 1.415-3(b)(1)(iv), the limitations of this Article shall not apply to (A) the portion of the Referee's annual retirement pension that is attributable to the Referee's Contribution Account and (B) the portion of the Referee's annual retirement pension that is attributable to the Referee's Employee Contribution Account.

(ii) "Compensation" shall mean the Referee's wages, salaries, and other amounts received for personal services rendered for the Employer.

Effective June 1, 1998, Compensation shall include amounts not includible in the gross income of the Referee under Code Sections 125, 132(f), 402(e)(3), 402(h)(1)(B) and 457(b).

(iii) "Social Security Retirement Age" shall mean:

(A) in the case of a Referee who attains age 62 before January 1, 2000, age 65;

(B) in the case of a Referee who attains age 62 after December 31, 1999, age 66; and

(C) in the case of a Referee who attains age 62 after December 31, 2016, age 67.

11.2 (a) If a Referee's annual retirement pension is payable in a form other than a Straight Life Annuity or a Qualified Joint and Survivor Annuity (as such terms are defined in Article VIII), for purposes of determining the maximum allowable benefit payable under Section 11.1, the annual retirement pension shall be adjusted so that it is the Actuarial Equivalent of a single life annuity.

(b) In making the adjustment described in paragraph (a), Actuarial Equivalence shall be based upon:

(i) in the case of a benefit payable in the form described in Sections 8.3(d)(i), d(iii) and (d)(v), the lesser of the benefit determined using (A) the interest rate and mortality table specified in Schedule A of the Plan or (B) an interest rate assumption of 5% per annum, and the mortality table specified in Schedule A; or

(ii) in the case of a benefit payable in the form described in Section 8.3(d) (other than paragraphs (d)(i), (d)(iii) and (d)(v) of such Section), the interest rate and mortality table specified in Schedule A of the Plan.

11.3 In the event that the annual retirement pension payable to a Referee under this Plan does not exceed $10,000 for a Limitation Year, and if the Referee (i) was not a participant in the Plan prior to June 1, 1995, and (ii) has never participated in any other defined contribution plan maintained by the Employer, the limitations otherwise imposed by Section 11.1 and the adjustments described in Section 11.2 shall not apply.

11.4 (a) If a Referee has less than ten (10) years of aggregate service with the Employer (including service in a capacity other than as a Referee) ("Employer Service") at the time at which he is entitled to receive benefits under the Plan, the limitation described in Section 11.1(a)(ii) and, if applicable, the $10,000 amount described in Section 11.3 or the limitation described in Section 11.5, shall be reduced by multiplying the applicable limitation by a fraction, the numerator of which is the Referee's number of Years of Employer Service and the denominator of which is ten.

(b) If a Referee has less than ten (10) Years of participation in the Plan at the time at which he is entitled to receive benefits under the Plan, the Dollar Amount shall be reduced by multiplying the Dollar Amount by a fraction, the numerator of which is the Referee's number of years of participation in the Plan and the denominator of which is ten.

(c) In no event shall paragraphs (a) and (b) of this Section 11.4 reduce any limitation described therein (including the Dollar Amount) to an amount less than one-tenth (1/10th) of such limitation.

11.5 (a) If a Referee either (i) was a participant in the Plan prior to June 1, 1995 or (ii) has at any time been a participant in any other defined contribution plan maintained by the Employer, the Referee's annual retirement pension under this Plan shall be limited or reduced so that the sum of the "Defined Benefit Fraction" and the "Defined Contribution Fraction" of such Referee for any Limitation Year shall not exceed 1.0; provided, however, that in determining the extent of any such limitation or reduction for a Limitation Year, the Referee's Defined Contribution Fraction for the Limitation Year shall be computed prior to considering any annual additions (within the meaning of Code Section 415(c)(2)) credited to the Referee's account under the National Basketball Association Staff Employees' Savings Plan.

(b) For purposes of this Section:

(i) The Defined Benefit Fraction shall mean the fraction defined in Section 415(e)(2) of the Code.

(ii) The Defined Contribution Fraction shall mean the fraction defined in Section 415(e)(3) of the Code.

(c) Effective June 1, 2000, the provisions of this Section 11.5 shall no longer apply to the benefit payable to a Referee under the Plan.

11.6 In applying the limitations described in this Article XI, the Limitation Year shall be the 12-month period corresponding with the Plan Year.

11.7 The provisions of this Article XI shall be applicable only for Limitation Years commencing on or prior to June 1, 2000.

ARTICLE XIA

LIMITATIONS ON BENEFITS FOR LIMITATION YEARS COMMENCING ON JUNE 1, 2001, JUNE 1, 2002 AND JUNE 1, 2003

11A.1 (a) In no event shall the annual pension payable to any Referee under this Plan exceed for any Limitation Year, the lesser of:

(i) $140,000, as adjusted for increases in the cost of living in the manner provided under Section 415(d)(2) of the Code (the "Dollar Limitation"); or

(ii) 100 percent of the Referee's average Compensation for the period of three consecutive calendar years yielding the highest such average during which he was a Referee.

(b) In determining the maximum allowable benefit otherwise payable under this Section, if a Referee's annual retirement pension commences or is paid prior to the Referee's Social Security Retirement Age, the Dollar Limitation shall be adjusted as follows:

(i) if the Referee's annual retirement pension commences after the Referee attains age 62, the Dollar Limitation shall be computed by using a reduction factor that is consistent with the reduction for old-age social security benefits commencing before the Referee's Social Security Retirement Age; or

(ii) if the Referee's annual retirement pension commences prior to the Referee's attaining age 62, the Dollar Limitation shall be the Actuarial Equivalent of the Dollar Limitation computed as if the Referee's annual retirement pension commenced at age 62, reduced for each month by which benefits commence before the month in which the Referee attains age 62. For purposes of

this paragraph (b), the Actuarial Equivalent of the Dollar Limitation shall be based upon the lesser of the benefit determined using (x) the early retirement reduction factors specified in Schedule A of the Plan or (y) an interest rate assumption of 5% per annum, and the mortality table specified in Schedule A of the Plan.

(c) (i) In determining the maximum allowable benefit otherwise payable under this Section, if a Referee's annual retirement pension commences or is paid after the Referee's Social Security Retirement Age, the Dollar Limitation shall be adjusted so that it is the Actuarial Equivalent of the Dollar Limitation computed as if the Referee's annual retirement pension commenced at the Referee's Social Security Retirement Age.

(ii) For purposes of this paragraph (c), the Actuarial Equivalent of the Dollar Limitation shall be based upon the lesser of the benefit determined using (x) the adjustment factor for Deferred Retirement described in Section 4.2 or (y) an interest rate assumption of 5% per annum, and the mortality table specified in Schedule A of the Plan.

(d) For purposes of this Article XIA:

(i) The limitations of this Article shall not apply to (A) the portion of the Referee's annual retirement pension that is attributable to the Referee's Contribution Account and (B) the portion of the Referee's annual retirement pension that is attributable to the Referee's Employee Contribution Account.

(ii) "Compensation" shall mean the Referee's wages, salaries, and other amounts received for personal services rendered for the Employer, and shall include amounts not includible in the gross income of the Referee under Code Sections 125, 132(f), 402(e)(3), 402(h)(1)(B) and 457(b).

(iii) "Social Security Retirement Age" shall mean:

(A) in the case of a Referee who attains age 62 before January 1, 2000, age 65;

(B) in the case of a Referee who attains age 62 after December 31, 1999, age 66; and

(C) in the case of a Referee who attains age 62 after December 31, 2016; age 67.

11A.2 (a) If a Referee's annual retirement pension is payable in a form other than a Straight Life Annuity or a Qualified Joint and Survivor Annuity (as such terms are defined in Article VIII), for purposes of determining the maximum allowable benefit payable under Section 11A.1, the annual retirement pension shall be adjusted so that it is the Actuarial Equivalent of a single life annuity.

(b) In making the adjustment described in paragraph (a), Actuarial Equivalence shall be based upon:

(i) in the case of a benefit payable in the form described in Sections 8.3(d)(i), (d)(iii) and (d)(v), the lesser of the benefit determined using (A) the interest rate and mortality table specified in Schedule A of the Plan or (B) an interest rate assumption of 5% per annum, and the mortality table specified in Schedule A; or

(ii) in the case of a benefit payable in the form described in Section 8.3(d) (other than paragraphs (d)(i), (d)(iii) and (d)(v) of such Section), the interest rate and mortality table specified in Schedule A of the Plan.

11A.3 Notwithstanding anything contained herein, in no event shall the benefit paid to any Referee under this Plan expressed as an annual benefit (as that term is defined in Section 415(b)(2) of the Code) cause the limitations on benefits and contributions imposed by Section 415 of the Code to be exceeded, which limitations are incorporated herein by reference.

11A.4 In the event that the annual retirement pension payable to a Referee under this Plan does not exceed $10,000 for a Limitation Year, and if the Referee (i) was not a participant in the Plan prior to June 1, 1995, and (ii) has never participated in any other defined contribution plan maintained by the Employer, the limitations otherwise imposed by Section 11A.1 and the adjustments described in Section 11A.2 shall not apply.

11A.5 (a) If a Referee has less than ten (10) years of aggregate service with the Employer (including service in a capacity other than as a Referee) ("Employer Service") at the time at which he is entitled to receive benefits under the Plan, the limitation described in Section 11A.1(a)(ii) and, if applicable, Section 415(b)(1)(B) of the Code and the $10,000 amount described in Section 11A.4 shall be reduced by multiplying the applicable limitation by a fraction, the numerator of which is the Referee's number of Years of Employer Service and the denominator of which is ten.

(b) If a Referee has less than ten (10) Years of participation in the Plan at the time at which he is entitled to receive benefits under the Plan, the Dollar Limitation and the applicable limitation under Section 415(b)(1)(A) shall be reduced by multiplying the Dollar

Limitation (or the applicable limitation) by a fraction, the numerator of which is the Referee's number of years of participation in the Plan and the denominator of which is ten.

(c) In no event shall paragraphs (a) and (b) of this Section 11A.5 reduce any limitation described therein (including the Dollar Limitation) to an amount less than one-tenth (1/10th) of such limitation.

11A.6 In applying the limitations described in this Article XIA, the Limitation Year shall be the 12-month period corresponding with the Plan Year.

11A.7 The provisions of this Article XIA shall be applicable only for Limitation Years commencing on June 1, 2001, June 1, 2002 and June 1, 2003.

ARTICLE XIB

LIMITATIONS ON BENEFITS FOR LIMITATION YEARS COMMENCING ON JUNE 1, 2004, JUNE 1, 2005, JUNE 1, 2006 AND JUNE 1, 2007

11B.1 (a) In no event shall the annual retirement pension payable to any Referee under this Plan exceed for any Limitation Year, the lesser of:

(i) $165,000, as adjusted for increases in the cost of living in the manner provided under Section 415(d)(2) of the Code ($175,000 for the Limitation Year commencing on June 1, 2006) (the "Dollar Limitation"); or

(ii) 100 percent of the Referee's average Compensation for the period of three consecutive calendar years yielding the highest such average during which he was a Referee.

(b) In determining the maximum allowable benefit otherwise payable under this Section, if a Referee's annual retirement pension commences or is paid prior to the Referee's attaining age 62, the Dollar Limitation shall be reduced so that it is the Actuarial Equivalent of the Dollar Limitation computed as if the Referee's annual retirement pension commenced at age 62, reduced for each month by which benefits commence before the month in which the Referee attains age 62. For purposes of this paragraph (b), the Actuarial Equivalent of the Dollar Limitation shall be based upon the lesser of the benefit determined using (x) the early retirement reduction factors specified in Schedule A of the Plan or (y) an interest rate assumption of 5% per annum, and the mortality table specified in Schedule A of the Plan.

(c) In determining the maximum allowable benefit otherwise payable under this Section, if a Referee's annual retirement pension commences or is paid after the Referee attains age 65, the Dollar Limitation shall be adjusted so that it is the Actuarial Equivalent of the

Dollar Limitation applicable to the Referee at age 65. For purposes of this paragraph (c), the Actuarial Equivalent of the Dollar Limitation shall be based upon the lesser of the benefit determined using (x) the adjustment factor for Deferred Retirement described in Section 4.2 or (y) an interest rate assumption of 5% per annum, and the mortality table specified in Schedule A of the Plan.

(d) For purposes of this Article XIB:

(i) The limitations of this Article shall not apply to (A) the portion of the Referee's annual retirement pension that is attributable to the Referee's Contribution Account and (B) the portion of the Referee's annual retirement pension that is attributable to the Referee's Employee Contribution Account. For purposes of this paragraph (d)(i), the portion of a Referee's annual retirement pension that is attributable to the Referee's Contribution Account shall be equal to the Actuarial Equivalent of the value of such Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(ii) "Compensation" shall mean the Referee's wages, salaries, and other amounts received for personal services rendered for the Employer, and shall include amounts not includible in the gross income of the Referee under Code Sections 125, 132(f), 402(e)(3), 402(h)(1)(B) and 457(b).

11B.2 (a) If a Referee's annual retirement pension is payable in a form other than a Straight Life Annuity or a Qualified Joint and Survivor Annuity (as such terms are defined in Article VIII), for purposes of determining the maximum allowable benefit payable under Section

11B.1, the annual retirement pension shall be adjusted so that it is the Actuarial Equivalent of a single life annuity.

(b) In making the adjustment described in paragraph (a), Actuarial Equivalence shall be based upon:

(i) in the case of a benefit payable in the form described in Sections 8.3(d)(i), (d)(iii) and (d)(v), the lesser of the benefit determined using (A) the interest rate and mortality table specified in Schedule A of the Plan or (B) an interest rate assumption of 5% per annum, and the mortality table specified in Schedule A; or

(ii) in the case of a benefit payable in the form described in Section 8.3(d) (other than paragraphs (d)(i), (d)(iii) and (d)(v) of such Section), the interest rate (but not less than 5.50% for Limitation Years commencing on June 1, 2004 and June 1, 2005, and not less than 5.50% or the interest rate that produces a benefit of not more than 105% of the benefit that would be provided using the interest rate specified in Schedule A for Limitation Years commencing on or after June 1, 2006) and mortality table specified in Schedule A of the Plan.

11B.3 Notwithstanding anything contained herein, in no event shall the benefit paid to any Referee under this Plan expressed as an annual benefit (as that term is defined in Section 415(b)(2) of the Code) cause the limitations on benefits and contributions imposed by Section 415 of the Code to be exceeded.

11B.4 In the event that the annual retirement pension payable to a Referee under this Plan does not exceed $10,000 for a Limitation Year, and if the Referee (i) was not a participant in the Plan prior to June 1, 1995, and (ii) has never participated in any other defined contribution

plan maintained by the Employer, the limitations otherwise imposed by Section 11B.1 and the adjustments described in Section 11B.2 shall not apply.

11B.5 (a) If a Referee has less than ten (10) years of aggregate service with the Employer (including service in a capacity other than as a Referee) ("Employer Service") at the time at which he is entitled to receive benefits under the Plan, the limitation described in Section 11B.1(a)(ii) and, if applicable, Section 415(b)(1)(B) of the Code and the $10,000 amount described in Section 11B.4 shall be reduced by multiplying the applicable limitation by a fraction, the numerator of which is the Referee's number of Years of Employer Service and the denominator of which is ten.

(b) If a Referee has less than ten (10) Years of participation in the Plan at the time at which he is entitled to receive benefits under the Plan, the Dollar Limitation and the applicable limitation under Section 415(b)(1)(A) shall be reduced by multiplying the Dollar Limitation (or the applicable limitation) by a fraction, the numerator of which is the Referee's number of years of participation in the Plan and the denominator of which is ten.

(c) In no event shall paragraphs (a) and (b) of this Section 11B.5 reduce any limitation described therein (including the Dollar Limitation) to an amount less than one-tenth (1/10th) of such limitation.

11B.6 In applying the limitations described in this Article XIB, the Limitation Year shall be the 12-month period corresponding with the Plan Year.

11B.7 The provisions of this Article XIB shall be applicable only for Limitation Years commencing on June 1, 2004, June 1, 2005, June 1, 2006 and June 1, 2007.

ARTICLE XIC

LIMITATIONS ON BENEFITS FOR LIMITATION YEARS

COMMENCING ON OR AFTER JUNE 1, 2008

11C.1 (a) In no event shall the annual retirement pension payable to any Referee under this Plan exceed for any Limitation Year, the lesser of:

(i) $200,000 (as adjusted for increases in the cost of living in the manner provided under Section 415(d) of the Code, Treasury Regulation §1.415(d)-1(a) and Treasury Regulation §1.415(b)-1)) (the "Dollar Limitation"); or

(ii) 100 percent of the Referee's average Compensation for the period of three (3) consecutive calendar years yielding the highest such average during which he was a Referee (as adjusted for increases in the cost of living in the manner provided under Section 415(d) of the Code, Treasury Regulation §1.415(d)-1(a) and Treasury Regulation §1.415(b)-1)) (the "High 3-Year Limitation").

(b) If the annual retirement pension of a Referee that would otherwise accrue in a Limitation Year would produce a benefit in excess of the maximum allowable annual retirement pension under paragraph (a) above, the annual retirement pension shall be limited (or the rate of accrual reduced) to a benefit that does not exceed the maximum allowable annual retirement pension under paragraph (a) above.

(c) In determining the maximum allowable benefit otherwise payable under this Section, if a Referee's Annuity Starting Date occurs prior to the Referee's attaining age 62, the Dollar Limitation applicable on the Referee's Annuity Starting Date shall be reduced so that it is the lesser of (i) the Dollar Limitation multiplied by the ratio of an immediately commencing straight life annuity under the Plan to a straight life annuity under the Plan commencing at age

62, both determined without applying the limitations of this Article XIC or (ii) the actuarial equivalent of the Dollar Limitation with actuarial equivalence computed using a 5% per annum interest rate assumption and the mortality table used to determine an Actuarial Equivalent benefit under Section 1.2 of the Plan (and expressing the Referee's age based on completed calendar months as of the Annuity Starting Date). The mortality decrement shall be ignored between the Annuity Starting Date and the Referee's attainment of age 62.

(d) In determining the maximum allowable benefit otherwise payable under this Section, if a Referee's Annuity Starting Date occurs after the Referee attains age 65, the Dollar Limitation applicable on the Referee's Annuity Starting Date shall be adjusted so that it is the lesser of (i) the Dollar Limitation multiplied by the ratio of the annual amount of an immediately commencing straight life annuity under the Plan computed disregarding benefit accruals after the Referee attains age 65 (but including actuarial adjustments) to the annual amount of an adjusted immediately commencing straight life annuity under the Plan at age 65, both determined without applying the limitations of this Article XIC or (ii) the actuarial equivalent Dollar Limitation where actuarial equivalence is computed using a 5% per annum interest rate assumption and the mortality table used to determine an Actuarial Equivalent benefit under Section 1.2 of the Plan (and expressing the Referee's age based on completed calendar months as of the Annuity Starting Date). For purposes of this paragraph (d), the adjusted immediately commencing straight life annuity under the Plan at age 65 is the annual amount of such annuity that would be payable under the Plan to a hypothetical participant who is age 65 and has the same Accrued Benefit as the Referee. The mortality decrement shall be ignored between age 65 and the Referee's age on the Annuity Starting Date.

(e) A Referee's High 3-Year Limitation shall not include, for any Limitation Year, Compensation that is in excess of the limitation under Code Section 401(a)(17) that is in effect for the calendar year in which such Limitation Year begins. If the Referee has less than three consecutive years of service, Compensation shall be averaged over the Referee's longest consecutive period of service, including fractional years, but no less than one year. In the case of a Referee who is rehired by the Employer after a severance of employment, the Referee's High 3-Year Limitation shall be calculated by excluding all years for which the Referee performs no services for, and receives no Compensation from, the Employer, and by treating the years immediately preceding and following the excluded years as consecutive. The High 3-Year Limitation for Referees who have separated from service with a non-forfeitable right to an Accrued Benefit shall be adjusted annually as provided in Code Section 415(d) pursuant to the applicable Treasury Regulations.

(f) The limitations of this Article shall not apply to (A) the portion of the Referee's annual retirement pension that is attributable to the Referee's Contribution Account and (B) the portion of the Referee's annual retirement pension that is attributable to the Referee's Employee Contribution Account. For purposes of this paragraph (f), the portion of a Referee's annual retirement pension that is attributable to the Referee's Contribution Account shall be equal to the Actuarial Equivalent of the value of such Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan.

(g) For purposes of this Article XIC:

(i) "Compensation" shall mean the Referee's wages, salaries, and other amounts received for personal services rendered for the Employer, and shall include amounts not includible in the gross income of the Referee under Code Sections 125(a), 132(f)(4), 402(e)(3), 402(h)(1)(B), 402(k) or 457(b).

(ii) "Annuity Starting Date" shall have the same meaning as provided in Section 8.1(b)(i) of the Plan.

(h) The application of the provisions modified or added to this Article XIC in accordance with the requirement of the Treasury Regulations issued and adopted on April 5, 2007 shall not cause the maximum permissible annual retirement of any Referee to be less than the Referee's accrued benefit under all of the defined benefit plans of the Employer or predecessor employer as of the end of the Limitation Year beginning before July 1, 2007 under provisions of the plans that were both adopted and in effect before April 5, 2007. The preceding sentence applies only if the provisions of such defined benefit plans that were both adopted and in effect before April 5, 2007 satisfied the applicable of statutory provisions, Treasury Regulations and other published guidance relating to Code Section 415 in effect as of the end of the last Limitation Year beginning before July 1, 2007, as described in Treasury Regulation §1.415(a)-1(g)(4).

11C.2 (a) If a Referee's annual retirement pension is payable in a form other than a Straight Life Annuity or a Qualified Joint and Survivor Annuity (as such terms are defined in Article VIII), for purposes of determining the maximum allowable benefit payable under Section 11C.1, the annual retirement pension shall be an actuarially equivalent straight life annuity as computed in accordance with paragraph (b).

(b) In adjusting an annual retirement benefit to an actuarially equivalent straight life annuity the following rules shall apply:

(i) in the case of a benefit payable in the form described in Sections 8.3(d)(i), (d)(iii), (d)(v) and (d)(vi), the actuarially equivalent straight life annuity is the greater of the (A) annual amount of the straight life annuity payable to the Referee under the Plan commencing on the Referee's Annuity Starting Date or (B) the annual amount of the straight life annuity commencing at the same Annuity Starting Date that has the same actuarial present value as the form of benefit payable to the Referee using an interest rate assumption of 5% per annum and the mortality table prescribed by the Internal Revenue Service under Section 417(e)(3)(B) of the Code applicable to the Limitation Year in which the Annuity Starting Date occurs; and

(ii) in the case of a benefit payable in the form described in Section 8.3(d) (other than paragraphs (d)(i), (d)(iii), (d)(v) and (d)(vi) of such Section), the actuarially equivalent straight life annuity is the greatest annual straight life annuity based on the following assumptions for actuarial equivalence: (A) 5.50% per annum, (B) the interest rate specified in Schedule A related to such form of payment, or (C) the rate that produces a benefit of not more than 105% of the benefit that would be produced using the "applicable interest rate" (as defined in Code Section 417(e)); and the mortality table prescribed by the Internal Revenue Service under Section 417(e)(3)(B) of the Code applicable to the Limitation Year in which the Annuity Starting Date occurs.

11C.3 In the event that (i) the annual retirement pension payable to a Referee under this Plan does not exceed $10,000 for a Limitation Year, (ii) the Referee was not a participant in the Plan prior to June 1, 1995 and (iii) the Referee has never participated in any other defined contribution plan maintained by the Employer or the Association, the limitations otherwise imposed by Section 11C.1 and the adjustments described in Section 11C.2 shall not apply. For purposes of this section, the $10,000 annual retirement pension shall not be adjusted for the form of benefit or the Annuity Starting Date.

11C.4 (a) If a Referee has less than ten (10) years of aggregate service with the Employer (including service in a capacity other than as a Referee) ("Employer Service") at the time at which he is entitled to receive benefits under the Plan, the High 3-Year Limitation and the $10,000 amount described in Section 11C.3 shall be reduced by multiplying the High 3-Year Limitation or the $10,000 limit by a fraction, the numerator of which is the Referee's number of years of Employer Service and the denominator of which is ten (10).

(b) If a Referee has less than ten (10) years of participation in the Plan at the time at which he is entitled to receive benefits under the Plan, the Dollar Limitation shall be reduced by multiplying the Dollar Limitation by a fraction, the numerator of which is the Referee's number of years of participation in the Plan and the denominator of which is ten (10).

(c) In no event shall paragraphs (a) and (b) of this Section 11C.4 reduce any limitation described therein to an amount less than one-tenth (1/10th) of such limitation.

11C.5 In applying the limitations described in this Article XIC, the Limitation Year shall be the 12-month period corresponding with the Plan Year.

11C.6 The provisions of this Article XIC shall be applicable only for Limitation Years commencing on or after June 1, 2008.

ARTICLE XID

LIMITATIONS ON BENEFITS IN THE EVENT OF PLAN UNDERFUNDING

11D.1 Limitations Applicable If the Plan's AFTAP Is Less Than 80% or If the Employer Is In Bankruptcy.

(a) Limitations Applicable If the Plan's AFTAP Is Less Than 80%, But Not Less Than 60%. Notwithstanding any other provisions of the Plan, if the Plan's adjusted funding target attainment percentage (as defined in Treasury Regulation Section 1.436-1(j)(1)) ("AFTAP") for a Plan Year is less than 80% (or would be less than 80% to the extent described in Section 11D.1(a)(ii) below) but is not less than 60%, then the limitations set forth in this Section 11D.1(a) shall apply.

(i) 50% Limitation on Single Sum Payments, Other Accelerated Forms of Distribution, and Other Prohibited Payments. A Referee or a Referee's Beneficiary shall not be permitted to elect, and the Plan shall not pay, a single sum payment or other optional form of benefit that includes a "Prohibited Payment" (as defined in Treasury Regulation Section 1.436-1(j)(6)) with an annuity starting date (as defined in Treasury Regulation Section 1.436-1(j)(2)) (a "Section 436 Annuity Starting Date") on or after the applicable "Section 436 Measurement Date" (as defined in Treasury Regulation Section 1.436-1(j)(8)), and the Plan shall not make any payment for the purchase of an irrevocable commitment from an insurer to pay benefits or any other payment or transfer that is a Prohibited Payment, unless the present value of the portion of the benefit that is being paid in a Prohibited Payment does not exceed the lesser of:

(A) 50% of the present value of the benefit payable in the optional form of benefit that includes the Prohibited Payment; or

(B) 100% of the PBGC maximum benefit guarantee amount (as defined in Treasury Regulation Section 1.436-1(d)(3)(iii)(C)).

The limitation set forth in this Section 11D.1(a)(i) shall not apply to any payment of a benefit which under Code Section 411(a)(11) may be immediately distributed without the consent of the Referee. If an optional form of benefit that is otherwise available under the terms of the Plan is not available to a Referee or Beneficiary as of the Section 436 Annuity Starting Date because of the application of the requirements of this Section 11D.1(a)(i), the Referee or Beneficiary shall be permitted to elect to bifurcate the benefit into unrestricted and restricted portions (as described in Treasury Regulation Section 1.436-1(d)(3)(iii)(D)). The Referee or Beneficiary may also elect any other optional form of benefit otherwise available under the Plan at that Section 436 Annuity Starting Date that would satisfy the 50 percent/PBGC maximum benefit guarantee amount limitation described in this Section 11D.1(a)(i), or may elect to defer the benefit in accordance with any general right to defer commencement of benefits under the Plan.

(ii) Plan Amendments Increasing Liability for Benefits. No amendment to the Plan that has the effect of increasing liabilities of the Plan by reason of increases in benefits, establishment of new benefits, changing the rate of benefit accrual, or changing the rate at which benefits become nonforfeitable shall take effect in a Plan Year if the AFTAP for the Plan Year is:

(A) Less than 80%; or

(B) 80% or more, but would be less than 80% if the benefits attributable to the amendment were taken into account in determining the AFTAP.

The limitation set forth in this Section 11D.1(a)(ii) shall not apply to any amendment to the Plan that provides a benefit increase under a Plan formula that is not based on compensation, provided that the rate of such increase does not exceed the contemporaneous rate of increase in the average wages of Referees covered by the amendment.

(b) Limitations Applicable If the Plan's AFTAP Is Less Than 60%. Notwithstanding any other provisions of the Plan, if the Plan's AFTAP for a Plan Year is less than 60%, then the limitations in this Section 11D.1(b) apply.

(i) Single Sums, Other Accelerated Forms of Distribution, and Other Prohibited Payments Not Permitted. A Referee or Beneficiary shall not be permitted to elect, and the Plan shall not pay, a single sum payment (if otherwise permitted under the Plan) or other optional form of benefit that includes a Prohibited Payment with a Section 436 Annuity Starting Date on or after the applicable Section 436 Measurement Date, and the Plan shall not make any payment for the purchase of an irrevocable commitment from an insurer to pay benefits or any other payment or transfer that is a Prohibited Payment. The limitation set forth in this Section 11D.1(b)(i) shall not apply to any payment of a benefit which under Code Section 411(a)(11) may be immediately distributed without the consent of the Referee.

(ii) Benefit Accruals Frozen. If not already frozen, benefit accruals under the Plan shall cease as of the applicable Section 436 Measurement Date. In addition, if the Plan is required to cease benefit accruals under this Section 11D.1(b)(ii), then the Plan shall not be amended in a manner that would increase the liabilities of the Plan by reason of an increase in benefits or establishment of new benefits.

(c) Limitations Applicable If the Employer Is In Bankruptcy. Notwithstanding any other provisions of the Plan, a Referee or Beneficiary shall not be permitted to elect, and the Plan shall not pay, a single sum payment or other optional form of benefit that includes a Prohibited Payment with a Section 436 Annuity Starting Date that occurs during any period in which the Employer is a debtor in a case under title 11, United States Code, or similar Federal or State law, except for payments made within a Plan Year with a Section 436 Annuity Starting Date that occurs on or after the date on which the Plan's enrolled actuary certifies that the Plan's AFTAP for that Plan Year is not less than 100%. In addition, during such period in which the Employer is a debtor, the Plan shall not make any payment for the purchase of an irrevocable commitment from an insurer to pay benefits or any other payment or transfer that is a Prohibited Payment, except for payments that occur on a date within a Plan Year that is on or after the date on which the Plan's enrolled actuary certifies that the Plan's AFTAP for that Plan Year is not less than 100%. The limitation set forth in this Section 11D.1(c) shall not apply to any payment of a benefit which under Code Section 411(a)(11) may be immediately distributed without the consent of the Referee.

(d) Provisions Applicable After Limitations Cease to Apply.

(i) Resumption of Prohibited Payments. If a limitation on Prohibited Payments under Section 11D.1(a)(i), Section 11D.1(b)(i), or Section 11D.1(c) applied to the Plan as of a Section 436 Measurement Date, but that limit no longer applies to the Plan as of a later Section 436 Measurement Date, then that limitation shall not apply to benefits with Section 436 Annuity Starting Dates that are on or after that later Section 436 Measurement Date. In addition, after the Section 436 Measurement Date on which the limitation on Prohibited Payments under Section 11D.1(a)(i) or Section 11D.1(b)(i) ceases to apply to the Plan, any Referee or Beneficiary who had a Section 436 Annuity Starting Date within the period during which that limitation applied to the Plan shall be permitted to make a new election (within 90 days after the Section 436 Measurement Date on which the limit ceases to apply or, if later, 30 days after receiving notice of the right to make such election) under which the form of benefit previously elected is modified at a new Section 436 Annuity Starting Date to be changed to a single sum payment for the remaining value of the Referee or Beneficiary's benefit under the Plan, subject to the other rules in this Section of the Plan and applicable requirements of Code Section 401(a), including spousal consent.

(ii) Resumption of Benefit Accruals. If a limitation on benefit accruals under Section 11D.1(b)(ii) applied to the Plan as of a Section 436 Measurement Date, but that limitation no longer applies to the Plan as of a later Section 436 Measurement Date, then benefit accruals may resume prospectively and that limitation shall not apply to benefit accruals that are based on service on or after that later Section 436 Measurement Date, except as otherwise provided

under the Plan. The Plan shall comply with the rules relating to partial years of participation and the prohibition on double proration under Department of Labor regulation 29 CFR § 2530.204-2(c) and (d). In addition, any benefit accruals that were not permitted to accrue because of the application of Section 11D.1(b)(ii) shall be restored when that limitation ceases to apply if the continuous period of the limitation was 12 months or less and the Plan's enrolled actuary certifies that the AFTAP for the Plan Year would not be less than 60% taking into account any restored benefit accruals for the prior Plan Year.

(iii) Treatment of Plan Amendments That Do Not Take Effect. If a Plan amendment does not take effect as of the effective date of the amendment because of the limitation of Section 11D.1(a)(ii) or Section 11D.1(b)(ii), but is permitted to take effect later in the same Plan Year (as a result of additional contributions or pursuant to the Plan's enrolled actuary's certification of the AFTAP for the Plan Year that meets the requirements of Treasury Regulation Section 1.436-1(g)(5)(ii)(C)), then the Plan amendment must automatically take effect as of the first day of the Plan Year (or, if later, the original effective date of the amendment). If the Plan amendment cannot take effect during the same Plan Year, then it shall be treated as if it were never adopted, unless the Plan amendment provides otherwise.

(e) Notice Requirement. Referees and Beneficiaries shall receive written notice within 30 days after certain specified dates if the Plan has become subject to a limitation described in Section 11D.1(a)(i), Section 11D.1(b)(i), or Section 11D.1(c) in accordance with 101(i) of ERISA.

(f) Methods to Avoid or Terminate Benefit Limitations. The Employer may, but shall not be required (other than by applicable law) to, make employer contributions and utilize the other methods to avoid or terminate the application of the limitations set forth in Sections 11D.1(a)-(c) for a Plan Year as described in Code Sections 436(b)(2), (c)(2), (e)(2), and (f) and Treasury Regulation Section 1.436-1(f). In general, the methods the Employer may use to avoid or terminate one or more of the benefit limitations under Sections 11D.1(a)-(c) for a Plan Year include making employer contributions and elections to increase the amount of Plan assets which are taken into account in determining the AFTAP, making an employer contribution that is specifically designated as a current year contribution that is made to avoid or terminate application of certain of the benefit limitations, or providing security to the Plan.

(g) Special Rules.

(i) Rules of Operation for Periods Prior to and After Certification of Plan's AFTAP.

(A) *In General.* Code Section 436(h) and Treasury Regulation Section 1.436-1(h) set forth a series of presumptions that apply (x) before the Plan's enrolled actuary issues a certification of the Plan's AFTAP for the Plan Year and (y) if the Plan's enrolled actuary does not issue a certification of the Plan's AFTAP for the Plan Year before the first day of the 10th month of the Plan Year (or if the Plan's enrolled actuary issues a range certification for the Plan Year pursuant to Treasury Regulation Section 1.436-1(h)(4)(ii) but does not issue a certification of the specific AFTAP for the Plan by the last day of the Plan Year). For any period during which a presumption under Code Section 436(h) and

Treasury Regulation Section 1.436-1(h) applies to the Plan, the limitations under Sections 11D.1(a)-(c) are applied to the Plan as if the AFTAP for the Plan Year were the presumed AFTAP determined under the rules of Code Section 436(h) and Treasury Regulation Section 1.436-1(h)(1), (2), or (3). These presumptions are set forth in Section 11D.1(g)(i)(2)-(4).

(B) *Presumption of Continued Underfunding Beginning First Day of Plan Year.* If a limitation under Sections 11D.1(a)-(c) applied to the Plan on the last day of the preceding Plan Year, then, commencing on the first day of the current Plan Year and continuing until the Plan's enrolled actuary issues a certification of the AFTAP for the Plan for the current Plan Year, or, if earlier, the date Section 11D.1(g)(i)(3) or Section 11D.1(g)(i)(4) applies to the Plan:

1. The AFTAP of the Plan for the current Plan Year shall be presumed to be the AFTAP in effect on the last day of the preceding Plan Year; and

2. The first day of the current Plan Year shall be a Section 436 Measurement Date.

(C) *Presumption of Underfunding Beginning First Day of 4th Month.* If the Plan's enrolled actuary has not issued a certification of the AFTAP for the Plan Year before the first day of the 4th month of the Plan Year and the Plan's AFTAP for the preceding Plan Year was either at least 60% but less than 70% or at least 80% but less than 90%, or is described in Treasury Regulation Section 1.436-1(h)(2)(ii), then,

commencing on the first day of the 4th month of the current Plan Year and continuing until the Plan's enrolled actuary issues a certification of the AFTAP for the Plan for the current Plan Year, or, if earlier, the date Section 11D.1(g)(i)(4) applies to the Plan:

1. The AFTAP of the Plan for the current Plan Year shall be presumed to be the Plan's AFTAP for the preceding Plan Year reduced by 10 percentage points; and

2. The first day of the 4th month of the current Plan Year shall be a section 436 measurement date.

(D) *Presumption of Underfunding On and After First Day of 10th Month.* If the Plan's enrolled actuary has not issued a certification of the AFTAP for the Plan Year before the first day of the 10th month of the Plan Year (or if the Plan's enrolled actuary has issued a range certification for the Plan Year pursuant to Treasury Regulation Section 1.436-1(h)(4)(ii) but has not issued a certification of the specific AFTAP for the Plan by the last day of the Plan Year), then, commencing on the first day of the 10th month of the current Plan Year and continuing through the end of the Plan Year:

1. The AFTAP of the Plan for the current Plan Year shall be presumed to be less than 60%; and

2. The first day of the 10th month of the current Plan Year shall be a section 436 measurement date.

(ii) Plan Termination and Other Special Rules.

(A) *Plan Termination.* The limitations on Prohibited Payments in Section 11D.1(a)(i), Section 11D.1(b)(i), or Section 11D.1(c) shall not apply to Prohibited Payments that are made to carry out the termination of the Plan in accordance with applicable law. Any other limitations under this Section 11D.1 of the Plan shall not cease to apply as a result of termination of the Plan.

(B) *Special Rules Relating to Plan Amendments Increasing Benefit Liability.* During any period in which none of the presumptions under Section 11D.1(g)(i) apply to the Plan and the Plan's enrolled actuary has not yet issued a certification of the Plan's AFTAP for the Plan Year, the limitations under Section 11D.1(a)(ii) shall be based on the inclusive presumed AFTAP for the Plan, calculated in accordance with the rules of Treasury Regulation Section 1.436-1(g)(2)(iii).

(iii) Special Rules Under Pension Relief Act of 2010.

(A) *Payments Under Social Security Leveling Options.* For purposes of determining whether the limitations under Section 11D.1(a)(i) or 11D.1(b)(i) apply to payments under a social security leveling option, within the meaning of Code Section 436(j)(3)(C)(i), the AFTAP for a Plan Year shall be determined in accordance with the "Special Rule for Certain Years" under Code Section 436(j)(3) and any Treasury Regulations or other published guidance thereunder issued by the Internal Revenue Service.

(B) *Limitation on Benefit Accruals.* For purposes of

determining whether the accrual limitation under Section 11D.1(b)(ii) applies to the Plan, the AFTAP for a Plan Year shall be determined in accordance with the "Special Rule for Certain Years" under Code Section 436(j)(3) (except as provided under section 203(b) of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, if applicable).

(iv) Interpretation of Provisions. The limitations imposed by this section of the Plan shall be interpreted and administered in accordance with Code Section 436 and Treasury Regulation Section 1.436-1.

(h) The provisions of this Section 11D.1 are intended solely to comply with the requirements of Code Section 436 and Treasury Regulation Section 1.436-1. Nothing contained in this Section 11D.1 shall be construed to allow any Referee or Beneficiary to receive any benefit accrual or form of benefit payment that is not otherwise specifically provided for under the terms of the Plan.

ARTICLE XII

INCAPACITY OF PAYEE

12.1 If any person to whom a benefit is payable hereunder is an infant or if the Committee determines that any person to whom such benefit is payable is incompetent by reason of physical or mental disability, the Committee may cause the payments becoming due to such person to be made to another for his benefit without responsibility of the Committee or the Trustee to see to the application of such payments. Any payment made pursuant to such power shall, as to such payment, operate as a complete discharge of the Fund, the Trustee and the Committee.

ARTICLE XIII

INALIENABILITY OF BENEFITS

13.1 Notwithstanding anything to the contrary contained herein, the interest of any Referee or Beneficiary in the Fund shall not be subject to assignment or transfer or be otherwise alienable, either by voluntary or involuntary act of such person or by operation of law, nor subject to attachment, execution, garnishment, sequestration or other seizure under any legal, equitable or other process, except for any loan or other indebtedness due to the Trust and created pursuant to the provisions hereof. Any attempted assignment or transfer or any attempted seizure by any legal or equitable process of any such person's interest in the Fund contrary to the provisions hereof shall be void and shall be given no recognition.

13.2 Except as may otherwise be provided under Section 401(a)(13)(B) (relating to special rules for "qualified domestic relations orders") and (C) of the Code, no benefit under this Plan shall be subject in any manner to anticipation, pledge, encumbrance, alienation or assignment, and any attempt to anticipate, pledge, encumber, alienate or assign any such benefit shall be void, nor shall any such benefits be in any way subject to seizure, attachment or other legal or equitable process for the debts, contracts or liabilities of any Referee or Beneficiary.

ARTICLE XIV

ORGANIZATION OF PENSION COMMITTEE; ADMINISTRATION OF THE PLAN

14.1 The Plan shall be administered by a Committee composed of at least two members appointed by the Employer; provided, however, that the Employer may delegate to the Association the power to appoint the members of the Committee. Each member of the Committee shall serve at the will of the Employer (or the Association if the Committee is appointed by the Association) and without compensation. Any person may serve in more than one fiduciary capacity with respect to the Plan, including service both as Trustee and as a member of the Committee. The Committee (and each member thereof) is a "named fiduciary" of the Plan. The Committee is the "plan administrator" of the Plan within the meaning and for the purposes of ERISA.

14.2 The Committee shall appoint a chairman and a secretary from its members. Action by the Committee shall be taken by a vote of two or more of its members at a meeting or in a writing without a meeting. Minutes of each meeting shall be kept and other appropriate books and records shall be maintained by the Committee. The Committee may establish such rules as may be necessary or desirable for its own operations. The proper expenses of the Committee in the performance of its duties, including fees for legal, clerical, medical, accounting, actuarial and other services rendered to the Committee shall be paid by the Trustee out of the Fund unless paid by the Employer, or the Association.

14.3 The Committee shall administer the Plan and shall have complete control in the administration thereof. In exercising any of its discretionary powers with respect to the administration of the Plan, the Committee shall act in a uniform and nondiscriminatory manner

and for the exclusive benefit of Referees and their Beneficiaries. The Employer and the Association shall have no responsibility for the operation of the Plan. The Committee shall have all powers which are reasonably necessary to carry out its responsibilities under the Plan including, but not by way of limitation, the power to construe the Plan and to determine all questions that shall arise hereunder, and shall also have all the powers elsewhere in the Plan conferred upon it. Such powers shall include, but are not limited to, the power to determine questions relating to eligibility for, and the amount of, benefits under the Plan. Except as otherwise provided herein, the decision of the Committee as to any disputed question arising hereunder, including questions of construction, interpretation and administration shall be final, binding and conclusive.

14.4 The Committee may employ one or more persons to render advice with regard to any responsibility it has under the Plan or Trust. The compensation of such person or persons shall be fixed by the Committee.

14.5 The Committee shall give instructions or directions to the Trustee on all matters within its discretion under the terms of the Trust. All disbursements by the Trustee, except for the reasonable expenses of administration of the Trust, shall be made upon, and in accordance with, the written instructions of the Committee. The Committee shall have the power and the responsibility to establish and carry out a funding policy and method consistent with the short and long term financial needs of the Plan and the requirements of ERISA, including the minimum funding requirements of Title I, Part 3 of ERISA. The Committee shall communicate with the Trustee as to its determination (and, if an investment manager has been appointed, with the investment manager). The Committee shall meet periodically, but at least annually, to reconsider the funding policy and method.

14.6 The Trustee may appoint an investment manager to manage any assets of the Plan. As used herein, the term "investment manager" shall mean any person or entity who: (a) has power to manage, acquire or dispose of any assets of the Plan; (b) is (1) registered as an investment advisor under the Investment Advisors Act of 1940, (2) a bank, as defined in that Act, or (3) an insurance company qualified, under the laws of more than one state, to perform services described in (a) above; and (c) has acknowledged in a writing delivered to the Committee and the Trustee that he is a fiduciary with respect to the Plan.

14.7 The Committee may allocate among its members or delegate to any person who is not a member of the Committee any administrative responsibility which it has hereunder. No responsibility of the Committee with respect to the management or control of the assets of the Fund may be so delegated or allocated. Any delegation or allocation of a responsibility pursuant to this Section shall be evidenced by the minutes of the meeting of the Committee at which such delegation or allocation was approved or, if no such meeting was held, by the writing under which such action was taken.

14.8 Decisions and directions of the Committee may be communicated to the Trustee, a Referee, a Beneficiary, the Association, the Employer, or any other person who is to receive such decision or direction by a document signed by any one or more members of the Committee (or persons other than members) so authorized, and such decision or direction of the Committee may be relied upon by its recipient as being the decision or direction of the Committee. The Committee may authorize one or more of its members, or a designee who is not a member, to sign on behalf of the entire Committee.

14.9 Any member of the Committee may resign by giving written notice to the Employer not less than 30 days before the effective date of his resignation. Any member of the

Committee may be removed, with or without cause, at any time by the Employer. The Employer shall fill vacancies in the Committee as soon as is reasonably possible after a vacancy occurs and, until a new appointment is made, the remaining members shall have full authority to act. If the Employer, pursuant to Section 14.1, has delegated to the Association the power to appoint the Committee, the Association shall be considered as the Employer for purposes of this Section.

ARTICLE XV

LIABILITY AND STANDARD OF CARE OF COMMITTEE

15.1 Each member of the Committee and any other fiduciary with respect to the Plan shall discharge his duties with respect thereto (a) solely in the interest of Referees and their Beneficiaries; (b) for the exclusive purpose of providing benefits to Referees and their Beneficiaries and defraying reasonable expenses of administering the Plan (except as may otherwise be provided in Sections 10.4 and 18.3); (c) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and (d) in accordance with the provisions of the Plan insofar as such provisions are not inconsistent with applicable law. As used herein, the term "fiduciary" shall have the meaning ascribed to it in Section 3(21) of ERISA.

15.2 No fiduciary with respect to the Plan shall be liable for an act or omission of another person resulting in a breach by such other person of his fiduciary responsibility with respect to the Plan, except to the extent that:

(a) such fiduciary participated knowingly in, or knowingly undertook to conceal, an act or omission of such other person, knowing such act or omission to be a breach of fiduciary responsibility;

(b) such fiduciary, by his failure to comply with the provisions of the preceding Section of the Plan or with Section 404(a)(1) of ERISA in the administration of his specific responsibilities which give rise to his status as a fiduciary, has enabled such other person to commit a breach of fiduciary responsibility;

(c) such fiduciary has knowledge of a breach of fiduciary responsibility by such other person, unless he makes reasonable efforts under the circumstances to remedy the breach; or

(d) such fiduciary is a "named fiduciary" (as such term is defined in Section 402(a)(2) of ERISA) and has violated his duties under Section 404(a)(1) of ERISA:

(i) with respect to the allocation of fiduciary responsibilities among "named fiduciaries" or the designation of persons other than "named fiduciaries" to carry out fiduciary responsibilities under the Plan;

(ii) with respect to the establishment or implementation of procedures for allocating fiduciary responsibilities among "named fiduciaries" or for designating persons other than "named fiduciaries" to carry out fiduciary responsibilities under the Plan; or

(iii) in continuing the allocation of fiduciary responsibilities among "named fiduciaries" or the designation of persons other than "named fiduciaries" to carry out fiduciary responsibilities under the Plan.

15.3 Notwithstanding anything to the contrary contained herein, no member of the Committee or other fiduciary with respect to the Plan shall incur any liability for any act or omission to the extent he would not be liable therefor under Part 4 of Subtitle B of Title I of ERISA and to the extent such act or omission is not the result of his own gross negligence or willful misconduct.

15.4 The Association and/or the Employer shall indemnify each member of the Committee and any employee of the Association or the Employer to whom a fiduciary responsibility with respect to the Plan is allocated or delegated from and against all liabilities,

costs and expenses incurred by such person as a result of act, omission or conduct in connection with the performance of his fiduciary duties, responsibilities and obligations under the Plan and under ERISA, except with respect to liabilities and claims arising from such person's own willful misconduct or gross negligence. The Association and/or the Employer may obtain, pay for and maintain a policy or policies of insurance, the proceeds of which may be used in satisfying obligations of the Association and the Employer under this Section.

ARTICLE XVI

CLAIMS PROCEDURE

16.1 Claim for Benefits. The claim of any person (hereinafter referred to as the "Claimant") with respect to any benefits to which such Claimant may be entitled under the Plan shall be considered in accordance with the following procedure:

(a) Any Claimant may make written application to the Committee for benefits to which he believes he is entitled, at the time the application is made, under the Plan. Such application shall set forth all information necessary to determine whether the claim should be approved or denied. The Committee shall furnish to the Claimant an acknowledgment of his application, including a notice of the time limits set forth in Article XVI.

(b) The Committee shall either approve the claim and take any appropriate action, or deny the claim. Such approval or denial shall be accomplished within an initial period of ninety (90) days after receipt of the claim by the Committee unless special circumstances require an extension of time for processing the claim. If such an extension is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial ninety (90) day period. Any such extension shall expire no later than ninety (90) days after the end of the initial period. The extension notice shall describe the special circumstances requiring the extension of time and the expected date of decision.

(c) If a claim is denied, the Committee shall furnish a written notice of such action to the Claimant within the applicable time limit described in paragraph (b). Such notice shall set forth, in a manner calculated to be understood by the Claimant:

(i) the specific reason or reasons for the denial;

(ii) specific reference to the pertinent provisions of this Plan on which the denial is based;

(iii) a description of any additional material or information necessary for the Claimant to perfect his claim and an explanation of why such material or information is necessary; and

(iv) an explanation of the review procedure, as set forth in Section 16.2.

16.2 Appeal of Denial of Claim for Benefit.

(a) A Claimant whose claim has been denied may appeal by written notice to the Committee requesting a review of the denial. The Claimant's written request for review must be submitted to the Committee within sixty (60) days after his receipt of the notice of the denial. A Claimant who wishes to appeal or has appealed a denial may:

(i) review all pertinent documents relating to his claim; and

(ii) submit issues and comments in writing for consideration by the Committee.

(b) The Committee shall render the decision on review within an initial period of sixty (60) days after receipt of the Claimant's written request for review, unless special circumstances (including a request for a conference, as described in Section 16.2(c)) require an extension of time. Any such extension shall expire no later than sixty (60) days after the end of the initial period. If such an extension is required, written notice thereof shall be furnished to the Claimant before the end of the initial period.

(c) If the Claimant so requests in his timely application for review, the Committee shall schedule a conference with the Claimant (and/or his authorized representative).

Such conference shall be held at the offices of the Employer or the Association at a date and time which is mutually agreed upon by the parties concerned, provided that in no event shall the conference be held more than sixty (60) days after the Committee receives the Claimant's written request for review of his claim. The decision of the Committee shall be communicated in writing to the Claimant or his authorized representative no later than sixty (60) days after the end of the initial period and shall set forth, in the same manner, the information required in Section 16.1(c).

(d) The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the Claimant with specific references to the pertinent provisions of the Plan on which the decision is based.

16.3 Any claim, request for review or other action which may be made or taken by the Claimant under this Section may be made or taken by the Claimant's duly authorized representative.

16.4 The Committee shall not be bound by any notice or other communication unless and until it shall have been received in writing addressed to NBA Services Corp. at Olympic Tower – 15th Floor, 645 Fifth Avenue, New York, New York 10022, Attention: Pension Committee.

ARTICLE XVII

TRUST FUND

17.1 The Fund shall consist of all payments to the Trustee as provided herein, together with the net income or loss (including capital items) which shall be produced by the investments of the Fund or the sale of any such investments, which shall be added to or deducted from the Fund by the Trustees. The Fund shall be held, administered and invested in the manner provided in the agreement pursuant to which the Trust is governed.

17.2 All assets of the Fund shall be owned by the Trustee and no asset shall be considered as belonging to any particular Referee or Beneficiary.

17.3 All benefits payable under the Plan shall be paid or provided for solely from the Fund, and neither the Employer nor the Association assumes any liability or responsibility therefor.

ARTICLE XVIII

AMENDMENT AND TERMINATION OF THE PLAN

18.1 Amendment.

The Plan may be amended in whole or in part at any time by the Employer; provided, however, that:

(a) Except as otherwise provided in accordance with the provisions of Sections 10.4 and 18.3 of the Plan and Section 403(c) of ERISA, prior to the satisfaction of all expenses of the Fund and all liabilities under the Plan with respect to all Referees, no amendment or modification may be made which would permit any part of the corpus or income of the Fund to be used for or diverted to purposes other than for the exclusive benefit of the Referees or their Beneficiaries and/or other persons entitled to benefits under the Plan;

(b) No amendment or modification shall deprive any Referee, joint annuitant or Beneficiary of any benefit already accrued and payable, except in connection with the termination of the Plan, nor shall a Plan amendment decrease a Referee's Accrued Benefit, except as may be permitted by Section 412(c)(8) of the Code;

(c) No amendment shall have the effect of reducing a Referee's vested Accrued Benefit with respect to anyone who has an Accrued Benefit under the Plan on the date the amendment is adopted or the date the amendment is effective, whichever is later;

(d) Except as permitted by Section 411(d)(6) of the Code and Treasury Regulations thereunder, no Plan amendment or transaction having the effect of a Plan amendment (such as a merger, plan transfer or similar transaction) shall be effective if it eliminates or reduces any "Section 411(d)(6) protected benefit" or adds or modifies conditions relating to "Section 411(d)(6) protected benefits," the result of which is a further restriction on

such benefits, unless such protected benefits are preserved with respect to benefits accrued as of the later of the adoption date or effective date of the amendment. "Section 411(d)(6) protected benefits" are benefits described in Code Section 411(d)(6)(A), early retirement benefits and retirement-type subsidies, and optional forms of benefit; and

(e) Notwithstanding the provisions of paragraphs (a), (b), (c) and (d), any amendment may be retroactive to the extent necessary to preserve the qualified tax-exempt status of the Plan.

18.2 Termination of the Plan.

While the Plan is intended to be permanent, it may be terminated at any time by the Employer. Written notification of such action shall be given to the Trustee and the Committee setting forth the termination date. After termination of the Plan, no further contributions shall be made hereunder. However, the Committee shall remain in existence and all provisions of the Plan shall remain in force which are necessary in the opinion of the Committee, other than the provisions for contributions; and the Trust Agreement shall remain in existence, and all of the provisions thereof shall remain in force which are necessary in the opinion of the Committee, other than the provisions relating to the contributions under the Plan.

18.3 Manner and Order of Allocation of Fund.

Upon termination or partial termination of the Plan, the rights of each Referee to benefits accrued to the date of such termination, to the extent then funded, shall be fully vested and nonforfeitable; provided, however, that in the event of a partial termination the nonforfeitable rights shall be applicable only to the portion of the Plan that is terminated.

In such event, amounts held in the Fund, after reserving an amount sufficient to pay all expenses and charges, including the payment of all expenses incurred in effectuating such

termination (such as the fees and retainers of the Trustee and any actuary, accountant, custodian, counsel, administrator or other specialist) shall be applied to provide benefits as stated below for the following classes of participants, in the priority listed:

(a) First, to the extent possible, an amount shall be allocated to provide any benefits payable from the Plan which are attributable to the value of any Referee's Employee Account as of the date of the Plan's termination.

(b) Second, to the extent possible, an amount shall be allocated to provide any additional benefits payable from the Plan for:

(i) Referees who are receiving benefit payments from the Plan, provided that payment of such benefits commenced at least 3 years prior to the date on which the Plan terminated; and

(ii) any other Referees who are eligible to retire in accordance with Section 4.1 and/or Section 4.1A, or who have retired in accordance with such Sections, provided that the date on which such Referees were first eligible to request such retirement was at least 3 years prior to the date on which the Plan terminated; provided, however, that in no event shall the benefit provided exceed the lowest level of such benefit in effect under the Plan at any time during the 5 year period preceding the date of termination of the Plan, or which would have been in effect during such period had payment of benefits commenced;

(c) Third, to the extent possible, an amount shall be allocated to provide any additional benefits payable from the Plan, to the extent that payment of such benefits is guaranteed by the Pension Benefit Guaranty Corporation, or which would have been guaranteed

by the Pension Benefit Guaranty Corporation, if the provisions of Section 4022(b)(5) of ERISA were not applicable;

(d) Fourth, to the extent possible, an amount shall be allocated to provide any additional benefits to which a Referee would have been entitled had his employment terminated on the date on which the Plan terminated, or to which he was entitled if his employment had terminated prior to such date; provided, however, that the percentage of benefits to which such Referee would have been entitled shall be computed as if the Plan had not terminated on such date; and

(e) Fifth, to the extent possible, an amount shall be allocated to provide any additional benefit liabilities (as defined under Section 4001(a)(16) of ERISA) accrued under the Plan.

If the balance in the Fund remaining for allocation under any of the foregoing paragraphs is insufficient to provide the allocations under such paragraph in full, such balance shall be used to provide a pro rata portion of such allocations, and allocations shall not be made under any subsequent paragraphs.

Any excess remaining in the Fund after all benefits payable to Referees and their Beneficiaries have been provided in accordance with paragraphs (a), (b), (c), (d) and (e) and after all expenses of termination have been paid, shall be paid to the Employer.

18.4 Termination of Trust Fund.

In the event that after termination of the Plan, the Committee shall determine the continuance of the Fund is not in the best interests of the Referees, the Employer may terminate the Fund and the Trustee shall pay to each Referee (or joint annuitant or Beneficiary) the benefit to which the Referee may be entitled under the Plan.

ARTICLE XIX

MISCELLANEOUS

19.1 Nothing herein contained shall be deemed to give any Referee any right to be retained in the Employer's employ nor shall it give any Referee any other rights in the future other than as herein specifically set forth. Except as otherwise specifically provided herein or by law, nothing herein contained shall give to any Referee, Beneficiary or any other person any right to inspect the books, records, reports, financial statements or tax returns of the Employer or the Association.

19.2 No person shall have any right or interest in the Fund other than as provided herein. Any final payment or distribution to any Referee, or Beneficiary in accordance with the provisions of the Plan shall be in full satisfaction of all claims against the Fund, the Trustee, the Committee, the Association, the Employer and any fiduciary with respect to the Plan or Trust. The Trustee or the Committee may require any Referee or Beneficiary to execute a receipt and a general release of any and all such claims upon a final payment or distribution, or a receipt to the extent of any partial payment or distribution.

19.3 All administrative expenses of the Plan and Trust, including, but not limited to, the compensation of consultants, auditors and counsel, may be paid from the Fund; provided, however, that the Employer and/or the Association may, at their discretion, elect to pay such expenses. Any expenses directly relating to the investments of the Fund, such as taxes, commissions, and registration charges, shall be paid from the Fund.

19.4 The headings in this Plan have been inserted for convenience of reference only, and are to be ignored in any construction of the provisions hereof.

19.5 In the construction of this Plan, the masculine shall include the feminine and the singular the plural, and vice-versa, in all cases where such meanings would be appropriate.

19.6 If any provision of this Plan or the application of such provision to any person or circumstance shall be held invalid, the remainder of this Plan (and the application of such provision to any person or circumstance other than the person or circumstance to which it is held invalid) shall not be affected thereby.

19.7 In the case of any merger or consolidation of the Plan with, or any transfer of assets or liabilities of the Plan to, any other plan, the benefit which each Referee would be entitled to receive immediately after the merger, consolidation or transfer (as if the Plan had then terminated) shall be equal to or greater than the benefit he would have been entitled to receive immediately before the merger, consolidation or transfer (as if the Plan had then terminated).

19.8 The Plan set forth herein shall amend and restate, effective as of June 1, 2012, except as otherwise provided herein, all provisions of the Plan, as in effect on May 31, 2012, except that the rights of former Referees who terminated employment, died or retired prior to June 1, 2012, shall be governed by the terms of such Plan as in effect at the time of termination of employment, death or retirement.

19.9 The provisions of this Plan shall be construed, regulated and administered according to the provisions of ERISA, and to the extent not inconsistent therewith, in accordance with the laws of the State of New York.

19.10 Notwithstanding any provision of the Plan to the contrary: (a) benefits and service credit with respect to qualified military service (as defined in Section 414(u)(5) of the Internal Revenue Code) shall be provided in accordance with Section 414(u)(8) of the Internal Revenue Code and in accordance with the Referee's reemployment rights under the Uniformed

Services Employment and Reemployment Rights Act; (b) effective for deaths occurring on or after January 1, 2007, the Plan shall provide the survivors of a Referee who dies while performing qualified military service with any additional benefits (other than benefit accruals relating to the period of qualified military service) provided under the Plan in accordance with the requirements of Section 401(a)(37) of the Internal Revenue Code (to the extent such benefits are otherwise provided under the Plan); (c) effective June 1, 2009, in the case of an individual receiving a differential wage payment under Section 3401(h)(2) of the Internal Revenue Code: (i) the individual shall be treated as being employed by the Employer making the payment, (ii) the differential wage payment shall be treated as "Compensation" (as defined in Section 11C.1(g)(i) for purposes of the Plan, and (iii) the Plan shall not be treated as having failed to meet the requirements of any provision described in Section 414(u)(1)(C) of the Internal Revenue Code by reason of any benefit based on the differential wage payment; and (d) the Plan shall be administered and operated in accordance with the Heroes Earnings Assistance and Relief Tax Act of 2008.

ARTICLE XX

SPECIAL EFFECTIVE AND APPLICABLE DATES

20.1 Articles III, IV, V, VI, VII, VIII, IX, X, XI and XVIII shall apply only to those Referees who, on or after June 1, 1995, are under contract with the Employer for performing officiating services in Championship and Exhibition Games.

20.2 Section 4.1A shall apply only to those Referees who are credited with a Year of Referee Service with respect to any Regular Season that commences in 2004 or any year thereafter.

20.3 Section 8.9 shall apply only to a Referee who on or after June 1, 2005 becomes eligible to receive or commence to receive payment of his Pension Benefit.

20.4 Article XI shall apply only to those Referees who receive an annual pension during the Limitation Years (as defined by Section 11.6) which commenced on or prior to June 1, 2000.

20.5 Article XIA shall apply only to those Referees who receive an annual pension during the Limitation Years (as defined by Section 11A.6) which commenced on June 1, 2001, June 1, 2002, and June 1, 2003.

20.6 Article XIB shall apply only to those Referees who receive an annual pension during the Limitation Years (as defined by Section 11B.6) which commenced on June 1, 2004, June 1, 2005, June 1, 2006 and June 1, 2007.

20.7 Article XIC shall apply only to those Referees who receive an annual pension during the Limitation Years (as defined by Section 11C.6) which commence on or after June 1, 2008.

20.8 Appendix A to this Plan shall, except as otherwise provided therein and in the Plan, be applicable (i) to Referees not described in Section 20.1 and (ii) for the period commencing June 1, 1989 and ending May 31, 1995, to Referees described in Section 20.1.

IN WITNESS WHEREOF, NBA Services Corp. has executed this Plan on this 10th day of January, 2013.

NBA SERVICES CORP.

By: _____

Title: VP

SCHEDULE A

ACTUARIAL FACTORS

1. The actuarial factors to be used for purposes of Sections 1.2, 8.3(b), 8.3(d) (other than Sections 8.3(d)(ii) and (iv)), 8.8(b), 9.1(b)(ii) (other than a benefit payable in the form of a lump sum payment), 9.1(c), 9.2(c) (other than a benefit payable in the form of a lump sum payment), 11.2(b)(i)(A), 11A.2(b)(i)(A), 11B.2(b)(i)(A) and 11C.2(b)(i)(A) shall be (i) the 1983 Group Annuity Mortality Table for males and (ii) an interest rate of 7.0%.

2. The actuarial factors to be used for purposes of Sections 1.3, 4.1(b)(ii), 4.1(d)(ii), 4.1(f)(ii), 4.1(h)(ii), 4.1(j)(ii), 4.1(l)(ii), 4.1(n)(ii), 4.1(p)(ii), 4.1(r)(ii), 4.1(t), 4.1A(b)(ii), 4.1A(d)(ii), 4.1A(f)(ii), 4.1A(h)(ii), 4.1A(j)(ii), 4.1A(m)(ii), 4.1A(n), 8.3(d)(ii) and (iv), 8.5, 11C.1(c)(2) (for the mortality table only), 11C.1(d)(2) (for the mortality table only), 11C.2(b)(i)(B) (for the mortality table only) and 11C.2(b)(ii) (for mortality table only) shall be (i) the mortality table prescribed by the IRS under Treasury Regulation §1.417(e)-1(d)(2) for the Plan Year in which the payment is made and (ii) an interest rate equal to the one derived from the three interest rate segments as required by Section 417(e)(3) of the Code for the second preceding month (April) before the Plan Year in which the distribution is made.

3. The actuarial reduction factors to be used for purposes of Sections 5.2, 6.2, 7.1(b), 9.1(e) and 11B.1(b)(x) shall be the early retirement factors set forth in the table attached hereto as Exhibit A.

4. For purposes of determining the actuarially equivalent life annuity payable to an alternate payee under a qualified domestic relations order as defined in Code Section 414(p), the actuarial factors shall be based on 7% interest and the 1983 Group Annuity Mortality Table for

males for the Referee and the 1983 Group Annuity Mortality Table for females for the alternate payee.

5. The actuarial factors to be used for purposes of Sections 11.1(b)(ii)(y) (for the mortality table only), 11.1(c)(ii)(y) (for the mortality table only), 11.2(b)(i)(B) (for the mortality table only) and 11.2(b)(ii) shall be the 1983 Group Annuity Mortality Table with a 50/50 gender blend and an interest rate equal to the average annual yield on 30-year Treasury bonds for the second month preceding the June 1 of the Plan Year in which the distribution is made.

6. The actuarial factors to be used for purposes of Sections 11A.1(b)(ii)(y) (for the mortality table only), 11A.1(c)(ii)(y) (for the mortality table only), 11A.2(b)(i)(B) (for the mortality table only) and 11A.2(b)(ii) shall be the mortality table prescribed in Rev. Rul. 2001-62 and an interest rate equal to the average annual yield on 30-year Treasury bonds for the second month preceding the June 1 of the Plan Year in which the distribution is made.

Exhibit A
THE RESTATED NATIONAL BASKETBALL ASSOCIATION
REFEREES' PENSION PLAN
EARLY RETIREMENT FACTORS

NORMAL RETIREMENT AGE

Retirement Age	62	63	64	65
20	0.0500	0.0500	0.0417	0.0417
21	0.0584	0.0500	0.0500	0.0417
22	0.0584	0.0584	0.0500	0.0500
23	0.0667	0.0584	0.0584	0.0500
24	0.0750	0.0667	0.0584	0.0500
25	0.0750	0.0667	0.0667	0.0584
26	0.0834	0.0750	0.0667	0.0584
27	0.0917	0.0834	0.0750	0.0667
28	0.0917	0.0834	0.0750	0.0667
29	0.1000	0.0917	0.0834	0.0750

Exhibit A
THE RESTATED NATIONAL BASKETBALL ASSOCIATION
REFEREES' PENSION PLAN
EARLY RETIREMENT FACTORS

NORMAL RETIREMENT AGE

Retirement Age	62	63	64	65
30	0.1084	0.1000	0.0917	0.0834
31	0.1167	0.1084	0.1000	0.0917
32	0.1250	0.1167	0.1084	0.0917
33	0.1334	0.1250	0.1167	0.1000
34	0.1417	0.1334	0.1250	0.1084
35	0.1584	0.1417	0.1334	0.1167
36	0.1667	0.1584	0.1417	0.1250
37	0.1834	0.1667	0.1500	0.1334
38	0.1917	0.1750	0.1667	0.1500
39	0.2084	0.1917	0.1750	0.1584
40	0.2250	0.2084	0.1917	0.1667
41	0.2417	0.2250	0.2000	0.1834
42	0.2667	0.2417	0.2167	0.2000
43	0.2834	0.2584	0.2417	0.2167
44	0.3084	0.2834	0.2584	0.2334
45	0.3334	0.3084	0.2750	0.2500
46	0.3584	0.3334	0.3000	0.2750
47	0.3917	0.3584	0.3250	0.2917
48	0.4250	0.3917	0.3500	0.3167
49	0.4584	0.4250	0.3834	0.3417
50	0.5000	0.4584	0.4167	0.3750
51	0.5417	0.5000	0.4584	0.4167
52	0.5834	0.5417	0.5000	0.4584
53	0.6250	0.5834	0.5417	0.5000
54	0.6667	0.6250	0.5834	0.5417
55	0.7084	0.6667	0.6250	0.5834
56	0.7500	0.7084	0.6667	0.6250
57	0.7917	0.7500	0.7084	0.6667
58	0.8334	0.7917	0.7500	0.7084
59	0.8750	0.8334	0.7917	0.7500
60	0.9167	0.8750	0.8334	0.7917
61	0.9584	0.9167	0.8750	0.8334
62	1.0000	0.9584	0.9167	0.8750
63	1.0000	1.0000	0.9584	0.9167
64	1.0000	1.0000	1.0000	0.9584
65	1.0000	1.0000	1.0000	1.0000

FIRST AMENDMENT TO THE RESTATED NATIONAL BASKETBALL ASSOCIATION REFEREES' PENSION PLAN

WHEREAS, the Restated National Basketball Association Referees' Pension Plan (the "Plan") was restated effective as of June 1, 2012;

WHEREAS, under Section 18.1 of the Plan, NBA Services Corp. reserved the right to amend the Plan at any time; and

WHEREAS, it is necessary to amend the Plan in order for the Internal Revenue Service to issue a favorable determination letter with respect to the Plan.

NOW, THEREFORE, the Plan is hereby amended as set forth below:

1. Section 11C.2(b) of the Plan is amended to read as follows:

"(b) In adjusting an annual retirement benefit to an actuarially equivalent straight life annuity the following rules shall apply:

(i) in the case of a benefit payable in the form described in Sections 8.3(d)(i), (d)(iii), (d)(v) and (d)(vi), the actuarially equivalent straight life annuity is the greater of the (A) annual amount of the straight life annuity payable to the Referee under the Plan commencing on the Referee's Annuity Starting Date or (B) the annual amount of the straight life annuity commencing at the same Annuity Starting Date that has the same actuarial present value as the form of benefit payable to the Referee using an interest rate assumption of 5% per annum and the mortality table prescribed by the Internal Revenue Service under Section 417(e)(3)(B) of the Code applicable to the Limitation Year in which the Annuity Starting Date occurs; and

(ii) in the case of a benefit payable in the form described in Section 8.3(d) (other than paragraphs (d)(i), (d)(iii), (d)(v) and (d)(vi) of such Section), the actuarially equivalent straight life annuity is the greatest annual straight life annuity based on the following assumptions for actuarial equivalence: (A) 5.50% per annum, (B) the interest rate specified in Schedule A related to such form of payment, or

(C) the rate that produces a benefit of not more than 105% of the benefit that would be produced using the annual rate of interest based on the three interest rate segments as prescribed by the Secretary of the Treasury (or a delegate thereof) in accordance with Section 417(e)(3)(C) of the Code for the second preceding month (April) before the Plan Year in which the distribution is made; and the mortality table prescribed by the Internal Revenue Service under Section 417(e)(3)(B) of the Code applicable to the Limitation Year in which the Annuity Starting Date occurs."

2. This amendment shall be effective as of June 1, 2012.

On this 14th day of January, 2014, NBA Services Corp. has executed this First Amendment to the Plan.

NBA SERVICES CORP.

By: _____

Title: VP

SECOND AMENDMENT TO THE RESTATED NATIONAL BASKETBALL ASSOCIATION REFEREES' PENSION PLAN

WHEREAS, the Restated National Basketball Association Referees' Pension Plan (the "Plan") was restated effective as of June 1, 2012;

WHEREAS, under Section 18.1 of the Plan, NBA Services Corp. reserved the right to amend the Plan at any time;

WHEREAS, the First Amendment to the Plan was adopted on January 14, 2014; and

WHEREAS, it is necessary to amend the Plan in order to clarify the provisions of the Plan relating to (i) the continuation of benefit payments to former Referees who become reemployed as Referees after entering into pay status and (ii) the timing of distributions under the Plan's Retroactive Annuity Starting Date rules.

NOW, THEREFORE, the Plan is hereby amended as set forth below:

1. Section 8.6 of the Plan is hereby deleted in its entirety, Sections 8.7 through 8.10 are hereby renumbered as Sections 8.6 through 8.9, respectively, and all references in the Plan to the old section numbers are deemed amended to correspond to their new designations.

2. Section 8.8 of the Plan, as renumbered pursuant to Paragraph 1 above, is hereby amended and restated to read in its entirety as follows:

"8.8 Special May 1 Retroactive Annuity Starting Date Election.

(a) For each Plan Year, any Referee who would have been eligible to receive or commence to receive payment of his Pension Benefit on May 1 of such Plan Year had he made a timely election under Section 8.4 prior to May 1 of such Plan Year, may elect during the time period and in accordance with procedures specified by the Committee, to receive or commence to receive payment of his Pension Benefit on August 1 of the immediately following Plan Year with such Pension Benefit to be determined based upon a retroactive annuity starting date of the May 1 immediately preceding such August 1 (the 'Retroactive Annuity Starting Date').

(b) Any Referee who wishes to make the Retroactive Annuity Starting Date election described in paragraph (a) shall receive from the Committee an explanation of rights with respect to the Qualified Joint and Survivor Annuity or the Single Life Annuity, whichever is applicable, and a general explanation of the financial effect on the Referee's benefit if he decides to accept the Qualified Joint and Survivor Annuity or the Single Life Annuity, at least 30 days prior to the August 1 on which he would receive or commence to receive payment of his Pension Benefit pursuant to such Referee's election; provided, however, that the Referee may elect (with any applicable spousal consent) to waive any requirement that the explanation of rights be provided at least 30 days prior to the applicable August 1, provided that the distribution commences more than 7 days after such explanation is provided.

(c) Any election made by a Referee under paragraph (a) to receive or commence to receive payment of his Pension Benefit based upon a Retroactive Annuity Starting Date of May 1 of any Plan Year, must be made no later than July 15 of the immediately following Plan Year.

(d) Any Referee who makes a Retroactive Annuity Starting Date election described in paragraph (a) shall not receive any actuarial increase of his Pension Benefit, but shall receive a payment (or, if applicable, payments) which shall include an adjustment for interest from the applicable Retroactive Annuity Starting Date through the July 31 following such Retroactive Annuity Starting Date based upon a reasonable rate of interest determined by the Committee.

(e) Except as otherwise provided in this Section 8.8, the applicable requirements of this Article VIII shall apply to a Referee's election under paragraph (a) to receive payment of his Pension Benefit based upon a Retroactive Annuity Starting Date."

3. This amendment shall be effective as of June 1, 2013.

On this 29th day of May, 2014, NBA Services Corp. has executed this Second Amendment to the Plan.

NBA SERVICES CORP.

By: _____

Title: VP

THIRD AMENDMENT TO THE RESTATED NATIONAL BASKETBALL ASSOCIATION REFEREES' PENSION PLAN

WHEREAS, the Restated National Basketball Association Referees' Pension Plan (the "Plan") was restated effective as of June 1, 2012;

WHEREAS, under Section 18.1 of the Plan, NBA Services Corp. reserved the right to amend the Plan at any time;

WHEREAS, the First Amendment to the Plan was adopted on January 14, 2014;

WHEREAS, the Second Amendment to the Plan was adopted on May 29, 2014; and

WHEREAS, it is necessary to amend the Plan in order to provide for a definition of "Spouse" to include a legally married same-sex spouse in accordance with IRS Revenue Ruling 2013-17 and IRS Notice 2014-19.

NOW, THEREFORE, the Plan is hereby amended as set forth below:

1. Sections 1.30 through 1.34 of the Plan are hereby renumbered as Sections 1.31 to 1.35, and a new Section 1.30 is hereby added to the Plan to read in its entirety as follows:

> "1.30 'Spouse' shall mean, effective as of June 26, 2013, an individual married to a Participant if the marriage is legally entered into in a state pursuant to the laws of that state, without regard to whether such marriage is recognized in the state in which such couple is domiciled. For purposes of the foregoing, the term 'state' means any domestic or foreign jurisdiction having the legal authority to sanction marriages."

2. The Plan is amended to change all references therein of "spouse" to "Spouse", and to change all references therein of "non-spouse" to "non-Spouse".

3. This Third Amendment to the Plan shall be effective as of June 26, 2013.

On this 23 day of December, 2014, NBA Services Corp. has executed this Third Amendment to the Plan.

NBA SERVICES CORP.

By: _____

Title: VP

FOURTH AMENDMENT TO THE RESTATED NATIONAL BASKETBALL ASSOCIATION REFEREES' PENSION PLAN

WHEREAS, the Restated National Basketball Association Referees' Pension Plan (the "Plan") was restated effective as of June 1, 2012;

WHEREAS, under Section 18.1 of the Plan, NBA Services Corp. reserved the right to amend the Plan at any time;

WHEREAS, the First Amendment to the Plan was adopted on January 14, 2014;

WHEREAS, the Second Amendment to the Plan was adopted on May 29, 2014;

WHEREAS, the Third Amendment to the Plan was adopted on December 23, 2014; and

WHEREAS, it is necessary to amend the Plan in order to clarify the provisions of the Plan relating to (i) certain former Referees who are not employed by NBA Services Corp., an affiliate of NBA Services Corp. or by the National Basketball Association in any capacity between June 1, 2014 and their benefit commencement date under the Plan and (ii) certain former Referees who are employed by any of the foregoing entities in any capacity on or after June 1, 2014.

NOW, THEREFORE, the Plan is hereby amended as set forth below:

1. Section 1.20 of the Plan is hereby amended and restated to read in its entirety as follows:

> "1.20 'Normal Retirement Date' shall mean the earlier of (i) the last day of the month in which the Referee attains age 65 or (ii) the last day of the month in which the Referee has both attained age 62 and completed ten (10) Regular Seasons on the Referees' Roster. Notwithstanding the foregoing, with respect to a Referee (i) whose last Year of Referee Service for purposes of Article IV of the

Plan was with respect to a Regular Season prior to the 2009-2010 Regular Season, (ii) who is not employed by the Employer, an affiliate of the Employer or by the Association in any capacity at any time between June 1, 2014 and the date on which he receives or commences to receive payment of his benefit under the Plan, and (iii) who has completed ten (10) Regular Seasons on the Referees' Roster, 'Normal Retirement Date' shall mean the last day of the month in which the Referee has attained age 58."

2. Sections 4.1(s) through 4.1(v) of the Plan are hereby renumbered as Sections 4.1(u) through 4.1(x), and new Sections 4.1(s) and (t) are hereby added to the Plan to read in their entirety as follows:

"(s) Notwithstanding anything in this Article IV to the contrary, with respect to a Referee (i) who did not participate in the Plan on or before May 31, 1995, (ii) who had not yet received or commenced to receive payment of his benefit under the Plan as of June 1, 2003, (iii) whose last Year of Referee Service for purposes of Article IV of the Plan was with respect to a Regular Season prior to the 2004-2005 Regular Season, (iv) who is employed by the Employer, an affiliate of the Employer or by the Association in any capacity on or after June 1, 2014, and (v) who has completed ten (10) Regular Seasons on the Referees' Roster, such Referee's Normal Retirement Benefit shall be an annual amount equal to $5,944 multiplied by the Referee's Years of Referee Service.

(t) Notwithstanding anything in this Article IV to the contrary, with respect to a Referee (i) who participated in the Plan on or before May 31, 1995, (ii) who does not have an Employee Account maintained on his behalf under the Plan, (iii) who had not yet received or commenced to receive payment of his benefit under the Plan as of June 1, 2003, (iv) whose last Year of Referee Service for purposes of Article IV of the Plan was with respect to a Regular Season prior to the 2004-2005 Regular Season, (v) who is employed by the Employer, an affiliate of the Employer or by the Association in any capacity on or after June 1, 2014, and (vi) who has completed ten (10) Regular Seasons on the Referees' Roster, such Referee's Normal Retirement Benefit shall be equal to the greater of:

(i) an annual amount equal to $5,944 multiplied by the Referee's Years of Referee Service; or

(ii) the Actuarial Equivalent of the value of the Referee's Contribution Account based upon the value of such Contribution Account as of the last day of the Plan Year preceding the date on which

the Referee receives or commences to receive payment of his Normal Retirement Benefit under the Plan."

3. This Fourth Amendment to the Plan shall be effective as of June 1, 2014.

On this 26th day of May, 2015, NBA Services Corp. has executed this Fourth Amendment to the Plan.

NBA SERVICES CORP.

By: _____

Title: VP

FIFTH AMENDMENT TO THE RESTATED NATIONAL BASKETBALL ASSOCIATION REFEREES' PENSION PLAN

WHEREAS, the Restated National Basketball Association Referees' Pension Plan (the "Plan") was restated effective as of June 1, 2012;

WHEREAS, under Section 18.1 of the Plan, NBA Services Corp. reserved the right to amend the Plan at any time;

WHEREAS, the First Amendment to the Plan was adopted on January 14, 2014;

WHEREAS, the Second Amendment to the Plan was adopted on May 29, 2014;

WHEREAS, the Third Amendment to the Plan was adopted on December 23, 2014;

WHEREAS, the Fourth Amendment to the Plan was adopted on May 26, 2015; and

WHEREAS, pursuant to the Collective Bargaining Agreement between NBA Services Corp. and the National Basketball Referees Association, dated August 26, 2015, it has become necessary to further amend the Plan in order to provide that assignments in the NBA Replay Center during a Regular Season shall be taken into account for purposes of determining whether a Referee is considered to be on the Referees' Roster for such Regular Season.

NOW, THEREFORE, the Plan is hereby amended as set forth below:

1. The third sentence of Section 1.27 of the Plan is hereby amended and restated to read as follows:

> "For any Regular Season beginning after May 31, 2004, 'Referees' Roster' shall mean a list of all Referees who had been a Referee for 30 or more of a combination of Championship and Exhibition Games played during the Regular

Season involved; provided, however, that (i) for any Regular Season beginning after May 31, 2009, any games officiated by a Referee in a Developmental League under circumstances described in Article IX, Section 2(c) of the Collective Bargaining Agreement between NBA Services Corp. and the National Basketball Referees Association, dated October 27, 2009, shall be included in determining if the Referee shall be considered to be on the Referees' Roster for the Regular Season involved and (ii) for any Regular Season beginning after May 31, 2015, any assignments worked by a Referee in the NBA Replay Center during a Regular Season (whether in conjunction with Championship or Exhibition Games) shall be included in determining if the Referee shall be considered to be on the Referees' Roster for the Regular Season involved."

2. This Fifth Amendment to the Plan shall be effective on October 1, 2015.

On this 30th day of November, 2015, NBA Services Corp. has executed this Fifth Amendment to the Plan.

NBA SERVICES CORP.

By: _____

Title: VP

SIXTH AMENDMENT TO THE RESTATED NATIONAL BASKETBALL ASSOCIATION REFEREES' PENSION PLAN

WHEREAS, the Restated National Basketball Association Referees' Pension Plan (the "Plan") was restated effective as of June 1, 2012;

WHEREAS, under Section 18.1 of the Plan, NBA Services Corp. reserved the right to amend the Plan at any time;

WHEREAS, the First Amendment to the Plan was adopted on January 14, 2014;

WHEREAS, the Second Amendment to the Plan was adopted on May 29, 2014;

WHEREAS, the Third Amendment to the Plan was adopted on December 23, 2014;

WHEREAS, the Fourth Amendment to the Plan was adopted on May 26, 2015;

WHEREAS, the Fifth Amendment to the Plan was adopted on November 30, 2015; and

WHEREAS, it has become necessary to amend the Plan in order to provide for changes required by the Highway and Transportation Funding Act of 2014 with respect to the application of the benefit restrictions set forth in Section 436 of the Internal Revenue Code.

NOW, THEREFORE, the Plan is hereby amended as set forth below:

1. Section 11D.1(c) of the Plan is hereby amended and restated to read in its entirety as follows:

> "(c) Limitations Applicable If the Employer Is In Bankruptcy. Notwithstanding any other provisions of the Plan, a Referee or Beneficiary shall not be permitted to elect, and the Plan shall not pay, a single sum payment or other optional form of benefit that includes a Prohibited Payment with a Section 436 Annuity Starting Date that occurs during any period in which the Employer is a

debtor in a case under title 11, United States Code, or similar Federal or State law, except for payments made within a Plan Year with a Section 436 Annuity Starting Date that occurs on or after the date on which the Plan's enrolled actuary certifies that the Plan's AFTAP (determined without taking into account any adjustment of segment rates under Section 430(h)(2)(C)(iv) of the Code) for that Plan Year is not less than 100%. In addition, during such period in which the Employer is a debtor, the Plan shall not make any payment for the purchase of an irrevocable commitment from an insurer to pay benefits or any other payment or transfer that is a Prohibited Payment, except for payments that occur on a date within a Plan Year that is on or after the date on which the Plan's enrolled actuary certifies that the Plan's AFTAP (determined without taking into account any adjustment of segment rates under Section 430(h)(2)(C)(iv) of the Code) for that Plan Year is not less than 100%. The limitation set forth in this Section 11D.1(c) shall not apply to any payment of a benefit which under Code Section 411(a)(11) may be immediately distributed without the consent of the Referee."

2. This Sixth Amendment to the Plan shall be effective as of June 1, 2016.

On this 24th day of May, 2017, NBA Services Corp. has executed this Sixth Amendment to the Plan.

NBA SERVICES CORP.

By: _____

Title: VP

SEVENTH AMENDMENT TO THE RESTATED NATIONAL BASKETBALL ASSOCIATION REFEREES' PENSION PLAN

WHEREAS, the Restated National Basketball Association Referees' Pension Plan (the "Plan") was restated effective as of June 1, 2012;

WHEREAS, under Section 18.1 of the Plan, NBA Services Corp. reserved the right to amend the Plan at any time;

WHEREAS, the First Amendment to the Plan was adopted on January 14, 2014;

WHEREAS, the Second Amendment to the Plan was adopted on May 29, 2014;

WHEREAS, the Third Amendment to the Plan was adopted on December 23, 2014;

WHEREAS, the Fourth Amendment to the Plan was adopted on May 26, 2015;

WHEREAS, the Fifth Amendment to the Plan was adopted on November 30, 2015;

WHEREAS, the Sixth Amendment to the Plan was adopted on May 24, 2017; and

WHEREAS, it has become necessary to amend the Plan in order to clarify the provisions of the Plan concerning the valuation of the Employee Accounts held by certain Referees who participated in the Plan on or before May 31, 1995.

NOW, THEREFORE, the Plan is hereby amended as set forth below:

1. Section 4.1(v) of the Plan (as renumbered by the Fourth Amendment to the Plan) is hereby amended and restated to read in its entirety as follows:

> "(v) If the Referee participated in the Plan on or before May 31, 1995 and has an Employee Account maintained on his behalf under the Plan, his Normal Retirement Benefit shall be the sum of (i) the amount that the Referee would be entitled to receive under the applicable paragraph of this Section 4.1 as if an

Employee Account were not maintained on his behalf, plus (ii) the Actuarial Equivalent of the value of the Referee's Employee Account, based upon the value of such Employee Account as of the latest Valuation Date determined to be administratively practicable by the Committee for purposes of determining such Actuarial Equivalent (but no later than the Valuation Date immediately preceding the date on which the Referee receives or commences to receive payment of his Pension Benefit under the Plan)."

2. Section 4.1A(n) of the Plan is hereby amended and restated to read in its entirety as follows:

"(n) If the Referee participated in the Plan on or before May 31, 1995 and has an Employee Account maintained on his behalf under the Plan, his Normal Retirement Benefit shall be the sum of (i) the amount that the Referee would be entitled to receive under the applicable paragraph of this Section 4.1A as if an Employee Account were not maintained on his behalf, plus (ii) the Actuarial Equivalent of the value of the Referee's Employee Account, based upon the value of such Employee Account as of the latest Valuation Date determined to be administratively practicable by the Committee for purposes of determining such Actuarial Equivalent (but no later than the Valuation Date immediately preceding the date on which the Referee receives or commences to receive payment of his Pension Benefit under the Plan)."

3. Section 9.1(a)(ii) of the Plan is hereby amended and restated to read in its entirety as follows:

"(ii) If a married Referee who participated in the Plan on or before May 31, 1995 dies prior to the date as of which the Referee receives or commences to receive payment of his Pension Benefit, such Referee's surviving spouse or non-spouse Beneficiary (designated pursuant to paragraph (f) of this Section) shall be entitled to a benefit in an amount equal to: (A) the greater of (x) ten times the annual amount of the Referee's Accrued Benefit on the date of the Referee's death based upon the Years of Referee Service completed by the Referee to the date of his death, or (y) the value of the Referee's Contribution Account as of the last day of the Plan Year preceding the Referee's death; plus, if applicable (B) the value of the Referee's Employee Account as of the latest Valuation Date determined to be administratively practicable by the Committee for purposes of determining the amount to be paid to the Referee's surviving spouse or non-spouse Beneficiary (but no later than the Valuation Date immediately preceding the date on which the Referee's surviving spouse or Beneficiary receives or commences to receive payment of her benefit under the Plan)."

4. This Seventh Amendment to the Plan shall be effective as of June 1, 2017.

On this 31st day of May, 2018, NBA Services Corp. has executed this Seventh Amendment to the Plan.

NBA SERVICES CORP.

By: _____

Title: VP

EIGHTH AMENDMENT TO THE RESTATED NATIONAL BASKETBALL ASSOCIATION REFEREES' PENSION PLAN

WHEREAS, the Restated National Basketball Association Referees' Pension Plan (the "Plan") was restated effective as of June 1, 2012;

WHEREAS, under Section 18.1 of the Plan, NBA Services Corp. reserved the right to amend the Plan at any time;

WHEREAS, the First Amendment to the Plan was adopted on January 14, 2014;

WHEREAS, the Second Amendment to the Plan was adopted on May 29, 2014;

WHEREAS, the Third Amendment to the Plan was adopted on December 23, 2014;

WHEREAS, the Fourth Amendment to the Plan was adopted on May 26, 2015;

WHEREAS, the Fifth Amendment to the Plan was adopted on November 30, 2015;

WHEREAS, the Sixth Amendment to the Plan was adopted on May 24, 2017;

WHEREAS, the Seventh Amendment to the Plan was adopted on May 31, 2018; and

WHEREAS, it has become necessary to amend the Plan in order to provide for special rules relating to the determination of the "Referees' Roster" for the 2019-20 Regular Season (for purposes of vesting service and the 10-year service requirement for a normal retirement benefit at age 62) in accordance with the June 25, 2020 letter agreement amending the Collective Bargaining Agreement between NBA Services Corp. and the National Basketball Referees Association.

NOW, THEREFORE, the Plan is hereby amended as set forth below:

1. Section 1.27 of the Plan, as previously amended by the Fifth Amendment, is hereby amended and restated to read in its entirety as follows:

"1.27 'Referees' Roster' shall mean:

(a) For a Regular Season ending on or before May 31, 1971, a list of all Referees who had been a Referee for 40 or more of the Championship Games played during the Regular Season involved.

(b) For a Regular Season ending between May 31, 1972 and May 31, 2004, a list of all Referees who had been a Referee for 40 or more of a combination of Championship Games and Exhibition Games played during the Regular Season involved; provided, however, that for the Regular Season commencing on February 5, 1999 (and only for such Regular Season), 'Referees' Roster' shall mean a list of all Referees who had been a Referee for 25 or more of a combination of Championship Games and Exhibition Games played during such Regular Season.

(c) For any Regular Season beginning after May 31, 2004, a list of all Referees who had been a Referee for 30 or more of a combination of Championship and Exhibition Games played during the Regular Season involved. Notwithstanding the foregoing:

(i) For any Regular Season beginning after May 31, 2009, any games officiated by a Referee in a Developmental League under circumstances described in Article IX, Section 2(c) of the Collective Bargaining Agreement between NBA Services Corp. and the National Basketball Referees Association, dated October 27, 2009, shall be included in determining if the Referee shall be considered to be on the Referees' Roster for the Regular Season involved.

(ii) For any Regular Season beginning after May 31, 2015, any assignments worked by a Referee in the NBA Replay Center during a Regular Season (whether in conjunction with Championship or Exhibition Games) shall be included in determining if the Referee shall be considered to be on the Referees' Roster for the Regular Season involved.

(iii) For the Regular Season commencing on September 30, 2019 (the '2019-20 Regular Season'), 'Referees' Roster' shall mean a list of all Referees who perform officiating services for thirty (30) or more of a combination of (A) Championship Games (which shall include Seeding Games and Scrimmages, provided that any half-Scrimmage worked shall be counted as a half-game) and Exhibition Games played and (B) NBA

Replay Center assignments worked during the 2019-20 Regular Season (including assignments worked through August 14, 2020).

(d) If and to the extent required by applicable law, 'Referees' Roster' shall also include any Referee who (i) terminates his or her employment to enter the Armed Forces of the United States and (ii) is not otherwise considered to be on the Referees' Roster for the Regular Season involved.

(e) For purposes of Section 1.27(c)(iii) and this paragraph (e), the following definitions shall apply:

(i) 'Orlando Campus' means the grounds of the ESPN Wide World of Sports Complex and any hotels or other areas on the same geographic footprint in Orlando, Florida.

(ii) 'Scrimmage' means a competition involving one or more Teams that is held on the Orlando Campus prior to the first Seeding Game.

(iii) 'Seeding Game' means a game between Teams that is played during the period from July 30, 2020 to August 14, 2020 and that is included with each Team's Regular Season record to determine a Team's qualification for the Association's playoffs.

(iv) 'Team' means a member team of the Association."

2. Section 1.28 of the Plan is hereby amended by adding the following sentence at the end thereof:

"Notwithstanding the foregoing, only with respect to the Association's 2019-20 season, 'Regular Season' shall mean the period beginning on September 30, 2019 and ending on August 14, 2020."

3. This Eighth Amendment to the Plan shall be effective as of June 25, 2020.

On this ___6th_ day of _____November_____, 2020, NBA Services Corp. has executed this Eighth Amendment to the Plan.

NBA SERVICES CORP.

By: _____

Title: Vice President

THE NBA RETIREMENT PLAN FOR REFEREES

As Restated and Amended Effective October 1, 2012

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THE NBA RETIREMENT PLAN FOR REFEREES

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XII. AMENDMENT, TERMINATION AND DISCONTINUANCE OF CONTRIBUTIONS

XIII MISCELLANEOUS

PREAMBLE

THE NBA RETIREMENT PLAN FOR REFEREES

WHEREAS, prior to October 1, 2010, eligible Referees participated in the NBA Retirement Plan;

WHEREAS, on October 27, 2009, NBA Services Corp. and the National Basketball Referees Association entered into a collective bargaining agreement (the "CBA"), which provided for NBA Services Corp. to establish and maintain a profit sharing plan qualified under Section 401(a) of the Internal Revenue Code with terms and conditions that are substantially similar to the terms and conditions of the NBA Retirement Plan;

WHEREAS, pursuant to the CBA, NBA Services Corp. established the NBA Retirement Plan for Referees (the "Plan") for the benefit of eligible Referees, effective October 1, 2010;

WHEREAS, in connection with the establishment of the Plan, all of the assets and liabilities associated with the account balances of the Referees in the NBA Retirement Plan (including all outstanding loan balances attributable thereto) were transferred from the NBA Retirement Plan to the Plan;

WHEREAS, under Section 12.1(a) of the Plan, the Employer reserves the right to amend the provisions of the Plan;

WHEREAS, in connection with the required on-cycle determination letter submission rules as provided under the IRS determination letter procedures set forth in Rev. Proc. 2007-44, it is necessary to amend and entirely restate the Plan in order to (i) incorporate the

amendments that have previously been made to the Plan, (ii) incorporate the applicable statutory and regulatory changes, (iii) provide for the amendments required by the IRS Cumulative List set forth in Notice 2011-97, and (iv) make certain other changes to the Plan.

NOW, THEREFORE, effective October 1, 2012, the Plan is hereby amended and restated as set forth herein.

ARTICLE I

DEFINITIONS

1.1 "Account Balance" shall mean the sum of the account balances in the Participant's Before Tax Savings Contribution Account and, if applicable, the Participant's Employer Contribution Account, Rollover Contribution Account, QNEC Contribution Account and/or Catch-Up Contribution Account.

1.2 "Adjusted Compensation" shall mean an Employee's wages within the meaning of Section 3401(a) of the Code (without regard to any rules under Section 3401(a) that limit the remuneration included in wages based on the nature or location of the employment or services performed) received by an Employee during a Plan Year and all other payments of compensation to the Employee during the Plan Year for which the Employer is required to furnish a written statement under Sections 6041(d), 6051(a)(3) and 6052 of the Code. Adjusted Compensation shall not include wages or other payments which are received by an Employee following a severance from employment for any reason, provided, however, that Adjusted Compensation shall include wages and other compensation which would have been paid to the Employee prior to a severance from employment if the Employee had continued in employment with the Employer, and payments for unused accrued bona fide vacation leave that the Employee would have been able to use if the Employee had continued in employment with the Employer, if such amounts described herein are received by an Employee following a severance from employment by the later of (i) two and one-half (2-1/2) months after the Employee's severance from employment with the Employer, or (ii) the end of the Limitation Year that includes the date of the Employee's severance from employment with the Employer.

1.3 "Adjustment Factor" shall mean the cost of living adjustment factor prescribed by the Secretary of the Treasury under Section 415(d) of the Code, as applied to such items and in such manner as the Secretary shall provide.

1.4 "Affiliate" shall mean with respect to the Employer, any corporation which is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Section 414(c) of the Code) with the Employer; and any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Section 414(m) of the Code) which includes the Employer.

1.5 "Anniversary Date" shall mean October 1, 2010 and each October 1 of each subsequent year.

1.6 "Annual Additions" shall mean the total of all Before Tax Savings Contributions and Employer Contributions credited to each Participant under this Plan for each Limitation Year. To the extent applicable, Annual Additions shall also include amounts described in Sections 415(l) and 419A(d)(2) of the Code.

1.7 "Association" shall mean the National Basketball Association and its successors.

1.8 "Base Salary" shall mean the annual base salary a Referee is scheduled to receive pursuant to Article IV, Section 1 of the CBA.

1.9 "Before Tax Savings Contributions" shall mean the amounts contributed to the Plan in accordance with Section 3.1.

1.10 "Before Tax Savings Contribution Account" shall mean the account of a Participant established and maintained in accordance with Section 3.5.

1.11 "Beneficiary" shall mean the person, legal representative, estate or trust designated under Article VIII to receive payments on account of the death of the Participant.

1.12 "CBA" shall mean the collective bargaining agreement between NBA Services Corp. and the National Basketball Referees Association, dated September 1, 2011.

1.13 "Catch-Up Contributions" shall mean the amounts contributed to the Plan in accordance with Section 3.3.

1.14 "Catch-Up Contribution Account" shall mean the separate account of a Participant established and maintained in accordance with Section 3.5.

1.15 "Championship Game" shall mean any game included in the National Basketball Association's schedule of Championship Games and shall not include Playoff Games or Exhibition Games.

1.16 "Code" shall mean the Internal Revenue Code of 1986, as amended.

1.17 "Committee" shall mean the NBA Retirement Plan for Referees Committee, which administers the Plan pursuant to Article X.

1.18 "Compensation" shall mean:

(a) Base Salary paid by the Employer during a Plan Year for services as a Referee, including Before Tax Savings Contributions under this Plan, any pre-tax salary reduction contributions under a Code Section 125 plan and any pre-tax salary reduction amounts under a Code Section 132(f) transportation program. Compensation shall not include any other amounts (excepting Base Salary) that may be payable to a Referee under the CBA or otherwise payable to a Referee.

(b) Notwithstanding anything contained in this Section 1.18, Compensation shall not include Base Salary or other payments which are received by Referee following a

severance from employment for any reason; provided, however, that Compensation shall include Base Salary which would have been paid to the Referee prior to a severance from employment if the Referee had continued in employment with the Employer, if such Base Salary is paid to the Referee by the later of (i) two-and-one-half (2-1/2) months after the Referee's severance from employment with the Employer, or (ii) the end of the Limitation Year that includes the date of the Referee's severance from employment.

1.19 "Disability" shall mean the inability of a Referee to engage in his customary activity for the Employer by reason of any physical or mental impairment which can be expected to result in death or be of continuous and indefinite duration, as certified from time to time by a physician selected by the Committee.

1.20 "Effective Date" shall mean October 1, 2010.

1.21 "Employee" shall mean any person hired by the Employer as an employee. For purposes of this Plan, an Employee shall not include (i) any person retained directly or through a third party agency, to perform services for the Employer (for either a definite or indefinite duration) in the capacity of a temporary service worker, leased worker, independent contractor, consultant or any similar capacity; or (ii) any Leased Employee.

1.22 "Employer" shall mean NBA Services Corp. and its Affiliates and successors thereto.

1.23 "Employer Contributions" shall mean the contributions made by the Employer in accordance with Section 3.2.

1.24 "Employer Contribution Account" shall mean the separate account of a Participant established and maintained in accordance with Section 3.5.

1.25 "Employment Commencement Date" shall mean the first date on which an Employee (or a returning Employee) completes an Hour of Service.

1.26 "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.27 "Exhibition Game" shall mean any game other than a Championship Game or Playoff Game.

1.28 "Fund" shall mean all funds and assets held and administered by the Trustee at any time under the Trust, out of which payments under this Plan shall be made.

1.29 (a) "Highly Compensated Employee" shall mean, with respect to the Employer, an Employee who performed services for the Employer during the "determination year" and at any time during the "determination year" or the "look-back year" was a 5% owner of the Employer or any Affiliate, or who, during the "look-back year," received Adjusted Compensation from the Employer or any Affiliate in excess of $110,000 (as adjusted by the Adjustment Factor in accordance with Section 414(q)(1) of the Code).

(b) For purposes of this Section 1.29: (i) the "determination year" shall be the Plan Year for which compliance is being tested, (ii) the "look-back year" shall be the calendar year that begins with the 12-month period immediately preceding the determination year, and (iii) "Adjusted Compensation" shall include Before Tax Savings Contributions, any pre-tax salary reduction contributions under a Code Section 125 plan and any pre-tax salary reduction amounts under a Code Section 132(f) transportation program.

(c) The determination of who is a Highly Compensated Employee and the Adjusted Compensation that is considered shall be made in accordance with Section 414(q) of the Code and the Regulations thereunder.

1.30 "Hour of Service" shall mean:

(a) Each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer during the first twelve month period beginning on the Employee's Employment Commencement Date and any Plan Year beginning with the Plan Year that includes the anniversary of such date.

(b) Each hour for which an Employee is paid, or entitled to payment, by the Employer on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty or military duty. Notwithstanding the preceding sentence, no more than 501 Hours of Service shall be credited under this paragraph (b) to an Employee on account of any single continuous period during which the Employee performs no duties. The determination of Hours of Service for reasons other than the performance of duties, and the crediting of such hours, shall be made in accordance with the rules provided by Department of Labor Reg. §§2530.200b-2(b) and (c).

(c) Each hour for which back pay, irrespective of mitigation of damages, is either awarded or agreed to by the Employer. The same Hours of Service shall not be credited both under paragraph (a) or paragraph (b), as the case may be, and under this paragraph. Crediting of Hours of Service for back pay awarded or agreed to with respect to periods described in paragraph (b) shall be subject to the limitations set forth in that paragraph.

1.31 "Investment Funds" shall mean the investment funds provided for in Section 11.2.

1.32 "Leased Employee" shall mean any individual who is not an Employee and who provides services to the Employer if (i) such services are provided pursuant to an agreement between the Employer and a leasing organization; (ii) such individual has performed services for

the Employer on a substantially full time basis for a period of at least one year; and (iii) such services are performed under the primary direction and control by the Employer.

1.33 "Limitation Year" shall mean the 12-month period corresponding with the Plan Year.

1.34 "Named Fiduciary" shall mean the Committee.

1.35 "Nonhighly Compensated Employee" shall mean an Employee of the Employer who is not a Highly Compensated Employee.

1.36 "Normal Retirement Date" shall mean the earlier of (i) the first day of the month in which the Referee attains age 65 or (ii) the first day of the month in which the Referee has both attained age 62 and completed ten (10) Regular Seasons on the Referee's Roster.

1.37 (a) "One-Year Period of Severance" shall mean a 12-month period beginning on the Severance from Service Date and ending on the first anniversary of such Severance from Service Date during which the Employee fails to perform an Hour of Service.

(b) For purposes only of determining whether an Employee has incurred a One Year Period of Severance,

(i) an Employee who is absent from work for maternity or paternity reasons shall not attain a Severance from Service Date until the second anniversary of the first date of such absence. For purposes of this paragraph, an absence from work for maternity or paternity reasons means an absence (A) by reason of the pregnancy of the Employee, (B) by reason of a birth of a child of the Employee, (C) by reason of the placement of a child with the Employee in connection with the adoption of such child by such Employee, or (D) for purposes of caring for such child for a period beginning immediately following such birth or placement. This paragraph shall not apply unless

such Employee furnishes to the Committee such timely information as the Committee may require to establish that the absence from employment is for the reasons described above and to establish the period for which there was such an absence; and

(ii) the entire period of an Employee's employment with the Employer or the Association, in any capacity, will be taken into account.

1.38 "Participant" shall mean any Referee who participates in the Plan as provided in Article II hereof. A Participant shall continue to be a Participant as long as he has an Account Balance hereunder. Notwithstanding anything contained herein, a Participant shall cease to be a Participant if he is deemed to have received a distribution of his Account Balance in accordance with Section 7.4(h) hereof.

1.39 "Pension Plan" shall mean the Restated National Basketball Association Referee's Pension Plan.

1.40 "Plan" shall mean the NBA Retirement Plan for Referees, as amended and restated herein.

1.41 "Plan Administrator" shall mean the Committee.

1.42 "Plan Transfer Effective Date" shall mean the date after the Effective Date on which the assets and liabilities associated with the account balances of the Referees in the NBA Retirement Plan (including all outstanding loan balances attributable thereto) were transferred from the NBA Retirement Plan to the Plan.

1.43 "Plan Year" shall mean any twelve-month period beginning on October 1 of any calendar year and ending on September 30 of the next calendar year.

1.44 "Playoff Game" shall mean any game included in the National Basketball Association's schedule of Playoff Games and shall not include Championship Games or Exhibition Games.

1.45 "Qualified Nonelective Contributions" shall mean the contributions made by the Employer in accordance with Section 3.7.

1.46 "QNEC Contribution Account" shall mean the separate account of a Referee established and maintained in accordance with Section 3.5.

1.47 "Referee" shall mean any person under contract with the Employer for performing officiating services in a Championship Game or an Exhibition Game, or where the context permits, a person who formerly performed such services. In no event shall any individual employed by a Developmental League as a Referee be considered a Referee under the Plan while so employed. For purposes of the Plan, Developmental League shall mean the NBA Development League or any other developmental basketball league that is affiliated with the Association.

1.48 "Referees' Roster" shall mean a list of all Referees who had been a Referee for thirty (30) or more of a combination of Championship and Exhibition Games played during the Regular Season involved; provided, however, that for the Plan Year commencing on October 1, 2011 and ending on September 30, 2012 (the "2012 Plan Year") and for the Regular Season commencing on December 25, 2011 (the "2011-2012 Regular Season"), "Referees' Roster" shall mean a list of all Referees who had been a Referee for twenty-four (24) or more of a combination of Championship and Exhibition Games played during the 2011-2012 Regular Season. Notwithstanding the foregoing, any games officiated by a Referee in a Developmental League under circumstances described in Article III, Section 8 of the CBA or Article IX, Section 2(c) of

the CBA, shall be included in determining if the Referee shall be considered to be on the Referees' Roster for the Regular Season involved. "Referees' Roster" shall also include any Referee who terminates his employment to enter the Armed Forces of the United States, who is not otherwise considered to be on the Referees' Roster for the Regular Season involved, if and to the extent that, applicable law requires the Referee to be so treated.

1.49 "Regular Season" shall mean the period beginning on the date of the first game of the Employer's schedule of Exhibition Games during the year involved and ending on the last day of regular season (as opposed to playoff) competition among or between Teams of the Association.

1.50 "Required Beginning Date" shall mean April 1 of the calendar year following the calendar year in which the Participant reaches age 70-1/2.

1.51 "Restatement Effective Date" shall mean, except as otherwise provided herein, October 1, 2012.

1.52 "Retirement" shall mean a Termination of Employment on or after a Participant's Normal Retirement Date.

1.53 "Rollover Contributions" shall have the meaning set forth in Section 3.4.

1.54 "Rollover Contribution Account" shall mean the separate account of a Referee established and maintained in accordance with Section 3.5.

1.55 (a) "Severance from Service Date" shall mean the earliest of (i) the day on which an Employee quits, retires, is discharged or dies or (ii) the first anniversary of a Period of Absence.

(b) An Employee who is absent on account of an Approved Absence shall not be considered to have attained a Severance from Service Date as a result of such absence;

provided, however, that this paragraph shall not apply unless the Employee returns to work on the first working day following the expiration of such Approved Absence.

(c) For purposes of paragraph (b), an Approved Absence shall mean a leave of absence granted by the Employer under rules uniformly applicable to all Employees similarly situated. An Approved Absence shall be granted for such purposes as vacation, military service in the Armed Forces of the United States, layoff or sickness. An Approved Absence shall not exceed twenty-four (24) consecutive months, or, in the case of a Participant in military service of the Armed Forces of the United States, that period during which his re-employment rights are protected by law.

(d) For purposes of this paragraph, "Period of Absence" shall mean an absence from service of twelve (12) months or less, with or without pay, for any reason other than a quit, discharge, Retirement or death.

1.56 "Termination of Employment" shall mean the voluntary severance from employment of a Referee, or the involuntary severance from employment of an Employee by the Employer, other than severance from employment by reason of death or Retirement under this Plan. For purposes of this Plan, an Employee shall not be considered to have a Termination of Employment until such Employee is no longer employed by the Employer or any Affiliate of the Employer in any capacity.

1.57 "Trust" shall mean the legal agreement between the Employer and the Trustee, fixing the rights and liabilities of each with respect to managing and controlling the Fund for the purposes of the Plan.

1.58 "Trustee" shall mean the trustee or trustees designated under the Trust.

1.59 "Valuation Date" shall mean each business day of the calendar year.

1.60 "Vested Account Balance" or "Vested Percentage" shall mean the portion of a Participant's Account Balance that is nonforfeitable under the Plan.

1.61 "Years of Referee Service" shall mean the number of Regular Seasons for which a Referee is on the Referees' Roster. In determining Years of Referee Service for the sole purpose of calculating a Referee's Vested Employer Contribution Account under Section 7.4, the Referee's entire "Period of Service" with the Employer and with the Association shall be taken into account. For purposes of the preceding sentence:

(a) "Period of Service" shall mean a period of time commencing on the date on which the Referee is employed by the Employer or the Association in any capacity (the "employment commencement date") and ending on the date that he is no longer employed by either the Employer or the Association ("severance from service date");

(b) All such Periods of Service shall, if noncontinuous, be aggregated and less than whole year Periods of Service (whether or not consecutive) shall be aggregated on the basis that twelve (12) months of such service equal a Year of Referee Service; and

(c) A Terminated Referee shall be credited with a full month of service for any fractional month which includes his employment commencement date or his severance from service date.

(d) Notwithstanding anything herein to the contrary, as of the Effective Date, each "Year of Referee Service" credited to a Referee under the Pension Plan as of September 30, 2010 shall constitute a Year of Referee Service credited to such Referee under the Plan for purposes of eligibility, vesting, and determining the amount of any Employer Contribution to be made on behalf of such Referee under the Plan pursuant to Section 3.2.

ARTICLE II

ELIGIBILITY AND PARTICIPATION

2.1 Eligibility to Participate.

(a) A Referee shall be eligible to participate in the Before Tax Savings Contribution portion of the Plan, subject to the terms hereunder.

(b) A Referee shall be eligible to participate in the Employer Contribution portion of the Plan, subject to the terms hereunder.

2.2 Participation in Before Tax Savings Contribution Portion of Plan.

(a) Any Referee who is a Participant in the Before Tax Savings Contribution portion of the Plan on the Restatement Effective Date shall continue as a Participant in such portion of the Plan, subject to the terms hereunder.

(b) Any individual who becomes a Referee after the Restatement Effective Date may become a Participant in the Before Tax Savings Contribution portion of the Plan as of the first day of any payroll period after becoming a Referee in accordance with paragraph (c) of this Section 2.2.

(c) A Referee who is not a Participant in the Before Tax Savings Contribution portion of the Plan may elect to become a Participant in the Before Tax Savings Contribution portion of the Plan by authorizing Before Tax Savings Contributions to the Plan in accordance with Section 3.1.

(d) A Participant, or any other Referee, who ceases to be a Referee, shall again become eligible to become a Participant in the Before Tax Savings Contribution portion of the Plan as of the first day of any payroll period following the first date on which he again becomes a Referee.

2.3 Participation in Employer Contribution Portion of Plan.

(a) Any Referee who is a Participant in the Employer Contribution portion of the Plan on the Restatement Effective Date, shall continue as a Participant in such portion of the Plan, subject to the terms hereunder

(b) Any individual who becomes a Referee after the Restatement Effective Date shall become a Participant in the Employer Contribution portion of the Plan on the Anniversary Date of the first Plan Year during which he is on the Referees' Roster for a Regular Season.

(c) (i) A former Referee who had participated in the Plan and who again becomes a Referee after having terminated his employment with the Employer shall again participate in the Plan as of the first Anniversary Date of the Plan Year in which he resumes employment, provided that he is on the Referee's Roster during the Plan Year in which he resumes employment; and

(ii) A former Referee who had participated in the Pension Plan and becomes a Referee after having terminated his employment with the Employer shall participate in the Plan as of the first Anniversary Date of the Plan Year in which he resumes employment, provided that he is on the Referee's Roster during the Plan Year in which he resumes employment.

ARTICLE III

CONTRIBUTIONS

3.1 Before Tax Savings Contributions.

(a) (i) Each Referee who is eligible to participate in the Before Tax Savings Contribution portion of the Plan may elect to become a Participant as of the first day of any payroll period by authorizing the Employer (on the appropriate election form) to reduce his Compensation for a Plan Year by an amount equal to from one percent (1%) to twenty-five percent (25%) (in whole percentages) of such Compensation and to have such amount deposited to the Plan as a Before Tax Savings Contribution hereunder. The percent limitations described above shall not apply to any Catch-Up Contributions made pursuant to Section 3.3.

(ii) Each such Referee shall make an election prior to the first day of any payroll period as of which he elects to become a Participant. The Referee's election shall specify the percentage of his Compensation for each payroll period that is to be contributed to the Plan as a Before Tax Savings Contribution. The amount contributed to the Plan shall be credited to the Participant's Before Tax Savings Contribution Account. The election of the Participant shall remain in effect unless a new election is made by the Participant in accordance with paragraph (b) of this Section or Contributions are suspended in accordance with paragraph (c) of this Section 3.1.

(iii) For purposes of this Section 3.1, "Compensation" shall mean Compensation as defined in Section 1.18, but shall be limited to amounts received by the

Participant for the period of time during which an election to make Before Tax Savings Contributions hereunder is in effect. Notwithstanding anything contained herein, in no event shall any Participant's Compensation taken into account under this Section 3.1(a)(iii) exceed such Participant's Compensation as defined under Section 415(c)(3) of the Code.

(iv) The amount of any Before Tax Savings Contribution that a Participant may make for any payroll period shall be determined without regard to the Plan Year compensation limitation set forth in Section 4.8; provided, however, that in no event shall the sum of a Participant's Before Tax Savings Contributions for a Plan Year exceed twenty-five percent (25%) of a Referee's Compensation, determined taking into account the Plan Year Compensation limitation of Section 4.8 in effect for that Plan Year.

(v) Except as necessary in response to an occasional and bona fide administrative consideration, a Before Tax Savings Contribution shall not be made (A) prior to the performance of services which relate to the Before Tax Savings Contribution; or (B) prior to the date that the Compensation, which a Referee has elected to defer pursuant to Section 3.1(a)(i), is currently available to the Referee.

(b) A Participant may elect to increase or decrease his Before Tax Savings Contributions as of the first day of any subsequent payroll period by giving notice in such form as the Committee may require. Such increase or decrease shall become effective as soon as practicable after the Committee receives notification of such change.

(c) A Participant may elect to suspend his Before Tax Savings Contributions effective as of the first day of any subsequent payroll period, by giving notice in such form as the Committee may require. Before Tax Savings Contributions so suspended may not be subsequently made up. A Participant may elect, by giving notice in such form as the Committee may require, to recommence Before Tax Savings Contributions to the Plan as soon as practicable following such election, but in any event no earlier than the beginning of the first payroll period which follows such election. Before Tax Savings Contributions shall cease automatically when a Participant ceases to be a Referee.

(d) A Participant shall be fully vested at all times in his Before Tax Savings Contribution Account.

3.2 Employer Contributions.

(a) In addition to any Before Tax Savings Contributions to be made for a Plan Year, the Employer shall make an Employer Contribution to the Plan for each Plan Year on behalf of those Referees who have satisfied the requirements of Section 2.3 and have been credited with a Year of Referee Service during such Plan Year. Employer Contributions made under this Section 3.2 are intended to be contributions to a profit sharing plan under Code Section 401(a)(27)(B) that are being made in accordance with Code Section 401(a)(27)(A) without regard to current or accumulated profits of the Employer.

(b) (i) The amount of the Employer Contribution to be made by the Employer for the Plan Year commencing on October 1, 2010 and ending on September 30, 2011 on behalf of each Referee described in paragraph (a), that was eligible to receive an Employer Contribution for such Plan Year shall be equal to:

(A) with respect to an individual who first became (or was rehired as) a Referee for the Regular Season commencing in 2010, one and one-half percent (1½%) of the Referee's Base Salary for such Plan Year times the number of Years of Referee Service that such Referee had been credited with the end of such Plan Year; provided, however, that in no event shall the amount to be contributed on behalf of a Referee under this Section exceed fifteen percent (15%) of such Referee's Base Salary for any such Plan Year.

(B) with respect to a Referee (a) who was credited with a Year of Referee Service under the Pension Plan for the Regular Season commencing in 2009 and (b) who had been credited with a total of thirteen (13) or less Years of Referee Service as of the last day of the Regular Season commencing in 2010, two percent (2%) of the Referee's Base Salary for such Plan Year times the number of Years of Referee Service that such Referee had been credited with the end of such Plan Year, provided, however, that in no event shall the amount to be contributed on behalf of a Referee under this Section exceed twenty percent (20%) of such Referee's Base Salary for such Plan Year.

(C) with respect to a Referee (a) who was credited with a Year of Referee Service under the Pension Plan for the Regular Season commencing in 2009 and (b) who had been credited with a total of fourteen (14) or more Years of Referee Service as of last day of the Regular Season commencing in 2010, fifteen percent (15%) of the Referee's Base Salary for such Plan Year.

(ii) The amount of the Employer Contribution to be made by the Employer for Plan Years commencing on or after October 1, 2011 on behalf of each

Referee described in paragraph (a), that is eligible to receive an Employer Contribution for the Plan Year shall be equal to:

(A) with respect to an individual who first becomes (or is rehired as) a Referee for the Regular Season commencing in 2011 or any Regular Season thereafter, one and one-half percent (1½%) of the Referee's Base Salary for such Plan Year times the number of Years of Referee Service that such Referee had been credited with the end of such Plan Year; provided, however, that in no event shall the amount to be contributed on behalf of a Referee under this Section exceed fifteen percent (15%) of such Referee's Base Salary for any such Plan Year.

(B) with respect to a Referee who was credited with a Year of Referee Service under the Plan for the Regular Season commencing in 2010 (or who received salary continuation for the entire Regular Season which commenced in 2010), two percent (2%) of the Referee's Base Salary for such Plan Year times the number of Years of Referee Service that such Referee had been credited with the end of such Plan Year, provided, however, that in no event shall the amount to be contributed on behalf of a Referee under this Section exceed twenty percent (20%) of such Referee's Base Salary for any such Plan Year.

(iii) In determining the Employer Contribution to be made under this Section 3.2, (a) every Year of Referee Service credited to a Referee under the Plan; and (b) each "Year of Referee Service" credited to a Referee under the Pension Plan as of September 30, 2010, shall constitute a Year of Referee Service credited to such Referee

under the Plan for purposes of determining the amount of any Employer Contribution to be made on behalf of a Referee under the Plan for a Plan Year.

(iv) For the Plan Year commencing on October 1, 2011 and ending on September 30, 2012, the amount of the Employer Contribution to be made by the Employer on behalf of each Referee described in paragraph (a) that is eligible to receive an Employer Contribution for such Plan Year (taking into account the definition of Referees' Roster under Section 1.48(b)), shall be equal to the applicable amount determined under Section 3.2(b)(ii)(A) or 3.2(b)(ii)(B) multiplied by 0.8049.

(v) For purposes of this Section, "Base Salary" shall mean Base Salary as defined in Section 1.8; provided, however, that "Base Salary" of a Referee shall be limited to amounts received by the Referee for the period of time during which he was employed by the Employer as a Referee.

3.3 Catch-Up Contributions. Each Referee who is eligible to make Before Tax Savings Contributions to the Plan pursuant to Section 3.1 who has attained age 50 before the end of a taxable year shall be eligible to make a Catch-Up Contribution in accordance with, and subject to the limitations of, Section 414(v) of the Code. Such Catch-Up Contributions shall not be taken into account for purposes of the limitations provided in Sections 4.1 and 4.7 of the Plan. The Plan shall not be treated as failing to satisfy the provisions of the Plan implementing the requirements of Sections 401(k)(3), 410(b) or 416 of the Code, as applicable, by reason of the making of such Catch-Up Contributions. Any Catch-Up Contributions made under the Plan on behalf of a Referee shall be credited to such Referee's Catch-Up Contribution Account. A Referee shall be fully vested at all times in his Catch-Up Contribution Account.

3.4 Rollover Contributions.

(a) The term "Rollover Contribution" shall mean

(i) a distribution from a qualified plan described in Sections 401(a) and 403(a) of the Code; an annuity contract described in Section 403(b) of the Code; or an eligible plan under Section 457(b) of the Code which is maintained by a state, political subdivision of a state, or any agency or instrumentality of a state or political subdivision of a state; or

(ii) a distribution from an individual retirement account described in Section 408(a) of the Code or an individual retirement annuity described in Section 408(b) of the Code.

Notwithstanding the foregoing, the term Rollover Contribution shall not include any distribution from a plan, annuity contract, individual retirement account or individual retirement annuity, which would not be fully includible in the gross income of the Participant if the distribution was not treated as a Rollover Contribution.

(b) Upon the request of a Referee (in a manner designated by the Committee), the Committee shall direct the Trustee to receive and accept funds constituting a Rollover Contribution from or on behalf of such Referee. Such request shall set forth the amount of the Rollover Contribution and the facts establishing that such amount constitutes a Rollover Contribution within the meaning of paragraph (a) of this Section 3.4. In no event shall the Trustee be obliged to (i) accept any funds as a Rollover Contribution if, upon advice of counsel, the receipt thereof could jeopardize the qualified or exempt status of the Plan or Trust, or (ii) accept property as a Rollover Contribution.

(c) A Rollover Contribution shall become part of the Fund, as of the date such contribution is made, subject to the following provisions:

(i) A Rollover Contribution shall be credited to the Rollover Contribution Account of the Referee on whose behalf such contribution is made. Such account shall be maintained as a separate account in addition to any other accounts for such Referee.

(ii) A Referee's interest in the Fund represented by his Rollover Contribution Account shall be distributed in full or segregated at the same time and in the same manner as such Referee's interest in the Fund as provided in Article VII.

(iii) A Referee shall be fully vested at all times in his Rollover Contribution Account.

3.5 Maintenance of Accounts for Each Participant. The Committee shall maintain (as applicable) a separate "Before Tax Savings Contribution Account," "Employer Contribution Account," "Rollover Contribution Account," "QNEC Contribution Account" and/or "Catch-Up Contribution Account" in the name of each Participant. The maintenance of separate accounts shall not require a segregation of assets and shall not in any way limit the powers of the Trustee or the Committee with respect to the operation of the Fund. Such accounts shall at all times reflect the Account Balance of such Participant (or his Beneficiary); and the Account Balance of a Participant on any date shall equal the sum of the balances in his accounts as of such date.

3.6 Irrevocable Divestiture by the Employer.

(a) Except as provided in Article IV and paragraphs (b) and (c) of this Section 3.6, and notwithstanding any other provision of this Plan or of the Trust to the contrary, the

Employer irrevocably divests itself of any interest or reversion whatsoever in any sums contributed by the Employer to the Fund, and it shall be impossible for any portion of the Fund to be used for, or diverted to, any purpose other than the exclusive benefit of Participants or their Beneficiaries and for payment of reasonable administrative expenses as provided in Section 15.4.

(b) If a contribution is made to the Plan due to a mistake of fact, such contribution shall be refunded to the Employer that made the mistaken contribution within one year of such contribution. Refunds of contributions due to a mistake of fact shall be governed by the following requirements:

(i) Earnings attributable to the amount being refunded shall remain in the Plan, but losses thereto must reduce the amount to be refunded.

(ii) In no event may a refund be made that would cause the Account Balance of any Participant to be reduced to less than what the Participant's Account Balance would have been had the mistaken amount not been contributed.

(c) All contributions by the Employer are conditioned upon their deductibility under Section 404 of the Code, and if part or all of the deduction for any contribution is disallowed, the contribution, to the extent disallowed, shall be returned to the Employer that made such contribution within one year after the disallowance of the deduction.

(d) If the Commissioner of Internal Revenue initially determines that the Plan and Trust as presently constituted or as amended prior to such determination do not qualify under Section 401(a) of the Code, (i) all Before Tax Savings Contributions made by the Employer on behalf of Participants, and all assets of the Fund attributable to such contributions, shall be returned to the Participants on whose behalf the Employer made such contributions, (ii) all

Employer Contributions made by the Employer, and all assets of the Fund attributable to such contributions, shall be returned to the Employer, and (iii) any Rollover Contributions made by Participants shall be returned to such Participants.

Upon the return of all such assets, this Plan and the Trust which forms a part of this Plan shall terminate the Trustee shall be discharged from all obligations under the Trust.

3.7 Qualified Nonelective Contributions.

(a) The Employer may make a Qualified Nonelective Contribution (within the meaning of Section 401(m)(4)(C) of the Code and applicable regulations) to the Plan for each Plan Year in such amounts (if any) as the Employer determines, in its sole discretion, to be desirable in order to meet the requirements of Sections 4.3(b) for such Plan Year.

(b) The Employer shall determine the group of Participants eligible to share in such Qualified Nonelective Contributions and the method of apportionment under which such eligible Participants shall share in such contributions in accordance with Treas. Reg. §1.401(k)-2(a)(6).

(c) A Qualified Nonelective Contribution shall be credited to an eligible Participant's QNEC Contribution Account. Qualified Nonelective Contributions shall be treated as Before Tax Savings Contributions for purposes of determining whether the Qualified Nonelective Contributions may be distributed under the Plan, except that a hardship distribution of such Qualified Nonelective Contributions and the earnings thereon shall not be permitted.

(d) A Participant shall be fully vested at all times in the Qualified Nonelective Contributions (if any) which are made to his QNEC Contribution Account.

ARTICLE IV

STATUTORY LIMITATIONS ON CONTRIBUTIONS

4.1 Maximum Dollar Amount of Before Tax Savings Contributions. For any calendar year, a Participant shall not be permitted to make total Before Tax Savings Contributions to this Plan, which, when added to any other amounts previously contributed as elective deferrals pursuant to Section 401(k) of the Code to any other tax qualified plans maintained by the Employer or an Affiliate, would exceed the maximum statutory limit of Section 402(g) of the Code ($17,000 for 2012) for that calendar year, as adjusted by the Adjustment Factor in accordance with Section 402(g)(4) of the Code. For purposes of this Section 4.1, Excess Deferrals that are distributed in accordance with Section 4.2 shall be disregarded. The maximum dollar amount limitation described in this Section 4.1 shall not apply to any Catch-Up Contributions made pursuant to Section 3.3.

4.2 Distribution of Excess Deferrals.

(a) In General. Notwithstanding any other provision of the Plan, Excess Deferrals and the income allocable thereto shall be distributed, where practicable, within the calendar year made, but in no event later than April 15 of the following calendar year to Participants who either file timely statements claiming such allocable Excess Deferrals, or who are deemed to have claimed such allocable Excess Deferrals, for the preceding calendar year. Any such distribution on or before the last day of the calendar year shall be made after the date on which the Plan received the Excess Deferral. Such distributions of Excess Deferrals and the income allocable thereto shall be considered distributions of the Before Tax Savings Contributions of the affected Participants and, if returned after the end of the calendar year in which they were

contributed, shall be considered distributions of such contributions for the preceding calendar year.

(b) Definition. For purposes of this Article IV:

(i) "Excess Deferrals" shall mean the excess of the total of the Participant's Before Tax Savings Contributions made under this Plan for any calendar year over the maximum statutory limit of Code Section 402(g) for such calendar year. Any such Excess Deferrals shall be deemed to have been claimed by the Participant as allocable Excess Deferrals and shall be distributed in accordance with paragraph (a) of this Section 4.2.

(ii) If the Participant also makes before tax contributions for the calendar year to plans or arrangements described in Code Sections 401(k), 408(k) or 403(b) that are not maintained by any Employer, then Excess Deferrals shall be the amount of excess Before Tax Savings Contributions for such calendar year that the Participant allocates to this Plan pursuant to the claim procedures set forth in paragraph (c) of this Section 4.2.

(c) Excess Deferrals Claims Procedure. The Participant's claim shall be in writing (or in electronic format); shall be submitted to the Committee no later than March 1; shall specify the Participant's Excess Deferrals for the preceding calendar year; and shall be accompanied by the Participant's statement that if such amounts are not distributed, such Excess Deferrals, when added to the before tax contributions under other plans or arrangements described in Code Sections 401(k), 408(k) or 403(b) that are not maintained by the Employer exceed the limit imposed on the Participant by Section 402(g) of the Code for the calendar year

in which the deferrals occurred. Any Excess Deferrals under this paragraph shall be distributed in accordance with paragraph (a) of this Section 4.2.

(d) Determination of Income or Loss. Distributions of Excess Deferrals shall be adjusted for income or loss, which shall be determined by a reasonable method in accordance with regulations prescribed by the Secretary of the Treasury; provided, however, that no adjustment shall be made for any income or loss for the period between the end of the calendar year and the date of distribution.

(e) Reduction For Excess Before Tax Savings Contributions Distributed. The amount of Excess Deferrals to be distributed with respect to any Participant for the taxable year shall be reduced by the amount of Excess Before Tax Savings Contributions (as defined in Section 4.4(b)) previously distributed to the Participant pursuant to Section 4.4(a) for the Plan Year beginning with or within such taxable year. In the event of a reduction pursuant to the terms of the preceding sentence, the amount of Excess Before Tax Savings Contributions includible in the gross income of the Participant and reported by the Employer as a distribution of Excess Before Tax Savings Contributions shall be reduced by the amount of such reduction.

4.3 Limitations on Before Tax Savings Contributions.

(a) Before Tax Savings Contributions of Referees who are Highly Compensated Employees for a Plan Year shall be subject to the limitations of Section 4.3(b). For purposes of this Section 4.3 and Section 4.4, Referees shall be those Referees who are eligible to participate in the Plan for the applicable Plan Year.

(b) Average Actual Deferral Percentage.

(i) The Average Actual Deferral Percentage for a Plan Year for Referees who are Highly Compensated Employees for the Plan Year shall not

exceed the Average Actual Deferral Percentage for the prior Plan Year for Referees who were Nonhighly Compensated Employees for such prior Plan Year multiplied by 1.25; or

(ii) The excess of the Average Actual Deferral Percentage for Referees who are Highly Compensated Employees for the Plan Year over the Average Actual Deferral Percentage for the prior Plan Year for Referees who were Nonhighly Compensated Employees for such prior Plan Year shall not exceed two (2) percentage points, and the Average Actual Deferral Percentage for Referees who were Highly Compensated Employees for the Plan Year shall not exceed the Average Actual Deferral Percentage for the prior Plan Year for Referees who were Nonhighly Compensated Employees for such prior Plan Year multiplied by 2.

(c) Definitions. For purposes of this Section, 4.3, the following definitions shall be used:

(i) "Actual Deferral Percentage" shall mean the ratio (expressed as a percentage) of Before Tax Savings Contributions on behalf of the Referee for the Plan Year (including Excess Before Tax Savings Contributions of Highly Compensated Employees) to the Referee's ADP Compensation for the Plan Year. At the election of the Committee, Qualified Nonelective Contributions may be taken into account as Before Tax Savings Contributions for purposes of determining the Actual Deferral Percentage of Participants under the Plan.

(ii) "Average Actual Deferral Percentage" shall mean the average (expressed as a percentage) of the Actual Deferral Percentages of the Referees in a specified group.

(iii) "ADP Compensation" shall mean for any Plan Year, the Adjusted Compensation received during the Plan Year by a Participant; provided, however, that at the election of the Committee, the ADP Compensation may be limited to Adjusted Compensation received by a Participant for the portion of the Plan Year in which such Participant was eligible to have Before Tax Savings Contributions contributed to the Plan on his behalf. For purposes of this Section 4.3, Adjusted Compensation shall include Before Tax Savings Contributions under this Plan, any pre-tax salary reduction contributions under a Code Section 125 plan and any pre-tax salary reduction amounts under a Code Section 132(f) transportation program.

(d) Special Rules.

(i) Except as provided below, if, in addition to this Plan, a Referee who is a Highly Compensated Employee participates (while employed by the Employer as a Referee) in two or more cash or deferred arrangements of the Employer or an Affiliate for a Plan Year, all of such arrangements shall be treated as one cash or deferred arrangement for purposes of determining the Actual Deferral Percentage of such Referee. However, if the cash or deferred arrangements have different plan years, then all Before Tax Savings Contributions made during the plan year being tested under all such cash or deferred arrangements shall be aggregated without regard to the plan years of the other

plans in accordance with Treas. Reg. §1.401(k)-2(a)(3)(ii). Notwithstanding the foregoing, plans that are not permitted to be aggregated are not required to be aggregated for purposes of this subparagraph.

(ii) The Committee may reduce or restrict Highly Compensated Employees' deferral elections made pursuant to Section 3.1 by the amount necessary to satisfy one of the tests set forth in Section 4.3(b).

(iii) If the Employer elects to apply Section 410(b)(4)(B) of the Code in determining whether the requirements of Section 410(b)(1) of the Code are satisfied, the Employer may exclude all Referees who are Nonhighly Compensated Employees who have not met the minimum age and service requirements of Section 410(a)(1)(A) of the Code in determining whether the requirements of Section 4.3(b) are satisfied.

(iv) At the election of the Committee, Qualified Nonelective Contributions may be taken into account as Before Tax Savings Contributions for purposes of determining the Actual Deferral Percentage of Participants in accordance with the rules set forth in Treas. Reg. § 1.401(k)-2(a)(6).

(v) The determination and treatment of the Before Tax Savings Contributions and the Actual Deferral Percentage of any Participant shall satisfy such other requirements as may be prescribed by the Secretary of the Treasury.

4.4 Distribution of Excess Before Tax Savings Contributions.

(a) In General. Notwithstanding any other provision of the Plan, Excess Before Tax Savings Contributions and income or loss allocable thereto shall be distributed to those Participants on whose behalf such Before Tax Savings Contributions

were made for a Plan Year, using the "dollar leveling method" starting with the Highly Compensated Employee with the greatest dollar amount of Before Tax Savings Contributions and other contributions treated as Before Tax Savings Contributions for the Plan Year until the amount of Excess Contributions has been accounted for, in accordance with the provisions of Section 401(k)(8)(C) of the Code. Such distributions shall, to the extent practicable, be made within two-and-one-half (2-1/2) months after the close of such Plan Year (in order to avoid the ten percent (10%) excise tax under Section 4979 of the Code) and in no event later than the last day of the Plan Year immediately following the Plan Year for which such excess Before Tax Savings Contributions were made. Such distributions of Excess Before Tax Savings Contributions and the income allocable thereto shall be considered distributions of the Before Tax Savings Contributions of the affected Participants for such Plan Year.

(b) Excess Before Tax Savings Contributions. For purposes of this Section 4.4, "Excess Before Tax Savings Contributions" shall mean, with respect to any Plan Year, the excess of:

(i) The aggregate amount of Before Tax Savings Contributions actually taken into account in computing the Actual Deferral Percentages of Highly Compensated Employees for such Plan Year, over

(ii) the maximum amount of such contributions permitted by the Average Actual Deferral Percentage test described in Section 4.3(b) (determined by reducing contributions made on behalf of Highly Compensated Employees in order of the Actual Deferral Percentages, beginning with the highest of such percentages).

Excess Before Tax Savings Contributions shall be considered as Annual Additions for purposes of Section 4.5 even if they are distributed from the Plan.

(c) Determination of Income or Loss. Excess Before Tax Savings Contributions shall be adjusted for income or loss (which shall not include income or loss for the period between the end of the Plan Year for which the Excess Before Tax Savings Contributions are being distributed and the date of distribution), by any reasonable method or any alternative or safe-harbor method provided under Treas. Reg. § 1.401(k)-2(b)(2)(iv).

(d) Reduction for Excess Deferrals Distributed. The amount of Excess Before Tax Savings Contributions to be distributed to the Participant pursuant to this Section 4.4 shall be reduced by the amount of the Excess Deferrals previously distributed to the Participant for the Participant's taxable year ending with or within the Plan Year, pursuant to Section 4.2 above.

4.5 Limitation on Contributions.

(a) The Annual Additions credited to a Participant under this Plan for any Limitation Year shall not exceed the lesser of (i) one-hundred percent (100%) of the Participant's Adjusted Compensation or (ii) $51,000 (as adjusted by the Adjustment Factor).

(b) Notwithstanding the foregoing, the compensation limitation referred to in subsection (a)(i) shall not apply to:

(i) Any amount otherwise treated as an Annual Addition under Section 415(l)(1) of the Code, or

(ii) Any contribution for medical benefits otherwise treated as an Annual Addition under Section 419A(d)(2) of the Code.

(c) In applying the limitations of paragraph (a):

(i) All "defined contribution plans" of the Employer or its Affiliates shall be aggregated with this Plan to the extent that contributions provided under this Plan are provided by the Employer or its Affiliates with respect to a Participant who also participates under any other defined contribution plan of the Employer or its Affiliate. The maximum amount of Annual Additions that may be credited to such Participant under this Plan shall be limited to the excess of the limitations described in paragraph (a) over the amount of the annual additions credited to the Participant under such other non-multiemployer defined contribution plan.

(ii) If Employer Contributions are credited to a Participant's Employer Contribution Account for a Limitation Year, the maximum amount of Before Tax Savings Contributions that may be made by such Participant under this Plan for such Limitation Year shall be limited to the excess of the limitations described in paragraph (a) over the amount of the Employer Contributions credited to such Participant's Employer Contribution Account for such Limitation Year.

(d) For purposes of this Section 4.5: (i) "defined contribution plan" shall mean a plan which provides for an individual account for each Participant and for benefits based solely on the amount contributed to the accounts of the Participant, and any income, expenses, gains and losses which may be credited to such Participant's accounts; (ii) the definition of "Affiliate" shall be modified by Section 415(h) of the Code; and (iii) 'Adjusted Compensation' shall include Before Tax Savings Contributions, any pre-tax salary reduction contributions under a Code Section 125 plan, any pre-tax salary reduction amounts under a Code Section 132(f)

transportation program and any income includible in the gross income of a Participant under Section 409A of the Code.

(e) In no event shall Annual Additions be made under this Plan for any Participant in a Limitation Year to the extent that there is an amount credited to such Participant's accounts in excess of the maximum amount permitted under this Section 4.5.

4.6 Limitation on Compensation. For purposes of this Plan, Adjusted Compensation, Compensation and ADP Compensation of a Participant for a Plan Year in excess of $250,000 (as adjusted by the Adjustment Factor under Section 401(a)(17)(B) of the Code) shall not be taken into account.

ARTICLE V

INVESTMENT OF TRUST ASSETS

5.1 Investment Funds. Each Participant's accounts shall be invested in the Investment Funds described in Section 11.2, and in the proportions and amounts as determined by the Participant pursuant to Section 5.2.

5.2 Investment Options of Participants.

(a) Each Participant shall elect to invest his accounts in the Investment Funds maintained by the Trustee under Section 11.2 in such proportions as the Participant shall indicate by giving notice of such investment direction in such form as the Committee may specify. If a Participant does not make an election specifying the Investment Fund(s) in which such Participant's accounts should be invested, such Participant's accounts shall be invested in a Qualified Default Investment Alternative (within the meaning of the Department of Labor regulations) as selected by the Committee. All investment directions, including requests for changes or transfers, shall be subject to such rules and regulations as the Committee shall determine in a uniform and nondiscriminatory manner.

(b) Designations of investments under this Section may be made by Participants only in increments of one percent (1%).

(c) The selection of any Investment Fund is the sole and exclusive responsibility of each Participant and it is intended that the selection of an Investment Fund by each Participant be within the parameters of Section 404(c) of ERISA and the regulations thereunder. Neither the Employers, nor the Trustee, nor any Committee member, nor any of the directors, officers, agents or Employees of the Employer are empowered to or shall be permitted

to advise a Participant as to the manner in which his Account Balance shall be invested or changed. No liability whatsoever shall be imposed upon the Employer, the Trustee, any Committee member, or any director, officer, agent or Employee of the Employer for any loss resulting to a Participant's account because of any sale or investment directed by a Participant under this Section or because of the Participant's failure to take any action regarding an investment acquired pursuant to such elective investment.

ARTICLE VI

VALUATION OF TRUST ASSETS

6.1 Time and Manner of Valuation. As of each Valuation Date, the Trustee shall value all of the assets in each Investment Fund maintained under Section 11.2 for the purpose of determining the amount, if any, of the net increase or net decrease in the fair market value of each such Fund. The fair market value of each Investment Fund shall represent the fair market value of all securities or other property held thereunder, plus cash and accrued earnings, less accrued expenses and proper charges against each Fund as of the Valuation Date. The Trustee's determination shall be final and conclusive for all purposes of this Plan.

6.2 Allocation of Net Increase and Net Decrease to Accounts of Participants. The Trustee shall compute the net increase or net decrease, as determined under Section 6.1, in the value of the assets of each of the Investment Funds as of the Valuation Date for which the determination is being made. The Trustee shall then allocate as of such Valuation Date a part of each such net increase or net decrease for each Fund to the Before Tax Savings Contribution Account, Employer Contribution Account, Catch-Up Contribution Account, QNEC Contribution Account and/or Rollover Contribution Account of each Participant in the ratio that the balance in each such account bears to all such accounts invested in such Fund.

ARTICLE VII

DISTRIBUTION OF ACCOUNT BALANCES

7.1 Payments on Account of Retirement.

(a) A Participant who ceases to be an Employee on account of his Retirement shall be fully vested in his interest in his Account Balance and shall, except as otherwise provided herein, be entitled to elect to receive a distribution of his Account Balance in any form of payment specified in Section 7.5 (subject to the rules specified in Section 7.6).

(b) If the value of the Participant's Account Balance does not exceed $5,000, the distribution of each Participant's Account Balance shall be made in a lump sum cash payment.

(c) (i) Except as otherwise provided in subparagraph (ii) of this paragraph (c) (and subject to the provisions of Section 7.7(b), if applicable), any distribution under this Section on account of Retirement shall be made or commence as soon as practicable after the Participant's Retirement, but in no event later than sixty (60) days after the close of the Plan Year in which his Retirement occurred.

(ii) A Participant who ceases to be an Employee due to his Retirement prior to his Required Beginning Date and whose Account Balance is greater than $5,000 shall be entitled to defer receipt of any distribution to be made under this paragraph until he elects to receive such distribution; provided, however, that such distribution must be made or commence no later than the Participant's Required Beginning Date.

(d) Whether or not a Participant retires upon attaining his Normal Retirement Date, the Participant's Account Balance shall be fully vested as of the Participant's Normal Retirement Date.

(e) For purposes of this Section 7.1, in determining whether the value of a Participant's Account Balance exceeds $5,000, the value of such Participant's Account Balance shall be determined without regard to that portion of the Account Balance that is attributable to Rollover Contributions (and any earnings thereon).

7.2 Payments on Account of Disability.

(a) If a Participant ceases to be an Employee on account of Disability, his Account Balance shall be fully vested and, subject to paragraphs (c) and (d) of this Section, he shall be entitled to elect to receive a distribution of his Account Balance in any form of payment specified in Section 7.5 (subject to the rules specified in Section 7.6). Subject to the provisions of paragraph (b) of this Section, such distribution shall be made or commence as soon as practicable following the Participant's Disability.

(b) A Participant who ceases to be an Employee on account of Disability shall be entitled to defer receipt of any distribution under paragraph (a) of this Section 7.2 until he elects to receive such distribution; provided, however, that such distribution shall be made or commence as soon as practicable following the Plan Year in which such Participant reaches age 65.

(c) (i) Notwithstanding paragraphs (a) and (b) of this Section, if the value of the Participant's Account Balance does not exceed $5,000, the distribution of the Participant's Account Balance shall be made in a lump sum cash payment as soon as practicable following the Participant's Disability.

(ii) In the event that the payment made under paragraph (c)(i) of this Section is greater than $1,000 and is made before the Participant attains age 65, then, if the Participant does not elect in accordance with Section 7.9(a) to have such distribution paid directly to an Eligible Retirement Plan (as defined in Section 7.9(b)(ii)) specified by the Participant in a Direct Rollover (as defined in Section 7.9(b)(iv)) or to receive the distribution directly, the Committee shall pay the distribution in a Direct Rollover to an individual retirement plan designated by the Committee.

(d) For purposes of this Section 7.2, in determining whether the value of a Participant's Account Balance exceeds $5,000, the value of such Participant's Account Balance shall be determined without regard to that portion of the Account Balance that is attributable to Rollover Contributions (and any earnings thereon). Notwithstanding the foregoing, for purposes of Section 7.2(c)(ii), in determining whether the value of a Participant's Account Balance exceeds $1,000, the portion of the Account Balance that is attributable to Rollover Contributions (and any earnings thereon) shall be taken into account.

7.3 Payment upon Death of Participant.

(a) Upon the death of a Participant while employed by the Employer or while performing qualified military service (as defined under Code Section 414(u)(5)), the Participant's Account Balance shall be fully vested. If a Participant dies before or after Termination of Employment but before the distribution of his Account Balance commences, the Participant's Beneficiary shall be entitled to receive a distribution of the Participant's Vested Account Balance. Except as otherwise provided in paragraph (b) of this Section, and pursuant to the Beneficiary's election, the Participant's Vested Account Balance shall be paid to the Beneficiary

in any form of payment specified in Section 7.5 or 7.6 (if the Beneficiary is the Participant's surviving spouse) and subject to the required minimum distribution rules contained in Sections 7.7 and 7.8.

(b) Notwithstanding paragraph (a) of this Section, if the value of the Participant's Vested Account Balance does not exceed $5,000 and the distribution of the Participant's Vested Account Balance has not commenced, the distribution of such Account Balance shall be made in a lump sum cash payment as soon as administratively feasible following the date of the Participant's death, but in no event later than December 31 of the calendar year immediately following the calendar year in which the Participant died. For purposes of this Section 7.3, in determining whether the value of a Participant's Vested Account Balance exceeds $5,000, the value of such Participant's Vested Account Balance shall be determined without regard to that portion of the Vested Account Balance that is attributable to Rollover Contributions (and any earnings thereon).

7.4 Payments on Account of Termination of Employment.

(a) In the event of a Termination of Employment of a Participant, the Participant shall be entitled to receive 100% of the balance in his Before Tax Savings Contribution Account, Rollover Contribution Account, QNEC Contribution Account and Catch-up Contribution Account plus the percentage of his interest in his Employer Contribution Account as provided in this paragraph (a). For purposes of this Article VII, the balance in a Participant's Before Tax Savings Contribution Account, Rollover Contribution Account, QNEC Contribution Account and Catch-up Contribution Account plus the vested percentage of a Participant's Employer Contribution Account shall constitute the Vested Account Balance. For purposes of this Section 7.4, the percentage of such interest to which the Participant is entitled

shall be based upon such Participant's Years of Referee Service as of the date of the Participant's Termination of Employment in accordance with the following schedule:

Years of Referee Service	Vested Interest
Less than 3 years	0%
3 or more	100%

For purposes of determining whether a Participant is vested in his Employer Contribution Account under this Section:

(i) The vested percentage of the balance in a Participant's Employer Contribution Account shall be computed without regard to any Period of Service after five (5) consecutive One-Year Periods of Severance; and

(ii) All Years of Referee Service credited to a Referee under the Pension Plan shall constitute Years of Referee Service under the Plan.

(b) If the value of the Participant's Vested Account Balance exceeds $5,000, then such Vested Account Balance (as determined under paragraph (a) of this Section) shall be paid to such Participant at the time provided in paragraph (d) in any form of payment elected by the Participant pursuant to Section 7.5 (subject to rules specified in Section 7.6).

(c) (i) If the value of the Participant's Vested Account Balance does not exceed $5,000, the distribution of the Participant's Vested Account Balance shall be made to the Participant in a lump sum cash payment.

(ii) In the event that the payment made under paragraph (c)(i) of this Section is greater than $1,000 and is made before the Participant's Required Beginning Date, then, if the Participant does not elect in accordance

with Section 7.9(a) to have such distribution paid directly to an Eligible Retirement Plan (as defined in Section 7.9(b)(ii)) specified by the Participant in a Direct Rollover (as defined in Section 7.9(b)(iv)) or to receive the distribution directly, the Committee shall pay the distribution in a Direct Rollover to an individual retirement plan designated by the Committee.

(d) (i) The payment of a Participant's Vested Account Balance in accordance with paragraphs (b) or (c) shall be made or commence no later than the Participant's Required Beginning Date.

(ii) Notwithstanding subparagraph (i) of this paragraph, a Participant may, however, elect to receive payment of his Vested Account Balance at any time following his Termination of Employment.

(e) For purposes of this Section 7.4, in determining whether the value of a Participant's Vested Account Balance exceeds $5,000, the value of such Participant's Vested Account Balance shall be determined without regard to that portion of the Vested Account Balance that is attributable to Rollover Contributions (and any earnings thereon). Notwithstanding the foregoing, for purposes of Section 7.4(c)(ii), in determining whether the value of a Participant's Vested Account Balance exceeds $1,000, the portion of the Participant's Vested Account Balance that is attributable to Rollover Contributions (and any earnings thereon) shall be taken into account.

(f) In the case of a Participant who receives a distribution of his Vested Account Balance under paragraph (c) of this Section in connection with his Termination of Employment and is not vested in his Employer Contribution Account as of the date of his Termination of Employment, such Employer Contribution Account shall be forfeited as of the

date on which the Participant receives such distribution of his Vested Account Balance. In the case of a Participant who is not vested in his Employer Contribution Account as of the date of his Termination of Employment and who does not elect to receive a distribution of his Vested Account Balance in connection with his Termination of Employment, such Employer Contribution Account shall be forfeited as of the earlier of (A) the last day of the Plan Year in which such Participant incurs five (5) consecutive One-Year Periods of Severance or (B) the date that the Participant receives payment of his Vested Account Balance pursuant to paragraph (c) of this Section 7.4. Except as otherwise provided under paragraph (g) of this Section, the amount of any forfeitures of a Participant described in this paragraph for the Plan Year shall be applied as a credit towards any Employer Contributions to be made by the Employer of such Participant under Section 3.2.

(g) If a Participant who has forfeited his Employer Contribution Account in accordance with the provisions of this Section and pursuant to his Termination of Employment returns to the employ of the Employer prior to completing five (5) consecutive One-Year Periods of Severance, the amount so forfeited shall be restored to the Participant. As of the time of the Participant's return to the employ of the Employer, an Employer Contribution Account shall be reestablished on behalf of such Participant and the amount forfeited shall be restored to such Employer Contribution Account. Any forfeitures to be applied as a credit under paragraph (f) toward any Employer Contributions to be made under the Plan may, in the sole discretion of the Committee, be used for the purpose of restoring, as required under this paragraph, the amounts forfeited in accordance with the provisions of this Section. To the extent such forfeitures are insufficient, the Employer shall make a special contribution to restore the forfeiture.

(h) If a Participant who ceases to be an Employee on account of his Termination of Employment is not vested in his Employer Contribution Account and does not have an Account Balance attributable to a Before Tax Savings Contribution Account, Catch-Up Contribution Account, QNEC Contribution Account and/or Rollover Contribution Account, such Participant shall be deemed to have received a distribution of his Employer Contribution Account for purposes of paragraphs (c) and (f) of this Section. If such Participant returns to the employ of the Employer prior to completing five (5) consecutive One-Year Periods of Severance, an Employer Contribution Account shall be reestablished on behalf of such Participant and the amount forfeited with respect to such Employer Contribution Account shall be restored as of the time that the Participant returns to the employ of the Employer.

7.5 Forms of Payment. Subject to the provisions of Section 7.6, a Participant or his Beneficiary may elect to receive payment of such Participant's Vested Account Balance in any of the following forms:

(a) A lump-sum payment.

(b) In the case of a married Participant, the distribution of an annuity contract in the form of an annuity for the life of the Participant.

(c) Substantially equal installment payments over a period of not more than ten (10) years to the Participant or Beneficiary (such installment payments to be made not more frequently than monthly); and upon the death of the Participant or Beneficiary, the balance in said account, if any, shall be paid to his Beneficiary in the manner provided herein for the payment of death benefits.

(d) Monthly payments to the Participant (or Beneficiary) from the Participant's Vested Account Balance until it is exhausted. The amount of any such payment for

the first year shall be equal to one-twelfth (1/12) of the amount of the Vested Account Balance, divided by the then life expectancy (as fixed by the Committee) of the Participant (or Beneficiary); thereafter the amount of each payment shall be equal to one-twelfth (1/12) of the remaining Vested Account Balance divided by the then life expectancy of the Participant (or Beneficiary), and upon the death of the Participant (or Beneficiary), the balance, if any, shall be paid to his Beneficiary in the manner provided herein for payment of death benefits; provided, however, the amount of any payment shall not be less than the required minimum distribution computed in accordance with Sections 7.7 and 7.8.

(e) Periodic payments over a period of time not exceeding the life expectancy of the Participant (or Beneficiary).

(f) A Qualified Optional Survivor Annuity.

7.6 Special Rules Relating to Annuity Forms of Payment.

(a) In the event that a Participant elects to receive payment of his Vested Account Balance in a life annuity form of payment under paragraph (b), (d), (e) or (f) of Section 7.5, then unless the Participant makes a Qualified Waiver Election within 90-day period ending on the Annuity Starting Date, the following special rules shall apply.

(i) The Participant's Vested Account Balance shall be distributed to him in the form of a Qualified Joint and Survivor Annuity.

(ii) If the Participant is married and dies prior to commencing to receive payment of his Vested Account Balance, then, unless the Participant's surviving spouse elects to receive payment of the Participant's Account in one of the forms described in Section 7.5, such surviving spouse shall receive a distribution of the

Participant's Vested Account Balance in the form of an annuity for the life of the surviving spouse.

(b) Definitions. For purposes of this Section 7.6:

(i) A "Qualified Joint and Survivor Annuity" is an annuity for the life of the Participant with a survivor annuity for the life of the spouse of the Participant which survivor annuity is equal to fifty percent (50%) of the amount of the annuity payable during the joint lives of the Participant and his spouse. The value of such annuity shall be equal in value to the Participant's Vested Account Balance interest on the Annuity Starting Date. If a Participant has no spouse, a "Qualified Joint and Survivor Annuity" is an annuity for the life of the Participant. Any annuity payable under this Plan may be purchased by the Committee from an insurance company under the terms generally available for such an annuity; provided, however, such annuity contract shall contain terms that provide for distributions under the annuity contract be made in accordance with the requirements of the Plan and Code Section 401(a)(9) and the Treasury Regulations thereunder.

(ii) The "Annuity Starting Date" shall be the date on which the payment of benefits commences or is made.

(iii) A "Qualified Waiver Election" is an election by the Participant made in writing to waive the right to receive his vested interest in his accounts in the form of a Qualified Joint and Survivor Annuity, which must be consented to by his spouse, if any, in the manner required under Section 417(a)(2)(A) of the Code (unless it is established that the consent of the spouse

may not be obtained for the reasons set forth under regulations prescribed thereunder). A Participant who has made a Qualified Waiver Election may subsequently cancel such Election at any time prior to the Annuity Starting Date. A spousal consent made under this subparagraph shall be irrevocable and shall be binding only with respect to the consenting spouse.

(iv) In the case of a Qualified Joint and Survivor Annuity, the Committee shall provide each Participant within a period not less than thirty (30) days or more than ninety (90) days prior to the Annuity Starting Date, a written explanation of: (a) the terms and conditions of a Qualified Joint and Survivor Annuity; (b) the Participant's right to make and the effect of an election to waive the Qualified Joint and Survivor Annuity form of benefit; (c) the rights of a Participant's spouse; and (d) the right to make and the effect of a revocation of a previous election to waive the Qualified Joint and Survivor Annuity.

(v) Notwithstanding the provisions of subparagraph (iv), a Participant may elect (with any applicable spousal consent) to waive any requirement that the explanation of rights be provided at least thirty (30) days before the Annuity Starting Date if the distribution commences more than seven (7) days after such explanation is provided.

(vi) A "Qualified Optional Survivor Annuity" is an annuity for the life of the Participant with a survivor annuity for the life of the spouse of the Participant which survivor annuity is equal to seventy-five percent (75%) of the amount of the annuity payable during the joint lives of the Participant and the

Participant's spouse. The value of such annuity shall be equal in value to the Participant's Vested Account Balance as of the Annuity Starting Date.

7.7 Special Distribution Rule.

(a) (i) Notwithstanding anything to the contrary in this Article VII, as required by Code Section 401(a)(9) and the Treasury Regulations thereunder, with respect to any Participant who is a "five percent (5%) owner" (as defined in Code Section 416), the distribution of such Participant's Account Balance shall be made (or commence) in accordance with subparagraph (ii) of this paragraph (a) no later than the Participant's Required Beginning Date, regardless of whether such Participant is still actively employed as of such date. If the Participant continues to participate in the Plan, the minimum amount that must be distributed to the Participant in accordance with subparagraph (ii) of this paragraph (a) for other calendar years, including the required minimum distribution for the calendar year in which the Participant's Required Beginning Date occurs, shall be distributed on or before December 31 of that calendar year.

(ii) At the election of the Participant, the Participant's Account Balance shall either be distributed in its entirety to the Participant in accordance with Code Section 401(a)(9)(A)(i) and the Treasury Regulations thereunder, or distributed to the Participant during the Participant's lifetime in an amount for each distribution calendar year that is the lesser of:

(A) the quotient obtained by dividing the Participant's Account Balance by the distribution period in the Uniform Lifetime Table set forth in Section 1.401(a)(9)-9 of the Treasury Regulations, using the

Participant's age as of the Participant's birthday in the distribution calendar year; or

(B) if the Participant's sole Beneficiary for the distribution calendar year is the Participant's spouse, the quotient obtained by dividing the Participant's Account Balance by the number in the Joint and Last Survivor Table set forth in Section 1.401(a)(9)-9 of the Treasury Regulations, using the Participant's and spouse's ages as of the Participant's and spouse's birthdays in the distribution calendar year.

For purposes of calculating the required minimum distribution pursuant to this subparagraph (ii), the first "distribution calendar year" shall be the calendar year immediately preceding the calendar year which contains the Participant's Required Beginning Date. All other "distribution calendar years" shall be the calendar year in which the minimum distribution is required. In addition, the Participant's Account Balance shall mean the Account Balance as of the last Valuation Date in the calendar year immediately preceding the distribution calendar year (the "Valuation Calendar Year"), increased by the amount of any contributions made and allocated to the Account Balance as of dates in the Valuation Calendar Year after the Valuation Date and decreased by distributions made in the Valuation Calendar Year after the Valuation Date.

(iii) Notwithstanding the foregoing provisions of this Section 7.7(a), the Required Beginning Date for any actively employed Participant who is not a "five percent (5%) owner" (as defined in Code Section 416) is the April 1 of the calendar year following the later of (A) the calendar year in which he attains

age 70½ or (B) the calendar year in which the Participant ceases to be an Employee on account of his Retirement.

(b) Notwithstanding any provision to the contrary and except as otherwise provided in Section 7.1(c)(ii) and paragraph (a) of this Section, the payment of benefits under this Plan to a Participant shall in all events commence within sixty (60) days after the close of the Plan Year in which the latest of the following events occurs:

(i) the attainment by the Participant of age 65;

(ii) the tenth anniversary of the year in which the Participant first became a Participant in the Plan; or

(iii) the Participant's Retirement or Termination of Employment with the Employer.

(c) All distributions made under this Article VII shall be made in accordance with Code Section 401(a)(9) (including Section 401(a)(9)(G) of the Code) and Sections 1.401(a)(9)-1 through 1.401(a)(9)-9 of the Treasury Regulations.

7.8 Period of Benefit Payment.

(a) The life expectancy of a Participant or Beneficiary, if the Beneficiary is an individual designated in accordance with Section 1.401(a)(9)-4 of the Treasury Regulations (the "Designated Beneficiary") for the purpose of determining required minimum distributions under this Section 7.8, shall be determined in accordance with the provisions of Section 7.7(a)(ii)(A), or if the Participant's surviving spouse is the sole Designated Beneficiary, then in accordance with the provisions of Section 7.7(a)(ii)(B).

(b) If the Participant dies before his Required Beginning Date, the Participant's Vested Account Balance shall be distributed, or commence to be distributed, no later than as follows:

(i) if the Participant's surviving spouse is the Participant's sole Designated Beneficiary, then payment of the required minimum distribution to the surviving spouse shall be made or commence by December 31 of the calendar year immediately following the calendar year in which the Participant died or by December 31 of the calendar year in which the Participant would have attained age 70½, if later;

(ii) if the Participant's spouse is not the sole Designated Beneficiary, then payment of the required minimum distribution to the Designated Beneficiary shall be made or commence within one year of the Participant's death; or

(iii) if there is no Designated Beneficiary as of September 30 of the calendar year following the calendar year of the Participant's death, the Participant's entire interest in the Participant's Vested Account Balance shall be distributed to the Beneficiary by December 31 of the calendar year containing the fifth anniversary of the Participant's death (to the extent that the Beneficiary is entitled to such interest).

(c) If the Participant's surviving spouse is the Participant's sole Designated Beneficiary and the spouse dies after the Participant but before distributions to the surviving spouse commence, paragraph (b), except for subparagraph (i), of this Section 7.8, will apply as if the surviving spouse were the Participant.

(d) If the Participant dies before his Required Beginning Date, the applicable distribution period of the Participant's Vested Account Balance shall be determined as follows:

(i) if the Participant's surviving spouse is the Participant's sole Designated Beneficiary, by measuring the period based on the surviving spouse's life expectancy using the surviving spouse's birthday for each distribution calendar year after the calendar year of the Participant's death up through the year of the surviving spouse's death; or

(ii) if the Participant's spouse is not the sole Designated Beneficiary, by measuring the period based on the Designated Beneficiary's remaining life expectancy using the Designated Beneficiary's age as of the Designated Beneficiary's birthday in the calendar year immediately following the calendar year of the Participant's death and in subsequent years, the applicable distribution period is reduced by one for each calendar year that has elapsed after the calendar year immediately following the calendar year of the Participant's death.

(e) If the Participant has a Designated Beneficiary (as determined under paragraph (a)) and such Participant dies on or after his Required Beginning Date, the applicable distribution period for distribution calendar years after the calendar year containing the Participant's date of death shall be the longer of:

(i) the remaining life expectancy of the Designated Beneficiary determined in accordance with subparagraphs (i) or (ii) of paragraph (d), whichever is applicable; and

(ii) the remaining life expectancy of the Participant using the age of the Participant as of the Participant's birthday in the calendar year of the Participant's death.

If the Participant has no Designated Beneficiary, any remaining Vested Account Balance to which the Participant's Beneficiary is entitled shall be distributed in a single lump sum no later than the end of the calendar year following the calendar year of the Participant's death.

7.9 Relative Value Disclosure: With respect to benefits subject to Section 417(e) of the Code, Participants shall be furnished with a notice on the relative value of optional forms of benefit under Section 417(a)(3) of the Code.

7.10 Rollovers to Other Plans or IRAs.

(a) Notwithstanding any provision of the Plan to the contrary that would otherwise limit a Participant's election under the Plan, the Participant may elect, at the time and in the manner prescribed by the Committee, to have any portion of an Eligible Rollover Distribution paid directly to an Eligible Retirement Plan specified by the Participant in a Direct Rollover.

(b) Definitions: For purposes of this Section 7.10, the following definitions shall apply:

(i) "Eligible Rollover Distribution" shall mean any distribution of all or any portion of the Participant's Vested Account Balance, except that an Eligible Rollover Distribution does not include:

(A) Any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually)

made for the life (or life expectancy) of the Participant or the joint lives (or joint life expectancies) of the Participant and the Participant's designated beneficiary, or for a specified period of ten (10) years or more.

(B) Any distribution to the extent such distribution is required under Section 401(a)(9) of the Code.

(C) The portion of any distribution that is not includible in gross income (determined without regard to the exclusion for net unrealized appreciation with respect to employer securities). A portion of a distribution shall not fail to be an eligible rollover distribution merely because the portion consists of after-tax employee contributions which are not includible in gross income. However, such portion may be transferred only to an individual retirement account or annuity described in Section 408(a) or (b) of the Code, or to a qualified defined contribution plan as described in Section 401(a) of the Code, or an annuity plan described under Section 403(a) of the Code that agree to separately account for amounts so transferred, including separately accounting for the portion of such distribution which is includible in gross income and the portion of such distribution which is not so includible.

(D) Any distribution of a Participant's Before Tax Savings Contributions made pursuant to Section 7.11 on account of hardship and any distribution of a Participant's Vested Account Balance made pursuant to Section 7.11 on account of hardship.

(ii) "Eligible Retirement Plan" shall mean an individual retirement account described in Section 408(a) of the Code, an individual retirement annuity described in Section 408(b) of the Code, an individual retirement plan described in Section 408A(b) of the Code, an annuity plan described in Section 403(a) of the Code, or a qualified trust described in Section 401(a) of the Code, that accepts the Participant's Eligible Rollover Distribution. "Eligible Retirement Plan" shall also mean an annuity contract described in Code Section 403(b) and an eligible plan under Code Section 457(b) which is maintained by a state, political subdivision of a state, or any agency or instrumentality of a state or political subdivision of a state and which agrees to separately account for amounts transferred into such plan from this Plan. This definition of "Eligible Retirement Plan" shall also apply in the case of a distribution to a surviving spouse, or to a spouse or former spouse who is an alternate payee under a qualified domestic relations order, as defined in Code Section 414(p). In the case of an Eligible Rollover Distribution to a Non-spouse Beneficiary, an Eligible Retirement Plan shall mean only an individual retirement account or annuity to which a Direct Rollover must be made and that will be treated as an inherited individual retirement account or annuity pursuant to Section 402(c)(11) of the Code.

(iii) "Participant" shall mean a Participant within the meaning of Section 1.38 who is entitled to receive a distribution under the Plan. In addition, the Participant's surviving spouse and the Participant's spouse or former spouse who is the alternate payee under a qualified domestic relations order as

defined in Section 414(p) of the Code, shall be considered as Participants with regard to the interest of the spouse or former spouse. Except as otherwise provided in this Section 7.10(b), a Non-spouse Beneficiary shall also be considered as a Participant with regard to the interest of the Non-spouse Beneficiary.

(iv) "Direct Rollover" shall mean a payment by the Plan to the Eligible Retirement Plan specified by the Participant.

(v) "Non-spouse Beneficiary" shall mean a non-spouse beneficiary who is a designated beneficiary within the meaning of Section 401(a)(9)(E) of the Code.

7.11 Hardship Distributions. A Participant shall be entitled to receive a hardship distribution up to the total amount of a Participant's Vested Account Balance, excluding the portion of his Vested Account Balance attributable to (a) his Employer Contribution Account, (b) the amount of any outstanding loan, (c) any income attributable to Before Tax Savings Contributions, (d) any income attributable to Catch-Up Contributions, and (e) Qualified Nonelective Contributions and any income attributable to such contributions, if the distribution is necessary to defray an immediate and severe financial hardship incurred by the Participant. The amount of the distribution may not exceed the amount required to meet the immediate financial need created by the hardship and not reasonably available from other resources of the Participant. The existence of an immediate and heavy financial need, and the amount necessary to meet such need, will be determined by the Committee in accordance with the standards set forth below.

(a) Immediate and Heavy Financial Need. For purposes hereof, an immediate and heavy financial need shall be limited to a need for funds for any of the following purposes:

(i) Unreimbursed medical expenses described in Section 213(d) of the Code incurred by the Participant, the Participant's spouse, or any dependents of the Participant (as defined in Section 152 of the Code);

(ii) Purchase (excluding mortgage payments) of a principal residence for the Participant;

(iii) Payment of tuition and related educational fees (including room and board expenses) for the next twelve (12) months of post-secondary education for the Participant or his spouse, children, or dependents;

(iv) Prevention of the eviction of the Participant from his principal residence or foreclosure on the mortgage on his principal residence;

(v) Payment for burial or funeral expenses for the Participant's deceased parent, spouse, child, or dependent; and

(vi) Expenses for the repair of damage to a Participant's principal residence that would qualify for the casualty deduction under Section 165 of the Code (determined without regard to whether the loss exceeds ten percent (10%) of adjusted gross income).

A Participant requesting a hardship withdrawal must represent that he has an emergency need for funds for one of the reasons specified above. The Participant shall provide the Committee with any information and evidence which the Committee considers necessary in

order to determine whether such a hardship exists and the amount of the withdrawal from the Plan that is necessary to meet the hardship.

(b) Distribution Necessary to Satisfy the Financial Need. A hardship withdrawal shall be considered to be necessary to meet such an immediate and heavy financial need only under the following circumstances:

(i) The distribution is not in excess of the amount of the immediate and heavy financial need of the Participant (that cannot be satisfied by distributions and/or non-taxable loans of the types described in subparagraph (ii) below). This distribution may include any amounts necessary to pay any federal, state or local income taxes or penalties reasonably anticipated to result from the distribution.

(ii) The Participant has obtained (or requested) all distributions, other than hardship distributions, and all non-taxable loans currently available under the Plan and, if applicable, under any other qualified and nonqualified plans of deferred compensation maintained by the Employer or any Affiliate.

In the event of a hardship distribution to a Participant hereunder, such Participant may not make Before Tax Savings Contributions and/or Catch-Up Contributions to the Plan or, if applicable, to any other qualified or nonqualified plans of deferred compensation, or stock option, stock purchase or similar plans maintained by the Employer or any Affiliate during the six (6) calendar months immediately following the date of such hardship withdrawal.

The foregoing provisions shall be applied on a uniform and nondiscriminatory basis and shall be subject to such changes as the Committee may deem to be necessary at any

time to comply with Treasury Regulations or other rules issued under Section 401(k) of the Code.

(c) Additional Operating Rules. The following rules shall apply to each request for a hardship distribution by a Participant:

(i) The Participant's request for a hardship distribution shall be made on such forms as are provided from time to time by the Committee and the Participant shall furnish the Committee with such information as the Committee requests in its evaluation of the Participant's request.

(ii) The amount of any hardship distribution shall in no event exceed the value of the Participant's Vested Account Balance (as determined for this purpose without including the amount of any outstanding loan).

(iii) The hardship distribution shall be made from the Investment Funds on a pro rata basis.

(iv) The minimum hardship withdrawal under this Section shall be $1,000.

7.12 Withdrawals After Attainment of Age 59-1/2.

(a) A Participant may apply to the Committee for a withdrawal of all or a portion of his Vested Account Balance at any time after attaining age 59-1/2.

(b) In the event of a withdrawal under this Section, the Participant may continue his participation in the Plan without interruption and shall not, because of such withdrawal, be penalized under the Plan in any way.

(c) The withdrawal of all or a portion of the Participant's Vested Account Balance shall be paid to the Participant as soon as practicable after the Participant's request is submitted to and approved by the Committee.

7.13 Lost Participant. If payment of a Participant's Account Balance is unable to be made under this Article VII because the Committee is unable to find the Participant or Beneficiary to whom payment is to be made, such Participant's Account Balance shall be forfeited as of the last day of the Plan Year in which the Committee determines that it is unable to find the Participant or Beneficiary. If the Participant or Beneficiary later makes a claim for such payment and the Committee determines that such claim is valid, the Participant's forfeited Account Balance shall be restored and payment shall be made as promptly as practicable thereafter.

ARTICLE VIII

DESIGNATION OF BENEFICIARY

8.1 Right to Designate Beneficiary. Subject to the provisions of Section 7.3(b) and Section 8.3, each Participant may designate, in a manner determined by the Committee and filed with the Committee, a Beneficiary to whom, in the event of the Participant's death, all benefits shall be payable. The Beneficiary so designated may be changed by the Participant (subject to the provisions of Section 8.3) at any time or from time to time during his life by signing and filing a new beneficiary designation form. The records of the Committee at the time of death shall be conclusive as to the identity of the proper Beneficiary and the amount properly payable, and payment made in accordance with such form shall constitute a complete discharge of any and all obligations hereunder.

8.2 Applicable Rules if No Beneficiary Designation is Made. If no Beneficiary designation is on file with the Committee at the time of death of the Participant, or if such designation is not effective for any reason, then such death benefit shall be payable to the deceased Participant's spouse, if living. If such spouse does not survive him, payment shall be made to the Participant's issue per stirpes, or if no issue survive him, to his estate.

8.3 Payment of Account Balance to Spouse upon Death of Participant. If the Beneficiary designated by the Participant to receive the benefits payable hereunder in the event of his death is not his spouse, then, notwithstanding the applicable provisions of Sections 7.1, 7.2, 7.4 and 8.1, such benefits shall be payable to the Participant's surviving spouse unless (a) there is no surviving spouse; (b) the spouse consents, in the manner required under Section 417(a)(2)(A) of the Code, to the payment of such benefits to the Designated Beneficiary; or (c) it

is established to the satisfaction of the Committee that the spousal consent may not be obtained because of the conditions specified in Section 417(a)(2)(B) of the Code or in regulations promulgated under such Section of the Code.

ARTICLE IX

LOANS

9.1 Availability of Loans.

(a) Upon the application of a Participant who is an Employee at the time of the application, the Trustee may make a loan to such Participant.

(b) The terms and conditions on which the Committee will approve loans under the Plan shall be applied on a reasonably equivalent basis and loans shall not be available to any Highly Compensated Employee in an amount equal to a percentage of his Vested Account Balance which is greater than the percentage made available to other Participants. For purposes of this Article IX, a Participant's Vested Account Balance shall not include the portion of such Vested Account Balance that is attributable to the Participant's Employer Contribution Account.

(c) The minimum loan shall be $1,000 and no more than two loans may be outstanding at any time.

9.2 Limitations on Loans. In no event shall the total amount of a loan made to any Participant pursuant to this Article IX (when added to the outstanding balance of all other loans made by the Plan to the Participant) exceed the lesser of:

(a) fifty percent (50%) of the Participant's Vested Account Balance, or

(b) $50,000.

The $50,000 limitation will be reduced by the excess, if any, of the highest outstanding loan balance from the Plan for such Participant during the one-year period ending on the day before the date on which the loan was made over the outstanding loan balance from the Plan on the date that such loan was made.

9.3 Interest Rate. The interest rate charged on any loan made pursuant to this Article IX shall be determined by the Committee and shall be at least equivalent to the prevailing interest rate charged by persons in the business of lending money for loans which would be made under similar circumstances.

9.4 Security for Loan. Any loan made pursuant to this Article IX shall be secured by the Participant's Vested Account Balance.

9.5 Term of Loan.

(a) The term of any loan shall not be for less than six (6) months or for more than five (5) years; provided, however, that the term of a loan used for the purpose of acquiring a dwelling unit which within a reasonable time is to be used (determined at the time the loan is made) as the principal residence of the Participant may be for a period of up to ten (10) years.

(b) If a Participant ceases to be an Employee, the Participant may continue to make loan payments in accordance with the loan repayment terms. If the loan is not repaid in accordance with the loan repayment terms, the Committee or the Trustee shall use the remedies provided under Section 9.8 to recover such loan.

9.6 Loan Agreement. Each Participant to whom a loan is made under this Article IX shall enter into an agreement with the Trustee. Such agreement shall set forth the principal amount of the loan, the repayment terms (subject to the provisions of Section 9.7), the interest rate and the provisions for securing the loan in accordance with Section 9.4.

9.7 Repayment of Loan.

(a) Payments of principal and interest shall be made by payroll deduction or in any other manner agreed to by the Participant and the Trustee; provided, however, that in all

cases, loan repayments of principal and interest shall be made in substantially level amounts and shall be made no less frequently than quarterly over the term of the loan.

(b) Principal and interest payments with respect to the loan shall be credited solely to the Participant's Before Tax Savings Contribution Account (and, if applicable, Rollover Contribution Account) based upon the Participant's current investment elections. Any loss caused by nonpayment or other default on a Participant's loan obligations shall be borne solely by such Participant's Before Tax Savings Contribution Account (and, if applicable, Rollover Contribution Account).

(c) If a Participant is on an unpaid leave of absence, such Participant shall continue to have an obligation to repay the loan pursuant to the Loan Agreement described in Section 9.6. Such loan shall be repaid in the manner agreed to by such Participant and the Trustee.

(d) A loan may be repaid in full as of any date without penalty.

9.8 Collection of Loan. In the event that the Participant does not repay such loan within the time and manner prescribed by the repayment terms, in addition to any legal remedies the Trustee or the Committee may have, the unpaid amount of such loan shall be offset against any distribution payable to such Participant or Beneficiary under Article VII at the time such distribution would first become payable thereunder. In the event that the amount of any such offset is not sufficient to repay the remaining balance of any such loan, such Participant shall be liable for and continue to make payments on any balance still due from him.

9.9 Loan Guidelines. The Committee may issue loan guidelines, which shall form part of the Plan, describing the procedures and conditions for making and repaying loans, and may revise those guidelines at any time and for any reason.

ARTICLE X

ADMINISTRATION OF THE PLAN

10.1 Definitions. For purposes of this Plan:

(a) "Fiduciary" shall mean any person who exercises any discretionary authority or discretionary control respecting the management or disposition of Plan assets, renders any investment advice for a fee or other compensation with respect to Plan assets, or exercises any discretionary authority or responsibility for Plan administration, and includes the Named Fiduciaries.

(b) "Named Fiduciary" shall mean the Committee established to administer the Plan. The Committee shall have the responsibility to designate the investment funds available under the Plan, but the Committee shall not have any responsibility with respect to the investment of any assets of the Plan that are properly subject to direction of investment by Participants.

10.2 Administration.

(a) The Committee shall be the administrator of the Plan and shall consist of at least two (2) individuals appointed by the Employer; provided however, that the Employer may delegate to the Association, the power to appoint the members of the Committee. The Committee shall have the authority to control and manage the operation and administration of the Plan in accordance with the responsibilities set forth in this Article, and shall have sole authority and discretion to determine all questions arising in the administration of the Plan, including questions relating to eligibility for, and the amount of, benefits under the Plan.

(b) The Committee may authorize any one or more individuals to execute any documents on behalf of the Committee, and any such documents so executed shall be accepted and relied upon as representing action by the Committee until the Committee shall revoke such authorization.

(c) The Committee may from time to time establish rules and regulations to implement the provisions of this Plan. The records of the Employer, as certified to the Committee, shall be conclusive with respect to any and all factual matters dealing with the employment of a Participant. The Committee shall interpret the Plan and shall have sole authority and discretion to determine all questions arising in the administration, interpretation and application of the Plan, and all such determinations by the Committee shall be conclusive and binding on all persons subject to the provisions of the Code and ERISA.

(d) The Committee shall direct the Trustee in writing (or in electronic format) to make payments from the Fund to Participants or Beneficiaries who qualify for such payments hereunder. Such order to the Trustee shall specify the name of the Participant or Beneficiary, his Social Security number, his address, and the amount and frequency of such payments.

(e) The Trustee may request instructions in writing (or in electronic format) from the Committee on any matters affecting the Trust and may rely and act thereon.

(f) The Committee shall be the agent for receipt of service of process by the Plan.

10.3 Allocation and Delegation of Responsibilities.

(a) The Committee may delegate the duties and responsibilities hereunder, other than the responsibility to reconsider the policy and method of funding the Plan as provided in this Article.

(b) The Committee may employ or engage accountants, legal counsel, actuaries, custodians, agents or other persons to render advice or perform ministerial duties with regard to any responsibility or duty which the Committee has under the Plan. To the extent permitted by law, a member of the Committee shall be entitled to rely upon and be fully protected in any action taken by him in good faith in reliance upon any opinions or reports which shall be furnished to him by such accountants, legal counsel, actuaries, custodians, agents or other persons, and shall not be precluded from rendering such advice in his individual capacity.

(c) The Committee may appoint an Investment Manager or Managers to manage, acquire and dispose of any assets of the Plan. Any such Investment Manager shall be an investment adviser registered under the Investment Advisers Act of 1940, a bank as defined in that Act, or an insurance company qualified to perform investment services under the laws of at least two states. The appointment of any such Investment Manager shall not be effective until such Investment Manager has acknowledged in writing that it is a Fiduciary under ERISA with respect to the Plan.

(d) The Committee shall periodically, but at least annually, review the performance of any persons to whom any duties or responsibilities have been allocated or delegated, and any persons who are employed or engaged to render advice or perform ministerial services. The Committee may require such formal or informal reports from such persons as it shall deem prudent and appropriate, and shall promptly terminate such allocation, delegation, employment, or engagement upon its determination that any such person or persons have failed to discharge their obligations to the satisfaction of the Committee or with the standard of care which would be imposed upon the Committee in the absence of such allocation, delegation, employment, or engagement.

(e) The Plan may purchase insurance for any Fiduciary to cover liability or losses occurring by reason of the act or omission of such Fiduciary, but such insurance shall permit recourse by the insurer against such Fiduciary in the case of a breach of a fiduciary obligation.

(f) The Association and/or the Employer shall indemnify any Committee member, director, officer, shareholder or employee of the Association and/or the Employer against any and all claims, losses, damages, expenses and liabilities arising from their responsibilities in connection with the Plan, unless the same is determined to be due to gross negligence or willful misconduct.

(g) Nothing herein shall prevent any person or group of persons from serving in more than one fiduciary capacity with respect to the Plan, nor prevent an Employee or Participant from serving as a Fiduciary with respect to the Plan.

10.4 Standard of Conduct.

(a) In discharging their duties, the Fiduciaries shall act with the skill, care, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims. All Fiduciaries shall discharge their duties with respect to this Plan solely in the interests of the Participants and Beneficiaries and for the exclusive purpose of providing benefits to Participants and their Beneficiaries and paying reasonable expenses of administering the Plan; provided that contributions (or the assets attributable thereto) may be returned to the Employer under Section 3.6 of this Plan.

(b) The Committee shall periodically, but at least annually, reconsider the policy and method of funding the Plan and shall take such action as it deems necessary and

advisable to implement its determinations. Such reconsideration shall take into account the short and long term financial needs of the Plan.

10.5 Bonding Requirement. All Fiduciaries and any other persons who handle assets of the Plan shall serve under such bond as may be required by ERISA, or other applicable law, but in the absence of any such requirement, shall serve without bond. The Plan shall purchase the bond for any Committee member, director, officer, shareholder or Employee of the Employer who is required to serve under bond.

10.6 Benefit Claims and Appeals. The claim of any person (hereinafter referred to as the "Claimant") with respect to any benefits to which such Claimant may be entitled under the Plan shall be considered in accordance with the following procedure:

(a) Any Claimant may make written application to the Committee for benefits to which he believes he is entitled, at the time the application is made, under the Plan. Such application shall set forth all information necessary to determine whether the claim should be approved or denied. The Committee shall furnish to the Claimant an acknowledgment of his application, including a notice of the time limits set forth in this Section 10.6.

(b) The Committee shall either approve the claim and take any appropriate action, or deny the claim. Such approval or denial shall be accomplished within an initial period of ninety (90) days after receipt of the claim by the Committee unless special circumstances require an extension of time for processing the claim. If such an extension is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial ninety (90) day period. Any such extension shall expire no later than ninety (90) days after the end of the initial period. The extension notice shall describe the special circumstances requiring the extension of time and the expected date of decision.

(c) If a claim is denied, the Committee shall furnish a written notice of such action to the Claimant within the applicable time limit described in paragraph (b). Such notice shall set forth, in a manner calculated to be understood by the Claimant:

(i) the specific reason or reasons for the denial;

(ii) specific reference to the pertinent provisions of this Plan on which the denial is based;

(iii) a description of any additional material or information necessary for the Claimant to perfect his claim and an explanation of why such material or information is necessary; and

(iv) an explanation of the review procedure, as set forth in paragraph (d).

(d) A Claimant whose claim has been denied may appeal by written notice to the Committee requesting a review of the denial. The Claimant's written request for review must be submitted to the Committee within sixty (60) days after his receipt of the notice of the denial. A Claimant who wishes to appeal or has appealed a denial may:

(i) review all pertinent documents relating to his claim; and

(ii) submit issues and comments in writing for consideration by the Committee.

(e) The Committee shall render the decision on review within an initial period of sixty (60) days after receipt of the Claimant's written request for review, unless special circumstances (including the need to hold a hearing, if the Committee has provided a procedure for holding hearings) require an extension of time. Any such extension shall expire no later than sixty (60) days after the end of the initial period. If such an extension is required, written notice

thereof shall be furnished to the Claimant before the end of the initial period. The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the Claimant with specific references to the pertinent provisions of the Plan on which the decision is based.

(f) Any claim, request for review or other action which may be made or taken by the Claimant under this Section may be made or taken by the Claimant's duly authorized representative.

(g) The Committee shall not be bound by any notice or other communication unless and until it shall have been received in writing addressed to NBA Services Corp. at Olympic Tower - 15th Floor, 645 Fifth Avenue, New York, New York 10022, Attention: NBA Retirement Plan for Referees Committee.

10.7 Records and Reports. The Committee shall keep a record of all proceedings and acts and shall keep such books of account, records, and other data as may be necessary for proper administration of the Plan. The Committee shall make the records available for examination during business hours to the Association, Employer or any person who may be entitled to benefits under the terms of this Plan, except that any such person shall examine only such records as pertain exclusively to such person, the Plan and Trust Agreement as currently in effect or hereafter amended, and any other documents which such person may be entitled to examine under ERISA or any other applicable law. The Committee shall also furnish to any person who may be entitled to benefits under the terms of this Plan such reports, descriptions, notifications or other materials as may be required under ERISA, the Code or other applicable law within the applicable time limits.

10.8 Expenses and Compensation of Fiduciaries.

(a) All Fiduciaries, except those receiving full time pay from the Association and/or Employer, may receive from the Plan such reasonable compensation for services rendered to the Plan as shall be determined by the Committee.

(b) All Fiduciaries shall be reimbursed for expenses reasonably incurred in performance of their duties.

(c) The Plan may make advances to a Fiduciary to cover expenses to be properly and actually incurred by such Fiduciary in the performance of that Fiduciary's duties with respect to the Plan, provided that

(i) the amount of the advance shall be reasonable with respect to the amount of the expense which is to be incurred, and

(ii) the Fiduciary must account to the Committee at the end of the period covered by the advance for the expenses actually incurred.

(d) Nothing shall preclude a Fiduciary from receiving any benefit to which he may be entitled under the terms of the Plan, provided that such benefit shall be computed and paid on a basis which is consistent with the terms of the Plan as applied to all other Participants and Beneficiaries.

ARTICLE XI

THE TRUST FUND

11.1 Trust Agreement. The Employer has entered into an Agreement of Trust with Trustee (the "Trust Agreement"), providing for the administration of the Fund by it as Trustee, in such form and containing such provisions as are deemed appropriate. The Trust Agreement shall be deemed to form a part of this Plan, and any and all rights and benefits which may accrue to any person under this Plan shall be subject to all the terms and provisions of said Trust Agreement.

11.2 Investment Funds. The Fund shall be composed of the Investment Funds designated by the Committee consisting of amounts in Participants' Before Tax Savings Contribution Accounts, Employer Contribution Account, Catch-Up Contribution Account, QNEC Contribution Account and/or Rollover Contribution Account and the earnings thereon that accrue from time to time.

11.3 No Segregation of Participants' Interests. Each Investment Fund may be maintained on an unallocated, undivided basis with no segregation of the interests of the Participants.

ARTICLE XII

AMENDMENT, TERMINATION AND DISCONTINUANCE OF CONTRIBUTIONS

12.1 Amendments.

(a) The provisions of this Plan may be amended at any time and from time to time, by a written instrument executed by the Employer. No such amendment, however, shall:

(i) vest in the Employer any interest or control over the funds accumulated in accordance with this Plan or the benefits provided hereunder, except as provided in Section 3.6;

(ii) operate to deprive a Participant of any rights or benefits irrevocably vested in him under the Plan prior to such amendment; provided, however, that if any amendment shall be necessary to conform the Plan to the provisions and requirements of the Code, any regulation issued pursuant thereto, or any other pertinent provisions of federal or state law, no such amendment shall be considered prejudicial to the interest of a Participant or his Beneficiary, or a diversion of any part of the Fund to a purpose other than for their exclusive benefit; or

(iii) increase the powers, duties or liabilities of the Trustee without their written consent.

(b) Any modification or amendment of the Plan may be made retroactive, if the Employer, on the advice of counsel, deems such retroactivity to be necessary in order for the Plan to conform to, or satisfy the conditions of any law, governmental regulations or ruling, to

meet the requirements of the applicable sections of the Code, or, where applicable, to reflect the operation of the Plan.

12.2 Termination.

(a) This Plan may be terminated by a written instrument executed by the Employer.

(b) If the operations of the Employer continues after termination, the Fund shall either (i) continue to be held for distribution in precisely the same time and manner as set forth in Article VII hereof or (ii) shall be held for distribution by the Trustee who shall distribute to the Participants then participating in the Fund the full amount standing to their credit, less the administrative costs to the Trustee for such distribution in accordance with Article VII; provided, however, that subparagraph (ii) shall apply only if the distribution is permitted under Section 401(k)(10) of the Code and the regulations thereunder.

(c) If the Plan is terminated and the Employer dissolves or ceases operations, the Fund shall be held for distribution by the Trustee who shall distribute to the Participants then participating in the Fund the full amount standing to their credit, less the administrative costs to the Trustee for such distribution in accordance with Article VII, provided that such distribution is permitted under Section 401(k)(10) of the Code and the regulations thereunder

12.3 Vesting on Termination. In the event of the partial or complete termination of the Plan, the interests of all affected Participants in the Fund shall be fully vested.

ARTICLE XIII

MISCELLANEOUS

13.1 No Rights to Employment. Nothing contained in this Plan or in the Trust shall be held or construed to create any liability upon the Employer to retain any Employee in its employ. The Employer reserves the right to discontinue the services of any Employee without any liability except for salary or wages that may be due and unpaid whenever, in its judgment, its best interests so require.

13.2 Exclusive Benefit. This Plan and the Trust is for the exclusive benefit of the Participants and their Beneficiaries. This Plan should be interpreted in a manner consistent with this intent and with the intention that the Trust satisfy those provisions of the Code relating to qualified employee plans.

13.3 Obligation to Pay Benefits. The Employer shall have no liability in respect to the payment of benefits or otherwise under the Plan; and the Employer shall have no liability in respect to the administration of the Trust or of the Fund held by the Trustee, and each Participant and/or Beneficiary shall look solely to the Fund for any payments or benefits under the Plan.

13.4 Administrative Expenses. The Association and/or Employer may pay all administrative expenses of the Plan and Trust, including the compensation of consultants, auditors and counsel, but the Employer shall not be obligated to pay such expenses. If the Association and/or Employer elect not to pay such expenses, the expenses shall be paid from the Fund. Any expenses directly relating to the investments of the Fund, such as taxes, commissions, and registration charges, shall be paid from the Fund.

13.5 Anti-Alienation. Except as may otherwise be provided under Section 401(a)(13)(B) and/or (C) of the Code, no benefit under this Plan shall be subject in any manner to anticipation, pledge, encumbrance, alienation or assignment, and any attempt to anticipate, pledge, encumber, alienate or assign any such benefit shall be void, nor shall any such benefits be in any way subject to seizure, attachment or other legal or equitable process for the debts, contracts or liabilities of any Participant or Beneficiary. For purposes of this Section 15.5, payments may be made under this Plan to an "alternate payee" (as defined in Code Section 414(p)(8)) prior to the Participant's "earliest retirement age" (within the meaning of Code Section 414(p)(4)(B)) to the extent that such payments are consistent with the qualified domestic relations order.

13.6 Merger. In the case of any merger or consolidation of the Plan with, or transfer of Plan assets or liabilities to, any other plan, provisions shall be made so that each Participant in the Plan on the date thereof (if the Plan then terminated) would receive a benefit immediately after the merger, consolidation or transfer which is equal to or greater than the benefit he would have been entitled to receive immediately prior to the merger, consolidation or transfer if the Plan had then terminated.

13.7 Employment With Affiliate. If an Employee transfers from employment with the Employer to employment with an Affiliate that has not adopted the Plan, his employment shall not be deemed terminated for purposes of the Plan until such time as he shall be employed by neither the Employer nor an Affiliate.

13.8 Transfer from NBA Retirement Plan. In connection with the transfer of the assets and liabilities associated with the account balances of Referees under the NBA Retirement Plan (including all outstanding loan balances attributable thereto) from the NBA Retirement Plan to

the Plan on the Plan Transfer Effective Date, with respect to each Referee who was a Participant under the NBA Retirement Plan as of such date (and who is not employed by the Association or any other participating employer in the NBA Retirement Plan on such date), all amounts transferred to the Plan shall be accounted for under the Plan in accordance with the following rules:

(a) Amounts transferred from the NBA Retirement Plan to this Plan consisting of a Participant's "Before Tax Savings Contribution Account" (as such term was defined in the NBA Retirement Plan), including any outstanding loan balances, are credited to such Participant's Before Tax Savings Contribution Account under this Plan.

(b) Amounts transferred from the NBA Retirement Plan to this Plan consisting of a Participant's "Rollover Contribution Account" (as such term was defined in the NBA Retirement Plan) are credited to such Participant's Rollover Contribution Account under this Plan.

(c) All applicable "benefit options" (within the meaning of Section 411(d)(6)(B)(ii) of the Code and Treasury Regulations thereunder) that are attributable to any amounts transferred from the NBA Retirement Plan shall continue to apply with respect to such transferred amounts held under this Plan.

13.9 Military Service. Notwithstanding any provision of the Plan to the contrary: (a) contributions and vesting service credit with respect to qualified military service (as defined in Section 414(u)(5) of the Code) shall be provided in accordance with Section 414(u)(8) of the Code and in accordance with an individual's re-employment rights under the Uniformed Services Employment and Re-employment Rights Act; (b) the Plan shall provide the survivors of a Participant who dies while performing qualified military service (as defined in Section 414(u)(5)

of the Code) with any additional benefits (other than contributions relating to the period of qualified military service) provided under the Plan in accordance with the requirements of Section 401(a)(37) of the Code (to the extent such benefits are provided under the Plan); (c) in the case of an Employee receiving a differential wage payment under Section 3401(h)(2) of the Code, (i) the Employee shall be treated as an Eligible Employee of the Employer making the payment, (ii) the differential wage payment shall be treated as Adjusted Compensation for purposes of the Plan, and (iii) the Plan shall not be treated as having failed to meet the requirements of any provision described in Section 414(u)(1)(C) of the Code by reason of the making of (or the right to make) any contribution based on the differential wage payment; and (d) the Committee shall administer and operate the Plan in compliance with the Heroes Earnings Assistance and Relief Tax Act of 2008.

13.10 ERISA. This Plan shall be construed and administered in complete accordance with ERISA and, to the extent not preempted by such Act, the laws of the state of New York.

13.11 Gender and Number. Pronouns shall be interpreted so that the masculine pronoun shall include the feminine, and the singular shall include the plural.

13.12 Headings. Headings of sections and subsections of this Plan are inserted for convenience of reference. They constitute no part of this Plan and are not to be considered in the construction thereof.

13.13 Severability. If any provision of this Plan is held to be illegal, invalid or unenforceable for any reason, this shall not affect any other provision of the Plan, and this Plan shall be construed as if said illegal, invalid or unenforceable provision had never been inserted herein.

13.14 Restatement. The Plan set forth herein shall amend and restate, effective as of October 1, 2012, unless otherwise provided herein, all provisions of the Plan, as in effect on September 30, 2012, except that the rights of former Employees who terminated employment, died or retired prior to October 1, 2012, shall be governed by the terms of such plan as in effect at the time of the Termination of Employment, death or Retirement.

IN WITNESS WHEREOF, NBA Services Corp. executed this Plan on the 18th day of January, 2013.

NBA SERVICES CORP.

By: _____

Title: V.P.

FIRST AMENDMENT
TO THE NBA RETIREMENT PLAN FOR REFEREES

WHEREAS, the NBA Retirement Plan for Referees (the "Plan") was last restated and amended effective as of October 1, 2012;

WHEREAS, under Section 12.1 of the Plan, NBA Services Corp. (the "Employer") reserves the right to amend the provisions of the Plan;

WHEREAS, it is necessary to amend the Plan in order to clarify (i) that the actual deferral percentage testing for the Plan continues to utilize the current year testing method; and (ii) that a participant who ceases to be an employee on account of disability may elect to defer any distribution in excess of $5,000 until the participant's "required beginning date."

NOW, THEREFORE, the Plan is hereby amended to read as follows:

1. Section 4.3(b) of the Plan is hereby amended to read as follows:

"(b) Average Actual Deferral Percentage.

(i) The Average Actual Deferral Percentage for a Plan Year for Referees who are Highly Compensated Employees for the Plan Year shall not exceed the Average Actual Deferral Percentage for such Plan Year for Referees who were Nonhighly Compensated Employees for such Plan Year multiplied by 1.25; or

(ii) The excess of the Average Actual Deferral Percentage for Referees who are Highly Compensated Employees for the Plan Year over the Average Actual Deferral Percentage for such Plan Year for Referees who were Nonhighly Compensated Employees for such Plan Year shall not exceed two (2) percentage points, and the Average Actual Deferral Percentage for Referees who were Highly Compensated Employees for the Plan Year shall not exceed the Average Actual Deferral Percentage for such Plan Year for Referees who were Nonhighly Compensated Employees for such Plan Year multiplied by 2."

2. Section 7.2(b) of the Plan is hereby amended to read as follows:

"(b) A Participant who ceases to be an Employee on account of Disability shall be entitled to defer receipt of any distribution under paragraph (a) of this Section 7.2 until he elects to receive such distribution; provided, however, that such distribution shall be made or commence no later than the Participant's Required Beginning Date."

3. Effective Date.

The amendments made by paragraphs 1 and 2 above shall be effective as of October 1, 2012.

IN WITNESS WHEREOF, NBA Services Corp. has executed this First Amendment to the Plan on this 30 day of September, 2013.

NBA SERVICES CORP.

By: _____

Title: VP

SECOND AMENDMENT

TO THE NBA RETIREMENT PLAN FOR REFEREES

WHEREAS, the NBA Retirement Plan for Referees (the "Plan") was last restated and amended effective as of October 1, 2012;

WHEREAS, under Section 12.1 of the Plan, NBA Services Corp. (the "Employer") reserves the right to amend the provisions of the Plan;

WHEREAS, the First Amendment to the Plan was adopted on September 30, 2013;

WHEREAS, it is necessary to amend the Plan in order to provide for a definition of "Spouse" in accordance with Revenue Ruling 2013-17 and Notice 2014-19.

NOW, THEREFORE, the Plan is hereby amended to read as follows:

1. Article I of the Plan is amended to add new Section 1.55A to read:

> "1.55A 'Spouse' shall mean, effective as of June 26, 2013, an individual married to a Participant if the marriage is legally entered into in a state pursuant to the laws of that state, without regard to whether such marriage is recognized in the state in which such couple is domiciled. For purposes of the foregoing, the term 'state' means any domestic or foreign jurisdiction having the legal authority to sanction marriages."

2. The Plan is amended to change all references therein of "spouse" to "Spouse", and to change all references therein of "non-spouse" to "non-Spouse".

3. Effective Date.

The amendments made by paragraphs 1 and 2 above shall be effective as of June 26, 2013.

IN WITNESS WHEREOF, NBA Services Corp. has executed this Second Amendment to the Plan on this 17th day of November, 2014.

NBA SERVICES CORP.

By: _____

Title: VP

THIRD AMENDMENT

TO THE NBA RETIREMENT PLAN FOR REFEREES

WHEREAS, the NBA Retirement Plan for Referees (the "Plan") was last restated and amended effective as of October 1, 2012;

WHEREAS, under Section 12.1 of the Plan, NBA Services Corp. reserves the right to amend the provisions of the Plan;

WHEREAS, the First Amendment to the Plan was adopted on September 30, 2013;

WHEREAS, the Second Amendment to the Plan was adopted on November 17, 2014; and

WHEREAS, pursuant to the Collective Bargaining Agreement between NBA Services Corp. and the National Basketball Referees Association, dated August 26, 2015, it has become necessary to further amend the Plan in order to provide that assignments in the NBA Replay Center during a Regular Season shall be taken into account for purposes of determining whether a Referee is considered to be on the Referees' Roster for such Regular Season.

NOW, THEREFORE, the Plan is hereby amended as set forth below:

1. The second sentence of Section 1.48 of the Plan is hereby amended and restated to read as follows:

> "Notwithstanding the foregoing, (i) any games officiated by a Referee in a Developmental League under circumstances described in Article III, Section 8 of the CBA or Article IX, Section 2(c) of the CBA, shall be included in determining if the Referee shall be considered to be on the Referees' Roster for the Regular Season involved and (ii) for any Regular Season beginning after May 31, 2015, any assignments worked by a Referee in the NBA Replay Center during a Regular Season (whether in conjunction with Championship or Exhibition Games) shall be

included in determining if the Referee shall be considered to be on the Referees' Roster for the Regular Season involved."

2. Effective Date.

This Third Amendment to the Plan shall be effective on October 1, 2015.

IN WITNESS WHEREOF, NBA Services Corp. has executed this Third Amendment to the Plan on this 30th day of November, 2015.

NBA SERVICES CORP.

By: _____

Title: VP

FOURTH AMENDMENT

TO THE NBA RETIREMENT PLAN FOR REFEREES

WHEREAS, the NBA Retirement Plan for Referees (the "Plan") was last restated and amended effective as of October 1, 2012;

WHEREAS, under Section 12.1 of the Plan, NBA Services Corp. reserves the right to amend the provisions of the Plan;

WHEREAS, the First Amendment to the Plan was adopted on September 30, 2013;

WHEREAS, the Second Amendment to the Plan was adopted on November 17, 2014;

WHEREAS, the Third Amendment to the Plan was adopted on November 30, 2015; and

WHEREAS, it is necessary to further amend the Plan in order to (i) apply the 20% top-paid group election with respect to the definition of Highly Compensated Employees effective as of October 1, 2018; (ii) provide for certain changes to the Plan's hardship withdrawal rules pursuant to the Bipartisan Budget Act of 2018; and (iii) make certain other changes to the Plan.

NOW, THEREFORE, the Plan is hereby amended as set forth below:

1. Section 1.29(a) of the Plan is amended to read as follows:

> "(a) 'Highly Compensated Employee' shall mean, with respect to the Employer, an Employee who performed services for the Employer during the 'determination year' and (i) who at any time during the 'determination year' or the 'look-back year' was a five percent (5%) owner of the Employer or any Affiliate, or (ii) who, during the 'look-back year' (A) received Adjusted Compensation from the Employer or any Affiliate in excess of $120,000 (as adjusted by the

Adjustment Factor in accordance with Section 414(q)(1) of the Code) and (B) effective for Plan Years commencing on or after October 1, 2018, was in the top twenty percent (20%) of all Employees of the Employer, ranked on the basis of their Adjusted Compensation paid during such look-back year. (For the sole purpose of applying the twenty percent rule set forth in this Section 1.29(a), Adjusted Compensation shall be determined without regard to the Limitation on Compensation set forth in Section 4.6 of the Plan.)"

2. Section 7.4(f) of the Plan is amended to read as follows:

"(f) In the case of a Participant who receives a distribution of his Vested Account Balance under paragraph (c) of this Section in connection with his Termination of Employment and is not vested in his Employer Contribution Account as of the date of his Termination of Employment, such Employer Contribution Account shall be forfeited as of the date on which the Participant receives such distribution of his Vested Account Balance. In the case of a Participant who is not vested in his Employer Contribution Account as of the date of his Termination of Employment and who does not elect to receive a distribution of his Vested Account Balance in connection with his Termination of Employment, such Employer Contribution Account shall be forfeited as of the earlier of (A) the last day of the Plan Year in which such Participant incurs five (5) consecutive One-Year Periods of Severance or (B) the date that the Participant receives payment of his Vested Account Balance pursuant to paragraph (c) of this Section 7.4. Except as otherwise provided under paragraph (g) of this Section, the amount of any forfeitures of a Participant described in this paragraph or other provisions of the Plan for the Plan Year may be used, at the discretion of the Committee, to pay administrative expenses of the Plan pursuant to Section 13.4 or a credit towards any Employer Contributions to be made by the Employer under Section 3.2."

3. Section 7.11 of the Plan is amended to read as follows:

"7.11 Hardship Distributions. A Participant shall be entitled to receive a hardship distribution up to the total amount of a Participant's Vested Account Balance, including, effective October 1, 2019, income attributable to Before Tax Savings Contributions or Catch-Up Contributions, but excluding the portion of his Vested Account Balance attributable to (a) his Employer Contribution Account, (b) the amount of any outstanding loan, and (c) Qualified Nonelective Contributions and any income attributable to such contributions, if the distribution is necessary to defray an immediate and severe financial hardship incurred by the Participant. The amount of the distribution may not exceed the amount required to meet the immediate financial need created by the hardship and not reasonably available from other resources of the Participant. The existence of an immediate and heavy financial need, and the amount necessary to meet such need, will be determined by the Committee in accordance with the standards set forth below.

(a) Immediate and Heavy Financial Need. For purposes hereof, an immediate and heavy financial need shall be limited to a need for funds for any of the following purposes:

(i) Unreimbursed medical expenses described in Section 213(d) of the Code incurred by the Participant, the Participant's Spouse, or any dependents of the Participant (as defined in Section 152 of the Code);

(ii) Purchase (excluding mortgage payments) of a principal residence for the Participant;

(iii) Payment of tuition and related educational fees (including room and board expenses) for the next twelve (12) months of post-secondary education for the Participant or his Spouse, children, or dependents;

(iv) Prevention of the eviction of the Participant from his principal residence or foreclosure on the mortgage on his principal residence;

(v) Payment for burial or funeral expenses for the Participant's deceased parent, Spouse, child, or dependent; and

(vi) Expenses for the repair of damage to a Participant's principal residence that would qualify for the casualty deduction under Section 165 of the Code (determined without regard to whether the loss exceeds ten percent (10%) of adjusted gross income or is attributable to a federally-declared disaster (within the meaning of Section 165(i)(5) of the Code))

A Participant requesting a hardship withdrawal must represent that he has an emergency need for funds for one of the reasons specified above. The Participant shall provide the Committee with any information and evidence which the Committee considers necessary in order to determine whether such a hardship exists and the amount of the withdrawal from the Plan that is necessary to meet the hardship.

(b) Distribution Necessary to Satisfy the Financial Need. A hardship withdrawal shall be considered to be necessary to meet such an immediate and heavy financial need only under the following circumstances:

(i) The distribution is not in excess of the amount of the immediate and heavy financial need of the Participant (that cannot be satisfied by distributions of the types described in subparagraph (ii) below). This distribution may include any amounts necessary to pay any federal, state or local income taxes or penalties reasonably anticipated to result from the distribution.

(ii) The Participant has obtained (or requested) all distributions, other than hardship distributions, and all non-taxable loans currently available under the Plan and, if applicable, under any other qualified and nonqualified plans of deferred compensation maintained by the Employer or any Affiliate; provided, however, that effective October 1, 2019, a hardship withdrawal shall be considered to meet an immediate and heavy financial need irrespective of whether the Participant has applied for or received any non-taxable loans available under the Plan or any other qualified and nonqualified plans of deferred compensation maintained by the Employer or any Affiliate.

For Plan Years prior to October 1, 2019, in the event of a hardship distribution to a Participant hereunder, such Participant may not make Before Tax Savings Contributions and/or Catch-Up Contributions to the Plan or, if applicable, to any other qualified or nonqualified plans of deferred compensation, or stock option, stock purchase or similar plans maintained by the Employer or any Affiliate during the six (6) calendar months immediately following the date of such hardship withdrawal. Effective October 1, 2019, the six (6) calendar months suspension rule described in the preceding sentence shall cease to apply to hardship distributions made to any Participant, and any such suspension that is applicable to a Participant on September 30, 2019, shall cease to apply effective October 1, 2019.

The foregoing provisions shall be applied on a uniform and nondiscriminatory basis and shall be subject to such changes as the Committee may deem to be necessary at any time to comply with Treasury Regulations or other rules issued under Section 401(k) of the Code.

(c) Additional Operating Rules. The following rules shall apply to each request for a hardship distribution by a Participant:

(i) The Participant's request for a hardship distribution shall be made on such forms as are provided from time to time by the Committee and the Participant shall furnish the Committee with such information as the Committee requests in its evaluation of the Participant's request.

(ii) The amount of any hardship distribution shall in no event exceed the value of the Participant's Vested Account Balance (as determined for this purpose without including the amount of any outstanding loan).

(iii) The hardship distribution shall be made from the Investment Funds on a pro rata basis.

(iv) The minimum hardship withdrawal under this Section 7.11 shall be $1,000."

4. Effective Dates.

(a) The amendment made by paragraphs 1 and 2 of this Fourth Amendment shall be effective as of October 1, 2018.

(b) The amendment made by paragraph 3 of this Fourth Amendment shall be effective on October 1, 2019.

IN WITNESS WHEREOF, NBA Services Corp. has executed this Fourth Amendment to the NBA Retirement Plan for Referees on this 30th day of September, 2019.

NBA SERVICES CORP.

By: _____

Title: Treasurer

FIFTH AMENDMENT

TO THE NBA RETIREMENT PLAN FOR REFEREES

WHEREAS, the NBA Retirement Plan for Referees (the "Plan") was last restated and amended effective as of October 1, 2012;

WHEREAS, under Section 12.1 of the Plan, NBA Services Corp. reserves the right to amend the provisions of the Plan;

WHEREAS, the First Amendment to the Plan was adopted on September 30, 2013;

WHEREAS, the Second Amendment to the Plan was adopted on November 17, 2014;

WHEREAS, the Third Amendment to the Plan was adopted on November 30, 2015;

WHEREAS, the Fourth Amendment to the Plan was adopted on September 30, 2019; and

WHEREAS, it is necessary to further amend the Plan in order to (i) incorporate certain rules provided for in final IRS regulations regarding hardship distributions and (ii) provide for a modified definition of "Referees' Roster" for the 2019-20 Regular Season in accordance with the June 25, 2020 letter agreement amending the Collective Bargaining Agreement between NBA Services Corp. and the National Basketball Referees Association.

NOW, THEREFORE, the Plan is hereby amended as set forth below:

1. Section 1.48 of the Plan, as previously amended by the Third Amendment, is hereby further amended to read in its entirety as follows:

"1.48 (a) 'Referees' Roster" shall mean a list of all Referees who had been a Referee for thirty (30) or more of a combination of Championship and Exhibition Games played during the Regular Season involved.

(b) Notwithstanding the foregoing:

(i) Any games officiated by a Referee in a Developmental League under circumstances described in Article III, Section 8 of the CBA or Article IX, Section 2(c) of the CBA, shall be included in determining if the Referee shall be considered to be on the Referees' Roster for the Regular Season involved.

(ii) For the Plan Year commencing on October 1, 2011 and ending on September 30, 2012 and for the Regular Season commencing on December 25, 2011 (the '2011-12 Regular Season'), 'Referees' Roster' shall mean a list of all Referees who had been a Referee for twenty-four (24) or more of a combination of Championship and Exhibition Games played during the 2011-12 Regular Season.

(iii) For any Regular Season beginning after May 31, 2015, any assignments worked by a Referee in the NBA Replay Center during a Regular Season (whether in conjunction with Championship or Exhibition Games) shall be included in determining if the Referee shall be considered to be on the Referees' Roster for the Regular Season involved.

(iv) For the Plan Year commencing on October 1, 2019 and ending on September 30, 2020 and for the Regular Season commencing on October 22, 2019 (the '2019-20 Regular Season'), 'Referees' Roster' shall mean a list of all Referees who perform officiating services for thirty (30) or more of a combination of (A) Championship Games (which shall include Seeding Games and Scrimmages, provided that any half-Scrimmage worked shall be counted as a half-game) and Exhibition Games played and (B) NBA Replay Center assignments worked during the 2019-20 Regular Season (including assignments worked through August 14, 2020).

(v) 'Referees' Roster' shall also include any Referee who terminates his employment to enter the Armed Forces of the United States, who is not otherwise considered to be on the Referees' Roster for the Regular Season involved, if and to the extent that, applicable law requires the Referee to be so treated.

(c) For purposes of Section 1.48(b)(iv), the following definitions shall apply:

(i) 'Orlando Campus' means the grounds of the ESPN Wide World of Sports Complex and any hotels or other areas on the same geographic footprint in Orlando, Florida.

(ii) 'Scrimmage' means a competition involving one or more NBA teams that is held on the Orlando Campus prior to the first Seeding Game.

(iii) 'Seeding Game' means a game between NBA teams that is played during the period from July 30, 2020 to August 14, 2020 and that is included with each team's Regular Season record to determine a team's qualification for the NBA Playoffs."

2. Section 3.2(b)(iv) is amended by replacing the reference to "Section 1.48(b)" with a reference to "Section 1.48(b)(ii)."

3. Section 7.11 of the Plan is amended to read as follows:

"7.11 Hardship Distributions. A Participant shall be entitled to receive a hardship distribution up to the total amount of the Participant's Vested Account Balance, including, effective October 1, 2019, income attributable to Before Tax Savings Contributions or Catch-Up Contributions, but excluding the portion of his or her Vested Account Balance attributable to (a) his or her Employer Contribution Account, (b) the amount of any outstanding loan, and (c) Qualified Nonelective Contributions and any income attributable to such contributions; provided, that the distribution is necessary to defray an immediate and heavy financial hardship incurred by the Participant. The existence of an immediate and heavy financial need, and the amount necessary to meet such need, will be determined by the Committee in accordance with the standards set forth below.

(a) Immediate and Heavy Financial Need. For purposes hereof, an immediate and heavy financial need shall be limited to a need for funds for any of the following purposes:

(i) Unreimbursed medical expenses described in Section 213(d) of the Code incurred by the Participant or the Participant's Spouse, dependents (as defined in Section 152 of the Code) or primary Beneficiary;

(ii) Purchase (excluding mortgage payments) of a principal residence for the Participant;

(iii) Payment of tuition and related educational fees (including room and board) for the next twelve (12) months of post-secondary

education for the Participant or the Participant's Spouse, children, dependents or primary Beneficiary;

(iv) Prevention of the eviction of the Participant from his or her principal residence or foreclosure on the mortgage on his principal residence;

(v) Payment for burial or funeral expenses for the Participant's deceased parent, Spouse, child, dependent or primary Beneficiary;

(vi) Expenses for the repair of damage to a Participant's principal residence that would qualify for the casualty deduction under Section 165 of the Code (determined without regard to whether the loss exceeds ten percent (10%) of adjusted gross income or is attributable to a federally-declared disaster (within the meaning of Section 165(i)(5) of the Code)); and

(vii) Expenses or losses incurred by Participant as a result of a federally declared disaster.

(b) Distribution Necessary to Satisfy the Financial Need. A hardship distribution shall be considered to be necessary to meet an immediate and heavy financial need only under the following circumstances:

(i) The distribution is not in excess of the amount of the immediate and heavy financial need of the Participant; this distribution may include any amounts necessary to pay any federal, state or local income taxes or penalties reasonably anticipated to result from the distribution;

(ii) The Participant has obtained (or requested) all distributions, other than hardship distributions under all the plans maintained by the Employer or any Affiliate;

(iii) The Participant has represented in writing (or electronic format) to the Committee that the Participant does not have sufficient funds or liquid assets reasonably available to satisfy the financial need; and

(iv) The Committee has no actual knowledge that is contrary to the Participant's written (or electronic) representation.

For Plan Years prior to October 1, 2019, in the event of a hardship distribution to a Participant hereunder, such Participant may not make Before Tax Savings Contributions and/or Catch-Up Contributions to the Plan or, if applicable, to any other qualified or nonqualified plans of deferred compensation, or stock option, stock purchase or similar plans maintained by the Employer or any

Affiliate during the six (6) calendar months immediately following the date of such hardship distribution. Effective October 1, 2019, the six (6) calendar months suspension rule described in the preceding sentence shall cease to apply to hardship distributions made to any Participant, and any such suspension that is applicable to a Participant on September 30, 2019, shall cease to apply effective October 1, 2019.

The foregoing provisions shall be applied on a uniform and nondiscriminatory basis and shall be subject to such changes as the Committee may deem to be necessary at any time to comply with Treasury Regulations or other rules issued under Section 401(k) of the Code.

(c) Additional Operating Rules. The following rules shall apply to each request for a hardship distribution by a Participant:

(i) The Participant's request for a hardship distribution shall be made on such forms as are provided from time to time by the Committee;

(ii) A Participant shall provide the Committee with any information and evidence that the Committee considers necessary in order to determine whether an immediate and heavy financial need exists and the amount of the distribution from the Plan that is necessary to meet the immediate and heavy financial need;

(iii) The amount of any hardship distribution shall in no event exceed the value of the Participant's Vested Account Balance (as determined for this purpose without including the amount of any outstanding loan);

(iv) The amount of any hardship distribution shall be made from the Investment Funds on a pro rata basis; and

(v) The minimum hardship distribution under this Section 7.11 shall be $1,000."

4. Effective Dates.

(a) The amendments made by paragraphs 1 and 2 of this Fifth Amendment shall be effective as of June 25, 2020.

(b) The amendment made by paragraph 3 of this Fifth Amendment shall be effective as of January 1, 2020.

IN WITNESS WHEREOF, NBA Services Corp. has executed this Fifth Amendment to the NBA Retirement Plan for Referees on this 25th day of September, 2020.

NBA SERVICES CORP.

By: _____

Title: Treasurer

EXHIBIT J

AGREEMENT AND RELEASE

AGREEMENT AND RELEASE made this ____ day of _____, 20__, by and among NBA Services Corp. ("NBA"), ***[name of Referee]*** ("Referee"), and the National Basketball Referees Association ("NBRA"):

WHEREAS, pursuant to the Collective Bargaining Agreement between the NBA and the NBRA effective as of September 1, 2022 ("CBA"), Referee is eligible for certain post-employment benefits following the cessation of Referee's employment by the NBA as an active game official; and

WHEREAS, the NBA's provision of such post-employment benefits is conditioned upon the execution by Referee, the NBRA and the NBA of an Agreement and Release and upon such Agreement and Release becoming effective and enforceable; and

WHEREAS, Referee and the NBRA acknowledge that Referee's employment by the NBA as an active game official has terminated; and

WHEREAS, Referee has elected to receive the post-employment benefits described below;

NOW, THEREFORE, the parties agree as follows:

1. Referee shall receive the post-employment benefits as provided for by [***insert Article and Section***] of the CBA.

[*insert terms of post-employment severance payment and/or insurance benefit]*

2. The post-employment benefits provided for in Section 1 above shall be in lieu of any other benefits or payments to which Referee might otherwise be entitled under any

other provision of the CBA. Absent the execution by Referee and the NBRA of this Agreement and Release, the NBA has no obligation under any term of the CBA, or under any of its policies, plans, or procedures, to provide Referee with any of the post-employment benefits provided for in Section 1, and, accordingly, Referee and the NBRA agree and acknowledge that such post-employment benefits exceed any payment, benefit or other thing of value to which Referee might otherwise be entitled from the NBA.

3. For and in consideration of the post-employment benefits provided for herein, Referee (for himself/herself, and for his/her heirs, executors, administrators, trustees, legal representatives and assigns) and the NBRA hereby forever release and discharge the NBA, the National Basketball Association and each of its member teams ("Member Teams"), NBA Properties, Inc., NBA Entertainment, NBA Media Ventures, LLC, and each of their respective past, current and future owners, affiliates, subsidiaries, welfare and retirement plans, directors, officers, employees, agents, partners and shareholders (hereinafter collectively referred to as "Releasees") from any and all claims, demands, causes of action and liabilities of any kind whatsoever (upon any legal or equitable theory, whether contractual, common-law, statutory, decisional, federal, provincial, state, local or otherwise), whether known or unknown, by reason of any act, omission, transaction or occurrence occurring up to and including (in the case of Referee) the date upon which Referee signs this Agreement and Release and (in the case of the NBRA) the date upon which the NBRA signs this Agreement and Release. Notwithstanding the foregoing, this Agreement and Release shall not release or waive Referee's rights to the post-employment benefits provided for by Section 1 above, claims or rights which cannot be waived as a matter of law, or Referee's rights, if any, under the National Basketball Association

Referees' Pension Plan or any successor thereto. For the avoidance of doubt, this Agreement and Release shall not release or waive Referee's rights with regard to claims arising after Referee signs this Agreement and Release.

4. Without limiting the generality of the foregoing, Referee and the NBRA hereby release and discharge Releasees from:

(a) any claims arising under the Age Discrimination in Employment Act, the Older Workers Benefit Protection Act, Title VII of the Civil Rights Act, the Americans With Disabilities Act, the Employee Retirement Income Security Act, and the Family and Medical Leave Act;

(b) any other claims for employment discrimination, claims otherwise related to Referee's employment with the NBA and termination of that employment (whether based on a federal, state, provincial or local statute, ordinance, regulation, or court decision), claims for wrongful termination, defamation, or emotional distress, or claims otherwise arising in tort or contract (either express or implied); and

(c) any claims relating to, or arising out of, the making of this Agreement and Release (except for claims related to enforcement of this Agreement and Release).

5. (a) Referee represents and warrants that he/she has not commenced, maintained, prosecuted or participated in any action, suit, charge, complaint or proceeding of any kind against Releasees, or any one or more of them, that is pending in any court or before any administrative or investigative body or agency.

(b) Except as set forth below, Referee and the NBRA covenant that they shall not at any time hereafter commence, maintain, prosecute, participate in, or permit to be filed by any other person on his/her or its behalf, any action, suit, charge, complaint or proceeding of any kind against Releasees, or any one or more of them, with respect to any act, omission, transaction or occurrence occurring up to and including the Effective Date (as defined below) of this Agreement and Release relating to Referee's employment with the NBA or the termination of that employment. Notwithstanding the foregoing, nothing in this Agreement shall be construed to prevent Referee or the NBRA from: (i) responding truthfully to a valid subpoena; (ii) filing a charge or complaint of, or otherwise reporting any good faith allegation of, alleged employment discrimination or retaliation or other unlawful employment practices with, or participating in an investigation or proceeding concerning an employment discrimination or retaliation charge or other unlawful employment practice conducted by, any governmental agency; or (iii) making disclosures that are protected under the whistleblower provisions of federal or state law or regulation; provided, however, that Referee and the NBRA agree that they will not accept any award or settlement from any source or proceeding (including, but not limited to, any proceeding brought by any person or by any governmental agency) with respect to any claim or right waived in this Agreement.

6. The making of this Agreement and Release is not intended, and shall not be construed, as an admission that Releasees, or any one or more of them, have or has violated any federal, state, provincial or local law (statutory or decisional), ordinance or regulation, breached any contract or committed any wrong whatsoever against Referee or the NBRA.

7. Referee is hereby advised by the NBA, and Referee acknowledges that he/she has been advised by the NBA, to consult an attorney before signing this Agreement and Release and that he/she has executed this Agreement and Release after having been afforded the opportunity to consider the terms and conditions of this Agreement and Release for a period of twenty-one (21) days. Referee agrees that any modification to this Agreement and Release, material or otherwise, does not restart, extend, or effect in any way the original 21-day consideration period. Referee further acknowledges that he/she has read this Agreement and Release in its entirety; that he/she fully understands all of its terms and their significance; and that he/she knowingly and voluntarily assents to all the terms and conditions herein.

8. This Agreement and Release shall not become effective until the eighth day following Referee's signing of this Agreement and Release (the "Effective Date"), and, then, only if it has also been signed by or on behalf of (i) the NBRA on or before such Effective Date and (ii) the NBA.

9. Referee may at any time prior to the Effective Date revoke his/her acceptance of this Agreement and Release by giving notice in writing of such revocation to the NBA, Attention: General Counsel, by (i) fax (to 212-888-7931) and (ii) certified mail, return receipt requested (to NBA, 645 Fifth Avenue, New York, NY 10022).

10. In the event Referee revokes this Agreement and Release prior to the Effective Date, or in the event the NBRA fails to execute this Agreement and Release by or before the Effective Date, this Agreement and Release, and the promises contained herein, shall automatically be deemed null and void.

11. This Agreement and Release is made under and shall be governed by the internal law of the State of New York, without regard to New York's principles of conflicts of law, except where United States federal law may govern. No action with respect to this Agreement and Release shall be brought or maintained in any court other than the United States District Court for the Southern District of New York or the Supreme Court of the State of New York, New York County, and the parties consent to personal jurisdiction accordingly.

12. If any provision of this Agreement and Release (or aspect of any provision) is held by a court of competent jurisdiction to be illegal, void or unenforceable, such provision (or aspect of any provision) shall have no effect; however, the remaining provisions shall be enforced to the maximum extent possible; provided, however, if the release and waiver above is deemed to be illegal, void or unenforceable, Referee agrees to enter into a valid release satisfactory to the NBA, or at Referee's option, to return the amounts received as consideration for this Agreement and Release. Further, if a court should determine that any portion of this Agreement and Release is overbroad or unreasonable, such provision shall be given effect to the maximum extent possible by narrowing or enforcing in part that aspect of the provision found overbroad or unreasonable.

13. This Agreement and Release represents the complete understanding between the parties with respect to the cessation or termination of Referee's employment with the NBA. No other promises or agreements shall be binding unless in writing and signed by the parties.

14. This Agreement and Release is binding upon, and shall inure to the benefit of, the parties and their respective heirs, executors, administrators, successors and assigns.

15. This Agreement and Release may be executed in several counterparts, each of which shall be deemed as an original, but all of which together shall constitute one and the same instrument.

ACCEPTED AND AGREED TO:

REFEREE

_____

Dated:_____

NATIONAL BASKETBALL REFEREES ASSOCIATION

By:_____

Dated:_____

NBA SERVICES CORP.

By:_____

Dated:_____

EXHIBIT K

REFEREE HEIGHTS

Name	Ht. (in.)
Acosta	73”
Adair	77”
Adams	76"
Barnaky	73"
Blair	74"
Boland	72"
Brothers	74"
Brown	73"
Buchert	71"
Butler	72”
Callahan	69"
Capers	71"
Collins	72"
Conley	75”
Corbin	71"
Cutler	80"
Dagher	74”
Dalen	79"
Davis	72"
DeRosa	72”
Ervin	73”
Fitzgerald	71"
Ford	69”
Forte, B	69"
Foster	71"
Fraher	70"
Goble, Ja.	71”
Goble, Jo.	72"
Goldenberg	72”
Green	77”
Guthrie	74"
Holtkamp	71"
Jelks	70"
Kennedy	69"
Kirkland	72"
Kogut	73"
Lane	75"
Lewis	72"
Lindsay	71"
Maddox	73"

Malloy	77"
Mehta	72"
Mott	76"
Moyer-Gleich	69”
Myers	72”
Nagy	71.5”
Nansel	76”
Orr	76"
Petraitis	73"
Ransom	75"
Richardson, D	72"
Sago	67"
Schroeder	66.5”
Schwab	72”
Scott, D	67”
Scott, E	69”
Scott, K	72"
Smith, A	70”
Smith, M	70"
Sterling	72"
Taylor, B	72"
Taylor, D	70"
Tiven	72"
Twardoski	70"
Van Duyne	73"
Wall	73"
Washington, CJ	72”
Washington, T	72"
Williams	71"
Wood	75"
Workman	74"
Wright	74"
Zarba	74"

CONFIDENTIALITY AND SETTLEMENT AGREEMENT

Agreement, dated April 1, 2014 (the "Agreement"), between the National Basketball Association and NBA Services Corp. (collectively, the "NBA") and the National Basketball Referees Association (the "Union") (collectively, the "Parties").

WHEREAS, on July 16, 2013, the Union requested certain information related to how referees are evaluated;

WHEREAS, the Union filed an unfair labor practice charge – NLRB Case No. 2-CA-111019 (the "Charge") – with the National Labor Relations Board (the "Board"), alleging that the NBA did not fulfill its statutory obligation to produce the requested information to the Union;

WHEREAS, the Parties have bargained over that request, and over what information the NBA is, for the period defined in Paragraph 7 below, required to produce to the Union concerning referee evaluations and/or the "Ernst & Young Report" (the "Report");

WHEREAS, the Parties have agreed to settle the Charge by agreeing to produce certain information related to how referees are evaluated and to the Report (the "Settlement");

WHEREAS, the NBA considers that information to be of a highly confidential nature; and

WHEREAS, the Parties have agreed to enter into this Agreement to permit disclosure of information deemed confidential pursuant to procedures protecting the confidentiality of such information;

IT IS HEREBY STIPULATED, as follows:

1. In connection with the Settlement, the NBA agrees to disclose the following information to the Union and to the individual referee in accordance with paragraph 3 below:

    a. A written mid-season review for each referee for the 2013-14 season and going forward;

    b. For Group 3 referees, Development Advisor emails to referees containing feedback on play calling or other aspects of job performance for the 2010-11, 2011-12, and 2012-13 seasons and going forward on a monthly basis;

c. For Group 3 referees, emails to the Referee Operations department's files from Development Advisors or other Referee Operations managers, recounting conversations with referees concerning play calling or other aspects of job performance for the 2010-11, 2011-12, and 2012-13 seasons and going forward on a monthly basis;

d. For Group 3 referees, narrative Development Advisor game evaluation summaries prepared by Development Advisors or other Referee Operations managers who attended games for the 2011-12, and 2012-13 seasons and going forward on a monthly basis;

e. For non-Group 3 referees who have been discharged or placed on formal notice, the information described in Paragraphs 1.a – 1.d above for the season in which they are discharged or placed on formal notice and for the two immediately preceding seasons.

f. Each referee's overall composite rating from the Report for the 2010-11, 2011-12, and 2012-13 seasons and going forward;

g. For each referee, the ratings in each performance standard category by the Senior VP of Referee Operations and Director of Officials from the Report for the 2010-11, 2011-12, and 2012-13 seasons and going forward; and

h. For each referee, the ratings in each performance standard category by each NBA Coach and General Manager from the Report for the 2010-11, 2011-12, and 2012-13 seasons and going forward. The NBA will not reveal the identities of the coach and general manager who give each rating. Instead, the team names associated with the coach and general manager ratings will be replaced by a number representing the team with the coach and general manager ratings listed by that team identifier.

2. The information set forth in Paragraphs 1.c through 1.h above shall be designated, collectively, as "Confidential Information."

3. Officers of and Counsel for the Union are permitted to review Confidential Information, and individual referees can review Confidential Information that pertains to them (i.e. a Group 3 referee can review emails and game summaries as described in Paragraphs 1.c and 1.d above that are about that Group 3 referee; a referee can review his or her own ratings as described in Paragraphs 1.f – 1.h above; when discharged or placed on formal notice, a non-Group 3 referee can review emails and game summaries as described in Paragraph 1.e above that are about that non-Group 3 referee). Persons who are permitted to review Confidential Information shall be known as "Qualified Persons."

4. Confidential Information shall be disclosed only as described above in Paragraph 3, and only to Qualified Persons. Each Qualified Person will maintain Confidential Information in confidence and will not reveal any Confidential Information to any person who is not a Qualified Person without the prior written consent of the NBA. Confidential Information shall not be disclosed, given, shown, discussed or otherwise divulged or communicated to any person or entity except as provided herein. Without limiting any other obligations hereunder, the Qualified Persons shall keep all such documents and copies secure and control access to them while they are in their possession or control and shall prevent such documents and copies from falling into any other person's possession, which preventive measures shall include using the same degree of care as they use to protect the Union's own Confidential Information, but in no event less than a reasonable standard of care.

5. This Agreement has no effect upon and shall not extend to the NBA's use or disclosure of its own Confidential Information.

6. The Union agrees to be responsible for enforcing the confidentiality of the Confidential Information and to take at its expense such action, legal or otherwise, to the extent necessary to prevent disclosure by any referee or any of the Union's employees or other representatives of Confidential Information. It is further understood and agreed that money damages would not be a sufficient remedy for any breach of this agreement by the Union and that the NBA shall be entitled to specific performance and injunctive relief as remedies for such a breach. Such remedies shall not be deemed to be the exclusive remedies for a breach of this agreement by the Union but shall be in addition to all other remedies available at law or equity to the NBA. Further, the Union, in both its individual and representative capacities, agree to indemnify and defend the NBA and its employees, officers, directors and representatives against any and all actions, damages, settlement and the like, arising out of the Union's breach of this Confidentiality Agreement.

7. In order to come to this Settlement and Agreement, the Parties bargained over the information that the NBA is required to produce to the Union under the Act. The Union agrees that the NBA has met its requirement under the Act, and that it will not seek additional information regarding referee performance evaluations, including, but not limited to, information regarding the Report, emails from Development Advisors, and written evaluations, until December 31, 2015. If the Union makes an information request for referee performance evaluation documents on or about December 31, 2015, the NBA will furnish in writing to the Union, by no later than March 1, 2016, an answer that briefly describes which types of documents, if any, that the NBA will provide in response to the request.

Thereafter, any documents to be provided by the NBA in response to the information request will be delivered without unreasonable delay.

8. The Union, by its signature below, affirms that it will contact the Regional Director of Region 2 of the Board and request withdrawal of the Charge. This Agreement will not go into effect until the Board approves the withdrawal. The Union will not seek reinstatement of the Charge provided the Parties abide by the terms of this Agreement.

9. This Agreement shall be governed by the laws of the State of New York. The parties agree to the exclusive jurisdiction and venue of the Federal or state courts of New York located in New York, New York, and hereby waive any objection to such venue and jurisdiction. A party may waive any rights under this Agreement only by written waiver duly signed by such party, and no failure to exercise or delay in exercising a right under this Agreement shall constitute a waiver of such right, and the invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement.

IN WITNESS WHEREOF, the parties have set their hands as of the day and year first above written.

NATIONAL BASKETBALL ASSOCIATION

By: _____
Title: EVP + GC
Date: 4/4/14

NATIONAL BASKETBALL REFEREES ASSOCIATION

By: _____
Title: Associate General Counsel
Date: April 3, 2014

NBA SERVICES CORP.

By: _____
Title: EVP + GC
Date: 4/4/14

ARTICLE 35A

MISCONDUCT OF PERSONS OTHER THAN PLAYERS

The provisions of this Article 35A shall apply only to Members and Owners; to Officers, Managers, Coaches, and other employees, agents or representatives of a Member or Owner; and to all Referees and other employees of the Association; except that the term "employees" as used in this Article 35A shall mean employees other than Players. The word "persons" as used herein shall include all such Members, Owners, Officers, Managers, Coaches, Referees, employees, agents or representatives of Members, Owners, or the Association, other than Players.

(a) Each Member must provide and require in every contract with any of its Owners, Officers, Managers, Coaches or other employees that they shall be bound and governed by the Constitution and By-Laws, rules, regulations, resolutions and agreements of the Association, as they may be modified or amended from time to time. Each Member, at the direction of the Board of Governors or the Commissioner, as the case may be, shall take such action as the Board or Commissioner may direct in order to effectuate the purposes of this Article.

(b) The Commissioner shall direct the dismissal and perpetual disqualification from any further association with the Association or any of its Members, of any person found by the Commissioner after a hearing to have been guilty of offering, agreeing, conspiring, aiding, or attempting to cause any game of basketball to result otherwise than on its merits.

(c) Any person who gives, makes, issues, authorizes or endorses any statement having, or designed to have, an effect prejudicial or detrimental to the best interests of basketball or of the Association or of a Member or its Team, shall be liable to a fine not exceeding $5,000,000 and/or a suspension for a definite or indefinite period to be imposed by the Commissioner. The Member whose Owner, Officer, Manager, Coach or other employee has been so fined shall pay the amount of the fine should such person fail to do so within ten (10) days of its imposition.

(d) The Commissioner shall have the power to: (i) suspend for a definite or indefinite period, or to impose a fine not exceeding $5,000,000, or inflict both such suspension and fine upon any person who, in his opinion, shall have been guilty of conduct prejudicial or detrimental to the Association, and (ii) impose the forfeiture of Draft picks held by the Member employing or otherwise affiliated with the offending person or the transfer of such Draft picks to another Member.

(e) No person may, directly or indirectly, (i) entice, induce, persuade or attempt to entice, induce or persuade any Coach, Trainer, General Manager or any other person who is under contract to any other Member of the Association to enter into negotiations for or relating to his services or negotiate or contract for such services or (ii) otherwise interfere with any such employer-employee relationship of any other Member of the Association. The Commissioner, either in his discretion or at the request of any Member who alleges that its employee has been tampered with, shall conduct an investigation into whether a person has violated the anti-tampering rule set forth in the prior sentence. In the event that, following such investigation and a hearing at which the person (and the Member employing the person allegedly tampered with) has an opportunity to be heard after due notice, the Commissioner determines that the anti-tampering rule has been violated, he shall have the power, in his sole discretion, to impose a penalty for such offense, which penalty may include (without limitation) the suspension of such person for a definite or indefinite period; the prohibition of the Member employing or otherwise affiliated with the offending person from hiring the person being tampered with for a definite or indefinite period; the forfeiture of Draft picks held by the Member employing or otherwise affiliated with the offending person or the transfer of such Draft picks to the Member aggrieved by the tampering; and/or the imposition of a fine upon the offending person and/or the Member employing or otherwise affiliated with such offending person in an amount not to exceed $10,000,000. In the event that the Commissioner imposes a fine, he may direct that some or all of the fine be paid directly to the Member aggrieved by the tampering.

(f) No person may, directly or indirectly, (i) entice, induce, persuade, or attempt to entice, induce or persuade, any Player who is under contract to, or whose exclusive negotiating rights are held by, any other Member of the Association to enter into negotiations for or relating to his services or

negotiate or contract for such services or (ii) otherwise interfere with any such employer-employee relationship (or prospective employer-employee relationship in the case of a Player subject to exclusive negotiating rights) of any other Member of the Association. The Commissioner, either in his discretion or at the request of a Member who alleges that its Player has been tampered with, shall conduct an investigation into whether a person has violated the anti-tampering rule set forth in the prior sentence. In the event that, following such investigation and a hearing at which the person (and the Member employing the person allegedly tampered with) has an opportunity to be heard after due notice, the Commissioner determines that the anti-tampering rule has been violated, he shall have the power, in his sole discretion, to impose a penalty for such offense, which penalty may include (without limitation) the suspension of such person for a definite or indefinite period; the prohibition of the Member employing or otherwise affiliated with the offending person from hiring the Player tampered with for a definite or indefinite period; the forfeiture of Draft picks held by the Member employing or otherwise affiliated with the offending person or the transfer of such Draft picks to the aggrieved Member; and/or the imposition of a fine upon the offending person and/or the Member employing or otherwise affiliated with such offending person in an amount not to exceed $10,000,000. In the event that the Commissioner imposes a fine, he may direct that some or all of the fine be paid directly to the Member aggrieved by the tampering.

(g) No person may:

(i) directly or indirectly wager money or anything of value on the outcome of any game played by a Team in the league operated by the Association;

(ii) directly or indirectly disclose confidential or non-public Association or Team information (which includes but is not limited to confidential or non-public information concerning the medical, personal, or other condition of any Player, Coach, or Referee; any Player transaction; any disciplinary action taken or to be taken by the Association or a Team; and Referee schedules, assignments, statistics, and ratings) to any individual or entity, under circumstances where the person knows or should know that

such individual or entity intends to use such information in connection with wagering money or anything of value on the outcome of any game played by a Team in the league operated by the Association;

(iii) directly or indirectly induce or attempt to induce any individual or entity to wager money or anything of value on the outcome of any game played by a Team in the league operated by the Association; or

(iv) engage in any other conduct related to wagering money or anything of value on the outcome of any game played by a Team in the league operated by the Association that the Commissioner deems prejudicial or detrimental to the Association.

Any person who is charged with such conduct shall be given an opportunity to answer such charges after due notice, and the decision of the Commissioner shall be final, binding, conclusive, and unappealable. The penalty for such offense shall be within the absolute and sole discretion of the Commissioner and may include a fine, suspension, expulsion and/or perpetual disqualification from further association with the Association or any of its Members.

(h) Any person who has been convicted of (including a plea of guilty, no contest, or nolo contendere to) a crime involving the use, possession, or distribution of heroin, cocaine or any other substance for which a Player could be dismissed or disqualified from further association with the Association or any of its Members under the terms of the collective bargaining agreement then in effect, shall be subject to dismissal and disqualification from further association with the Association or any of its Members. Notwithstanding the foregoing, after a period of at least two years from the time of such person's dismissal and disqualification, such person may apply for reinstatement. However, such person shall have no right to reinstatement under any circumstance and the reinstatement shall be granted only with the prior approval of the Board of Governors, which may be conditioned upon such terms as the Board may determine in its sole discretion.

(i) All persons shall comply with such anti-drug programs as may be instituted by the Board of Governors from time to time. Such programs may include drug testing and penalties for violators. Penalties may include fines, suspensions, or dismissal and disqualification from further association with the Association or any of its Members. Any person dismissed and disqualified from further association with the Association or any of its Members pursuant to an anti-drug program instituted by the Board of Governors may apply for reinstatement after a period of at least two years from the time of such dismissal and disqualification. However, such person shall have no right to reinstatement under any circumstance and the reinstatement shall be granted only with the prior approval of the Board of Governors, which may be conditioned upon such terms as the Board may determine in its sole discretion.

NBA/NBRA ANTI-DRUG AGREEMENT

Section 1. Definitions.

As used in this Anti-Drug Agreement, the following terms shall have the following meanings:

(a) “Agreement” shall mean this NBA/NBRA Anti-Drug Agreement.

(b) "Authorization for Testing" shall mean a notice issued pursuant to the provisions of Section 5 of this Agreement.

(c) “CBA” shall mean the Collective Bargaining Agreement between NBA Services Corp. and the National Basketball Referees Association, dated September 12, 2022.

(d) "Come Forward Voluntarily" shall mean that a referee has directly communicated to the NBA, the NBRA, or the Medical Director his desire to enter the Program and seek treatment for a problem involving the use of a Prohibited Substance. A referee may not Come Forward Voluntarily if, prior to their direct communication with the NBA, NBRA, or Medical Director, they have been notified that their most recent drug test was positive for a Prohibited Substance.

(e) "Counselors" shall mean persons selected by the Medical Director to provide counseling and other treatment to referees in the Program.

(f) "Drugs of Abuse" shall mean any of the substances listed as drugs of abuse in Paragraph A of Exhibit 2 to this Agreement.

(g) "Drugs of Abuse Program" shall mean (i) the testing program for Drugs of Abuse set forth in this Agreement, and (ii) the education, treatment, and counseling program for Drugs of Abuse established by the Medical Director, which program may contain such elements—including, but not limited to, urine testing for Prohibited Substances—as may be determined by the Medical Director in his or her professional judgment.

(h) "In-Patient Facility" shall mean such treatment center or other facility as may be selected by the Medical Director.

(i) "Independent Expert" or "Expert" shall mean the person selected by the NBA and the NBRA in accordance with Section 2(b), below.

(j) "Marijuana Program" shall mean (i) the testing program for marijuana set forth in this Agreement, and (ii) the education, treatment, and counseling program for marijuana established by the Medical Director, which program may contain such elements—including, but not limited to, urine testing for marijuana—as may be determined by the Medical Director in his or her professional judgment.

(k) "Medical Director" shall mean the person selected by the NBA in accordance with Section 2(a) below.

(l) "Prohibited Substance" shall mean any of the substances listed on Exhibit 2 to this Agreement.

(m) "Program" shall mean this Anti-Drug Program, and shall include the Drugs of Abuse Program and the Marijuana Program.

(n) “Substance Abuse Professional” (SAP) shall mean the person selected by the NBA who satisfies the qualification criteria of 49 CFR Part 40, Subpart O, §40.281 and is responsible for determinations relevant to Sections 7 and 8 below. The NBA may select the same individual to be the Medical Director and the SAP.

Section 2. Administration.

(a) The NBA shall select a Medical Director who shall be a person experienced in the field of testing and treatment for substance abuse and who satisfies the Medical Review Officer qualification criteria of 49 CFR Part 40, Subpart G. The Medical Director shall have the responsibility, among other duties, for selecting and supervising the Counselors and other personnel necessary for the effective implementation of the Program, for evaluating and treating referees subject to the Program, for making medical review determinations for

Prohibited Substances, for evaluating and treating referees subject to the Program, and for otherwise managing and overseeing the Program, subject to the control of the NBA.

(b) The NBA and the NBRA shall jointly select an Independent Expert who shall have the responsibility for issuing Authorizations for Testing in accordance with Section 5 below.

(c) The Medical Director and Independent Expert shall serve for the duration of this Agreement, unless either the NBA or the NBRA has, by September 1 of any year covered by this Agreement, served written notice of discharge upon the other party and the Medical Director and/or Independent Expert. Such notice of discharge shall be effective as of the immediately following September 30; provided, however, that if the parties do not reach agreement by such September 30 as to who shall serve thereafter as the Medical Director and/or Independent Expert, each party shall, by the immediately following October 10, appoint a person who shall have no relationship to or affiliation with that party. Such persons shall then have until the immediately following November 1 to agree on the appointment of a new Medical Director and/or Independent Expert. Until a new Medical Director and/or Independent Expert has been appointed, the previous Medical Director and/or Independent Expert shall continue to serve.

(d) Unless specifically stated otherwise in this Agreement, all costs of the Program in excess of those covered by the NBA Referees Group Health Plan shall be paid by the NBA.

(e) Any and all disputes arising under this Agreement shall be resolved under the grievance procedures set forth in Article XV, Section 2 of the CBA; provided, however, that in any challenge to a decision, recommendation, or other conduct of the Medical Director or Independent Expert, or in any challenge to an action or process over which the Medical Director has supervision, the arbitrator shall apply an "arbitrary and capricious" standard of review.

Section 3. Confidentiality.

(a) Other than as reasonably required in connection with the suspension or disqualification of a referee, the NBA and the NBRA, and all of their members, affiliates, agents, consultants, and employees, are prohibited from publicly disclosing information about the diagnosis, treatment, prognosis, test results, compliance, or the fact of participation of a referee in the Program ("Program Information"). If a referee is suspended or disqualified for conduct involving a Prohibited Substance, the NBA shall not publicly disclose the Prohibited Substance involved, absent the agreement of the NBRA or the prior disclosure of such information by the referee (or by a person authorized by the referee to disclose such information).

(b) The Medical Director and the Counselors, and all of their affiliates, agents, consultants, and employees, are prohibited from publicly disclosing Program Information; provided, however, that the Medical Director shall not be prohibited from disclosing such information to the NBA and the NBRA.

(c) The Independent Expert is prohibited from publicly disclosing any information supplied to him by the NBA or the NBRA pursuant to Section 5 below.

(d) Any Program Information that is publicly disclosed (i) under subsection (a) above, (ii) by the referee, (iii) with the referee's authorization, or (iv) through release by sources other than the NBA, the NBRA, the Medical Director, the Counselors, or the Independent Expert, or any of their members, affiliates, agents, consultants, and employees, will, after such disclosure, no longer by subject to the confidentiality provisions of this Section.

(e) Other than as reasonably required by the Reasonable Cause Testing procedure set forth in Section 5 below, neither the NBA nor the NBRA shall divulge to any other person or entity (including their respective members, affiliates, agents, consultants, employees, and the referee involved):

(i) that it has received information regarding the use, possession, or distribution of a Prohibited Substance by a referee;

(ii) that it is considering requesting, has requested, or has had, a conference with the Independent Expert concerning the suspected use, possession, or distribution of a Prohibited Substance by a referee;

(iii) any information disclosed to the Independent Expert; or

(iv) the results of any conference with the Independent Expert.

Section 4. Testing.

(a) Collection and testing of urine specimens conducted pursuant to this Agreement, whether by the NBA or the Medical Director, shall be conducted in compliance with the analytical techniques described in 49 CFR Part 40, Subpart F, §§40.83, 40.85, 40.87, 40.89, 40.91, 40.93, 40.95, and 40.97(a). Such testing shall also comply with the collection procedures set forth in 49 CFR Part 40, Subpart D, §§ 40.43 (d), 40.49 and 40.51, and Subpart E §§ 40.61(b)-(e) and (g), 40.63(a)-(c) and (e), 40.65(a), and 40.71 and such additional procedures as may be established by the NBA after notice to the NBRA. All urine specimens will be collected by direct observation. The NBA and the Medical Director (after consultation with the NBA) are authorized to retain such consultants and support services as are necessary and appropriate to administer and conduct such testing.

(b) All tests conducted pursuant to this Agreement shall be analyzed by laboratories selected by the Medical Director, approved by the NBA, and certified by the Substance Abuse and Mental Health Services Administration (“SAMHSA”).

(c) Any test conducted pursuant to this Agreement will be considered "positive" for a Prohibited Substance under the following circumstances:

(i) If the test is positive for a Prohibited Substance and it is confirmed by laboratory analysis under the standards set forth in

49 CFR Part 40, Subpart F, §§40.83, 40.85, 40.87, 40.89, 40.91, 40.93, 40.95, and 40.97(a), and has been reviewed and verified by the Medical Director pursuant to Section 4(e) below.

(ii) If the referee fails or refuses to submit to a scheduled test, or refuses to cooperate fully with the testing process, without a reasonable explanation satisfactory to the Medical Director.

(iii) If the referee attempts to substitute, dilute, mask, or adulterate a specimen sample or in any other manner alter a test result and such result has been reviewed and verified by the Medical Director pursuant to Section 4(f) below.

(d) The NBA shall promptly notify the NBRA of any positive laboratory result from a test conducted by the NBA, and shall thereafter notify the referee. The Medical Director shall promptly notify the NBA and the NBRA of any positive laboratory result of a test conducted by the Medical Director, and (i) if a positive test would result in a penalty to be imposed on the referee, the NBA shall thereafter notify the referee of such result and such penalty, or (ii) if a positive test would not result in a penalty to be imposed on the referee, the Medical Director shall thereafter notify the referee of such result.

(e) Any positive laboratory result pursuant to Section 4(c)(i) or 4(c)(iii) above shall be reviewed and verified by the Medical Director. If the Medical Director determines, in his or her professional judgment, that there is a valid alternative medical explanation for such positive result, then the test shall be deemed negative. This medical review will be performed in accordance with the standards set forth in 49 CFR Part 40, Subpart G, §§ 40.133, 40.135 (a)-(c), 40.137, 40.139, 40.140, 40.141 and 40.151.

(f) Any positive laboratory result pursuant to Sections 4(c)(iii) above shall be reviewed and verified by the Medical Director. If the Medical Director determines, in his professional judgment, that there is a legitimate alternative medical explanation for such positive result, then the test shall be deemed negative. This medical review will be performed in accordance with the standards set forth in 49 CFR Part 40, Subpart G, §§ 40.133, 40.135 (a)-(c), 40.141, 40.145 and 40.151.

(g) Once the Medical Director has determined that a test result is positive pursuant to Section 4(c)(i) or 4(c)(iii) above, the Medical Director shall notify the NBA of such positive test in writing. The NBA shall notify the NBRA and shall thereafter notify the referee. Any referee who is notified of a positive test pursuant to this Section may, within five (5) business days of such notification, inform the NBA and the NBRA that they request testing of the split or "B" sample of their specimen. Any such test shall be subject to the provisions of this Section 4 and shall be performed within ten (10) business days of the referee's request. The test of the "B" sample will be performed at a SAMHSA-certified laboratory selected by the NBRA other than the laboratory that performed the test on the original or "A" sample.

(h) If a referee's test result is reported as "invalid" by the laboratory in accordance with the standards set forth in 49 CFR Part 40, Subpart F, §40.96 and that result is reviewed and verified by the Medical Director in accordance with the standards set forth in 49 CFR Part 40, Subpart G, §40.159, that referee will be subject to an additional test to be collected within thirty (30) days of the date that the Medical Director verified the invalid test result.

Section 5. Reasonable Cause Testing or Hearing.

(a) In the event that either the NBA or the NBRA has information that gives it reasonable cause to believe that a referee is engaged in the use, possession, or distribution of a Prohibited Substance, such party shall request a conference with the other party and the Independent Expert, which shall be held within twenty-four (24) hours or as soon thereafter as the Expert is available. Upon hearing the information presented, the Independent Expert shall immediately decide whether there is reasonable cause to believe that the referee in question has been engaged in the use, possession, or distribution of a Prohibited Substance. If the Independent Expert decides that such reasonable cause exists, the Independent Expert shall thereupon issue an Authorization for Testing with respect to such referee.

(b) In evaluating the information presented to him, the Independent Expert shall use his independent judgment based upon his experience in substance abuse detection and enforcement. The parties

acknowledge that the type of information to be presented to the Independent Expert is likely to consist of reports of conversations with third parties of the type generally considered by law enforcement authorities to be reliable sources, and that such sources might not otherwise come forward if their identities were to become known. Accordingly, neither the NBA nor the NBRA shall be required to divulge to each other or to the Independent Expert the names (or other identifying characteristics) of their sources of information regarding the use, possession, or distribution of a Prohibited Substance, and the absence of such identification of sources, standing alone, shall not constitute a basis for the Expert to refuse to issue an Authorization for Testing with respect to a referee. In conferences with the Independent Expert, the referee involved shall not be identified by name until such time as the Independent Expert has determined to issue an Authorization for Testing with respect to such referee in the form annexed hereto as Exhibit 1-A.

(c) If a referee is arrested for, or charged with, an offense involving the use, possession or distribution of a Prohibited Substance, the NBA may issue an Authorization for Testing, in the form annexed hereto as Exhibit 1-B, within fourteen (14) days of such arrest or charge without a hearing before the Independent Expert. If the offense involves a Drug of Abuse, the Authorization for Testing will only cover Drugs of Abuse. If the offense involves marijuana, the Authorization for Testing will only cover marijuana.

(d) Immediately upon the issuance of an Authorization for Testing under this Section 5 with respect to a particular referee, the NBA shall arrange for such referee to undergo testing for Drugs of Abuse (if the Authorization for Testing was based on information regarding the use, possession, or distribution of a Drug of Abuse), or for marijuana (if the authorization for Testing was based on information regarding the use, possession or distribution of marijuana) no more than four (4) times during the six-week period commencing with the issuance of the Authorization for Testing. Such testing may be administered at any time, in the discretion of the NBA, without prior notice to the referee.

(e) In the event that the referee tests positive for a Drug of Abuse pursuant to this Section 5, he shall immediately be dismissed and disqualified from any association with the NBA in accordance with the provisions of Section 10(a). If the referee tests positive for marijuana

pursuant to this Section 5, he shall enter the Program and suffer the applicable consequences set forth in Section 8 below.

(f) In the event that either the NBA or the NBRA determines that there is evidence to demonstrate that, within the previous year, a referee has engaged in the use, possession, or distribution of a Prohibited Substance, or has received treatment for use of a Prohibited Substance other than in accordance with the terms of this Agreement, it may, in lieu of requesting the testing procedure set forth in subsections (a)-(d) above, request a hearing in accordance with the grievance procedures set forth in Article XV, Section 2 of the CBA . If the arbitrator concludes that, within the previous year, the referee has used, possessed, or distributed a Prohibited Substance, or has received treatment other than in accordance with the terms of this Agreement, the referee shall immediately be dismissed and disqualified from any association with the NBA in accordance with the provisions of Section 10(a) below, notwithstanding the fact that the referee has not undergone the testing procedure set forth in this Section 5; provided, however, that if the arbitrator concludes that the referee has used or possessed marijuana, he shall enter the Program and suffer the applicable consequences set forth in Section 8 below.

Section 6. Random Testing.

(a) In addition to the testing procedures set forth in Section 5, above, a referee may be required to undergo testing for Prohibited Substances by the NBA no more than one (1) time each Season during the officials' pre-season training camp.

(b) In the event that a referee tests positive for a Drug of Abuse pursuant to this Section 6, he shall immediately be dismissed and disqualified from any association with the NBA in accordance with the provisions of Section 10(a). If the referee tests positive for marijuana pursuant to this Section 6, he shall enter the Program and suffer the applicable consequences set forth in Section 8 below.

Section 7. Drugs of Abuse Program.

(a) Voluntary Entry.

(i) A referee may enter the Drugs of Abuse Program voluntarily at any time by Coming Forward Voluntarily for a problem involving the use of a Drug of Abuse; provided, however, that a referee may not Come Forward Voluntarily: (A) until he has been invited to an NBA officials' pre-season training camp; (B) during any period in which an Authorization for Testing as to that referee remains in effect pursuant to Section 5 above; ((C) during any period in which he remains subject to in-patient or aftercare treatment in Stage 1 of the Drugs of Abuse Program; or (D) after he has reached Stage 2 of the Drugs of Abuse Program.

(ii) If a referee who has not previously entered the Drugs of Abuse Program Comes Forward Voluntarily for a problem involving the use of a Drug of Abuse, he shall enter Stage 1 of the Drugs of Abuse Program.

(iii) If a referee who has not previously entered Stage 2 of the Drugs of Abuse Program, but who has been notified by the SAP or Medical Director that he has successfully completed Stage 1 of that Program, Comes Forward Voluntarily for a problem involving the use of a Drug of Abuse, he shall enter Stage 2 of the Drugs of Abuse Program.

(iv) No penalty of any kind will be imposed on a referee as a result of having Come Forward Voluntarily for a problem involving the use of a Drug of Abuse. The foregoing sentence shall not preclude the imposition of a penalty under Section 7(c)(iv) below as a result of the referee's entering Stage 2 of the Drugs of Abuse Program, or any penalty called for by this Agreement as a result of conduct by the referee that occurs after he has Come Forward Voluntarily.

(b) Stage 1.

(i) Any referee who has entered Stage 1 of the Drugs of Abuse Program shall be required to submit to an evaluation by the

SAP, provide (or cause to be provided) to the SAP such relevant medical and treatment records as the SAP may request, and commence the treatment and testing program prescribed by the SAP.

(ii) If a referee, within ten (10) days of the date on which he was notified that he had entered Stage 1 of the Drugs of Abuse Program and without a reasonable excuse, fails to comply (in the professional judgment of the SAP) with any of the obligations set forth in Section 7(b)(i) above, he shall be suspended until such time as the SAP determines that he has fully complied with Section 7(b)(i). If such non-compliance continues without a reasonable excuse (in the professional judgment of the SAP) for thirty (30) days from the date on which the referee was notified that he had entered Stage 1 of the Drugs of Abuse Program, the referee shall (A) advance to Stage 2 of the Drugs of Abuse Program, or (B) the NBA may dismiss and disqualify that referee from any association with the NBA in accordance with the provisions of Section 10(a) below.

(iii) Except as provided in this Agreement, no penalty of any kind will be imposed on a referee while he is in Stage 1 of the Drugs of Abuse Program and, provided he complies with the terms of his prescribed treatment, he will continue to receive his compensation during the term of his treatment for a period of up to three (3) months of care in an In-Patient Facility and such aftercare as may be required by the SAP.

(c) Stage 2.

(i) Any referee who has entered Stage 2 of the Drugs of Abuse Program shall be required to submit to an evaluation by the SAP, provide (or cause to be provided) to the SAP such relevant medical and treatment records as the SAP may request, and commence the treatment and testing program prescribed by the SAP.

(ii) If a referee, within thirty (30) days of the date on which he was notified that he had entered Stage 2 of the Drugs of Abuse Program and without a reasonable excuse, fails to comply

(in the professional judgment of the SAP) with any of the obligations set forth in Section 7(c)(i) above he shall immediately be dismissed and disqualified from any association with the NBA in accordance with the provisions of Section 10(a) below.

(iii) A referee in Stage 2 of the Drugs of Abuse Program shall be suspended without pay during the period of his in-patient treatment and for at least the first six (6) months of his aftercare treatment. The referee shall remain suspended without pay during any subsequent period in which he is undergoing treatment that, in the professional judgment of the SAP, prevents him from rendering the officiating services called for by the CBA.

(iv) Any subsequent use, possession, or distribution of a Drug of Abuse by a referee in Stage 2, even if voluntarily disclosed, or any conduct by a referee in Stage 2 that results in his advancing one Stage in the Drugs of Abuse Program, shall result in the referee being immediately dismissed and disqualified from any association with the NBA in accordance with the provisions of Section 10(a) below.

(d) Treatment and Testing Program.

A referee who enters the Drugs of Abuse Program shall be required to comply with such in-patient and aftercare program as may be prescribed and supplemented from time to time by the SAP. Such program may include random testing for Prohibited Substances and for alcohol, and such non-testing elements as may be determined in the professional judgment of the SAP.

Section 8. Marijuana Program.

(a) Voluntary Entry.

(i) A referee may enter the Marijuana Program voluntarily at any time by Coming Forward Voluntarily; provided, however, that a referee may not Come Forward Voluntarily for a problem involving the use of marijuana: (A) until he has been invited to an NBA officials' pre-season training camp; (B) during any

period in which an Authorization for Testing as to that referee remains in effect pursuant to Section 5 above; or (C) during any period in which he remains subject to in-patient or aftercare treatment in the Marijuana Program.

(ii) If a referee who has not previously entered the Marijuana Program, or who has been notified by the SAP that he has successfully completed that Program, Comes Forward Voluntarily for a problem involving the use of marijuana, he shall enter the Marijuana Program.

(iii) No penalty of any kind will be imposed on a referee as a result of having Come Forward Voluntarily for a problem involving the use of marijuana. The foregoing sentence shall not preclude the imposition of any penalty called for by this Agreement as a result of conduct by the referee that occurs after he has Come Forward Voluntarily.

(b) Treatment.

(i) A referee who enters the Marijuana Program shall be required to submit to an evaluation by the SAP, provide (or cause to be provided) to the SAP such relevant medical and treatment records as the SAP may request, and commence the treatment and testing program prescribed by the SAP. Such program may include random testing for Prohibited Substances and for alcohol, and such non-testing elements as may be determined in the professional judgment of the SAP.

(ii) If a referee, within five (5) days of the date on which he was notified that he had entered the Marijuana Program and without a reasonable excuse, fails to comply (in the professional judgment of the SAP) with any of the obligations set forth in the first sentence of Section 8(b)(i) above, be shall be fined $1,000; if the referee thereafter fails to comply, without a reasonable excuse, with such obligations (in the professional judgment of the SAP) within eight (8) days of such notification, he shall be fined an additional $1,000; and for each additional day beyond the 8th day that the referee, without a reasonable excuse, fails to comply with such obligations (in the professional judgment of the SAP), he shall be

fined an additional $1,000. The total amount of such fines may not exceed the referee's total compensation.

(c) Penalties.

Any referee who (i) tests positive for marijuana pursuant to Section 5 or Section 6, (ii) is adjudged by the arbitrator pursuant to Section 5(e) to have used or possessed marijuana, or (iii) has been convicted of (including a plea of guilty, no contest or nolo contendere to) the use or possession of marijuana in violation of the law, shall suffer the following penalties:

(A) For the first such violation, the referee shall be required to enter the Marijuana Program;

(B) For the second such violation, the referee shall be fined $5,000 and, if the referee is not then subject to in-patient or aftercare treatment in the Marijuana Program, required to enter the Marijuana Program;

(C) For the third such violation, the referee shall be suspended without pay for five (5) games and, if the referee is not then subject to in-patient or aftercare treatment in the Marijuana Program, required to enter the Marijuana Program; and

(D) For any subsequent violation, the referee shall be suspended for five (5) games longer than their immediately-preceding suspension for violating the Marijuana Program and, if the referee is not then subject to in-patient or aftercare treatment in the Marijuana Program, be required to enter the Marijuana Program.

Section 9. Non-Compliance with Treatment.

(a) Drugs of Abuse.

(i) Any referee who, after entering Stage 1 or Stage 2 of the Drugs of Abuse Program, fails to comply with his treatment or

his aftercare program as prescribed and determined by the SAP, shall be suspended without pay. Such suspension without pay shall continue until the referee has, in the professional judgment of the SAP, resumed full compliance with his treatment program.

(ii) Notwithstanding Section 9(a)(i) above, any referee who in the professional judgment of the SAP, after entering Stage 1 or Stage 2 of the Drugs of Abuse Program, fails to comply with his treatment program through (A) a pattern of behavior that demonstrates a mindful disregard for his treatment responsibilities, or (B) a positive test for a Prohibited Substance that is not clinically expected by the Medical Director, shall suffer the following penalties:

(1) if the referee is in Stage 1 of the Drugs of Abuse Program, he shall advance to Stage 2 and be suspended without pay until, in the professional judgment of the Medical Director, he has resumed full compliance with his treatment program; or

(2) if the referee already is in Stage 2 of the Drugs of Abuse Program, he shall immediately be dismissed and disqualified from any association with the NBA in accordance with the provisions of Section 10(a) below.

(b) Marijuana.

(i) Any referee who, after entering the Marijuana Program, fails to comply (without a reasonable excuse) with his treatment program as prescribed and determined by the SAP, shall be fined $500 for each day that he fails to comply. Such fines shall continue until the referee has, in the professional judgment of the Medical Director, resumed full compliance with his treatment program. The total amount of such fines shall not exceed the referee's total compensation.

(ii) Notwithstanding Section 9(b)(i) above, any referee who, after entering the Marijuana Program, fails to comply with his treatment program through (A) a pattern of behavior that demonstrates a mindful disregard for his treatment responsibilities,

or (B) a positive test for marijuana that is not clinically expected by the Medical Director, shall suffer the following penalties:

(1) if the referee has not previously been fined $5,000 under Section 8(c) above or this Section 9(b)(ii), a fine of $5,000;

(2) if the referee has previously been fined $5,000 under Section 8(c) above or this Section 9(b)(ii), a suspension without pay of five (5) games; or

(3) if the referee has previously been suspended without pay for five (5) games under Section 8(c) above or this Section 9(b)(ii), a suspension that is at least five (5) games longer than their immediately-preceding suspension and that shall continue until, in the professional judgment of the Medical Director, the referee resumes full compliance with their treatment program.

(iii) In addition to any consequence to the referee under Section 9(b)(ii) above, any referee who has entered the Marijuana Program but not the Drugs of Abuse Program, and tests positive for a Drug of Abuse in any test conducted by the Medical Director or the SAP, shall enter Stage 1 of the Drugs of Abuse Program.

(c) Directed Testing.

Any referee who, after entering the Program, and without a reasonable explanation satisfactory to the Medical Director, fails to appear for any of his scheduled games shall submit to a urine test, to be conducted by the NBA, within twenty-four (24) hours of the game for which the referee failed to appear. The referee shall be required to telephone the Medical Director within the required 24-hour period, advise the Medical Director of his location, and comply with the Medical Director's instructions as to where and when he will be tested. If any test conducted pursuant to this Section 9(c) is positive: (x) for a Drug of Abuse (for a referee in the Drugs of Abuse Program), then the referee shall suffer the applicable consequences set forth in Section 9(a)(ii) above; or (y) for marijuana (for a referee in the Marijuana Program), then the referee shall suffer the applicable consequences set forth in Section 9(b)(ii) above. Nothing in

this Section 9(c) shall affect any right that the NBA may have by contract or by law to discipline a referee (up to and including termination of unemployment) for that referee's failure to appear for any scheduled game.

Section 10. Dismissal and Disqualification.

(a) A referee who, under the terms of this Agreement, is "dismissed and disqualified from any association with the NBA in accordance with the provisions of Section 10(a)" shall, without exception, be terminated for just cause by the NBA pursuant to Article X, Section 3(b) or Section 4(d) of the CBA, as applicable. Such dismissal and disqualification shall be mandatory and may not be rescinded or reduced by the NBA.

(b) In addition to any other provision of this Agreement requiring that a referee be dismissed and disqualified from any association with the NBA in accordance with the provisions of Section 10(a) above, a referee will also be dismissed and disqualified under Section 10(a) if he is convicted of (including a plea of guilty, no contest, or nolo contendere to) a crime involving the use, possession or distribution of a Prohibited Substance other than marijuana or a crime involving the distribution of marijuana.

Section 11. Reinstatement.

(a) After a period of at least two (2) years from the time of a referee's dismissal and disqualification under Section 10(a) above, such referee may apply for reinstatement as a referee in the NBA. However, such referee shall have no right to reinstatement under any circumstance and the reinstatement shall be granted only with the prior approval of both the NBA and the NBRA. The approval of the NBA and the NBRA shall rest in their absolute and sole discretion, and their decision shall be final, binding, and unappealable. Among the factors that may be considered by the NBA and the NBRA in determining whether to grant reinstatement are (without limitation): the circumstances surrounding the referee's dismissal and disqualification; whether the referee has satisfactorily completed a treatment and rehabilitation program; the referee's conduct since his

dismissal and disqualification; and whether the referee is judged to possess the requisite qualities of good character and morality.

(b) A referee will not be reinstated unless he can demonstrate, by proof of random urine testing acceptable to the Medical Director (conducted on at least a weekly basis), that he has not tested positive (i) for a Prohibited Substance within the twelve (12) months prior to the submission of his application for reinstatement and during any period while his application is being reviewed, and (ii) if the Medical Director deems it necessary in his or her professional judgment, for alcohol for the six (6) months prior to the submission of his application for reinstatement and during any period while his application is being reviewed.

(c) The granting of an application for reinstatement may be conditioned upon random testing of the referee or such other terms as may be agreed upon by the NBA and the NBRA, whether or not such terms are contemplated by the terms of this Agreement.

Section 12. Additional Bases for Testing.

(a) Any referee who seeks treatment outside the Program for a problem involving a Prohibited Substance shall, as directed by the NBA (after notice to the NBRA), submit himself to an evaluation by the Medical Director and provide (or cause to be provided) to the Medical Director such medical and treatment records as the Medical Director may request. The Medical Director may, in his or her professional judgment, also require such a referee, without prior notice, to submit to testing for Prohibited Substances, provided that the frequency of such testing shall not exceed three (3) times per week and the duration of such testing shall not exceed one (1) year from the date of the referee's initial evaluation by the Medical Director.

(b) Any referee who is formally charged with "driving while intoxicated," "driving under the influence of alcohol," or any other crime or offense involving suspected alcohol or illegal substance (other than a Prohibited Substance) use may be required to submit to a urine test, conducted by the NBA, within seven (7) days of being so charged.

(c) If, pursuant to Section 12(a) or 12(b) above, a referee: (i) tests positive for a Drug of Abuse; (ii) refuses or fails to submit to an evaluation or provide (or cause to be provided) the information requested by the Medical Director or SAP; or (iii) submits to treatment outside the Program for a substance abuse problem involving a Prohibited Substance, but does not Come Forward Voluntarily within 60 days of being requested to do so by the NBA (with notice to the NBRA), the referee shall advance two stages in the Drugs of Abuse Program—i.e., the referee shall enter Stage 2 of the Drugs of Abuse Program (if the referee had not previously entered Stage 1 of such Program), or the referee shall be dismissed and disqualified from any association with the NBA in accordance with the provisions of Section 10(a) above (if the referee had previously entered Stage 1 or Stage 2 of such Program).

(d) If, pursuant to Section 12(a) or 12(b) above, a referee tests positive for marijuana, he shall suffer the consequences set forth in Section 8(c)(B) above or, if the referee had previously been penalized under Section 8(c)(B), the consequences set forth in Section 8(c)(C) or (D) above.

(e) If a referee is or, within the previous six (6) months, (i) has been in possession of any device or product used or designed for substituting, diluting, or adulterating a specimen sample, or (ii) has been subject to a finding by another sports league or anti-doping organization that the referee has substituted, diluted, or adulterated a specimen sample and that finding has not been overturned on appeal, that referee shall be required to undergo testing for Prohibited Substances no more than four (4) times during the six-week period following his notification by the NBA of the commencement of such testing. If the referee (i) tests positive for a Drug of Abuse or (ii) tests positive pursuant to Section 5 above, he shall be dismissed and disqualified from any association with the NBA in accordance with the provisions of Section 10(a) above. If the referee tests positive for marijuana, he shall suffer the applicable consequences set forth in Section 8 above.

(f) Nothing in this Section 12 shall limit or otherwise affect any of the provisions of Section 5 (Reasonable Cause Testing).

EXHIBIT 1-A
AUTHORIZATION FOR TESTING

To: _____
Referee

Please be advised that on _____, you were the subject of a meeting or conference call held pursuant to the Anti-Drug Program set forth in Article XI, Section 5 of the Collective Bargaining Agreement between NBA Services Corp. and the National Basketball Referees Association, dated September 12, 2022 (the "Agreement"). Following the meeting or conference call, I authorized the NBA to conduct the testing procedures set forth in the Agreement, and you are hereby directed to submit to those testing procedures, on demand, no more than four (4) times during the next six (6) weeks.

Please be advised that your failure to submit to these procedures may result in the imposition of penalties.

_____
Independent Expert

Dated: _____

EXHIBIT 1-B
AUTHORIZATION FOR TESTING

To: _____
Referee

Please be advised that, pursuant to the Anti-Drug Program set forth in Article XI, Section 5 of the Collective Bargaining Agreement between NBA Services Corp. and the National Basketball Referees Association, dated September 12, 2022 (the "Agreement"), if a referee is arrested for, or charged with, an offense involving the use, possession or distribution of a Prohibited Substance, the NBA may issue an Authorization for Testing with respect to that referee. Based upon [your arrest][the charges filed against you], the NBA is therefore authorized to conduct the testing procedures set forth in the Agreement, and you are hereby directed to submit to those testing procedures, on demand, no more than four (4) times during the next six (6) weeks.

Please be advised that your failure to submit to these procedures may result in the imposition of penalties.

_____
NBA Commissioner (or his designee)

Dated: _____

EXHIBIT 2
PROHIBITED SUBSTANCES

A. Drugs of Abuse

Amphetamine and its analogs (including, but not limited to, methamphetamine and MDMA)

Cocaine

Opiates (Heroin, Codeine, Morphine,Hydrocodone/ Hydromorphone, Oxycodone/Oxymorphone, 6-Acetylmorphine Fentanyl (also called Actiq or Duragesic))

Phencyclidine (PCP)

This list shall be deemed automatically amended to include any additional drugs adopted for testing pursuant to 49 CFR Part 40 for which SAMHSA protocols have been approved.

B. Marijuana and its By-Products