# EXHIBIT 7 - Vol. 1

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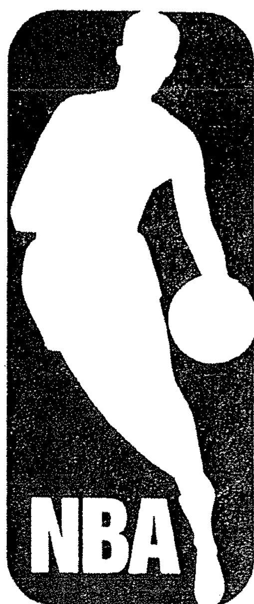


# A Guide to Benefits for NBA Referees

YOUR SUMMARY PLAN DESCRIPTIONS FOR

THE MEDICAL PLAN

THE DENTAL PLAN

THE DISABILITY PLAN

LIFE INSURANCE

ACCIDENT INSURANCE

EMPLOYEE ASSISTANCE

THE 401(k) PLAN

THE PENSION PLAN

# Your NBA benefits

This book describes the benefit plans available to the National Basketball Association's referees. You can read here about the plans provided by the NBA that can reduce your health care expenses, protect you and your family from loss of income, and help you build your long-term financial security.

We hope that you'll find the book a useful reference tool as you use your benefits. Take some time to get familiar with its layout and with the information it contains—it can probably answer most of the day-to-day questions you'll have about your coverage and the opportunities provided by your benefits program.

This book contains "summary plan descriptions" of the NBA benefits plans for referees. It supersedes all previous versions and any other books or summary plan descriptions previously issued about referees' benefits.

The plans described in these summary plan descriptions are also governed by explicit legal documents. Should any question ever arise about the nature and extent of your benefits, the formal language of these legal plan documents (and not the informal wording of the summaries in this publication) will govern.

# Contents

Each plan is described in a separate chapter, and each chapter has its own table of contents at the beginning.

**The Medical Plan** (page 3)
The Medical Plan gives you a choice between two approaches to medical coverage. Whenever you need medical care, you can go to a doctor, hospital, or another health care provider who participates in a nationwide network managed by the insurance company. Or you can go to any health care provider you like. Either way, the Plan pays a significant portion of your eligible expenses, but you can reduce your expenses considerably if you go to a network provider.

**The Dental Plan** (page 20)
The Dental Plan covers most common forms of dental treatment. You can use any dentist you like, but if you use a dentist who participates in the special network, his or her charges will be lower and your benefits may be greater.

**The Disability Plans** (page 29)
For an absence that lasts longer than a week, state-mandated short-term disability comes into effect. If you're still disabled after 90 days, you may receive payments from the Long-Term Disability (LTD) Plan.

**Life and Accident Insurance** (page 35)
Your NBA-provided life insurance makes payments to your beneficiary if you die. Your accident insurance pays a additional benefit if you die in an accident or if you suffer certain serious injuries as a result of an accident that leave you permanently disabled.

**The Employee Assistance Program** (page 40)
The EAP is a confidential counseling and referral service, staffed with professionals who can help you and your family deal with the challenges of life and work.

**The 401(k) Plan** (page 41)
This Plan gives you a unique opportunity to make significant savings on a tax-deferred basis, so that you can build your retirement income. You can change the amount of your contributions and the way your balance is distributed among the Plan's investment funds at frequent intervals, if you wish.

**The Pension Plan** (page 49)
The National Basketball Association Referees' Pension Plan provides the basis of a pension that grows as you continue to officiate for the NBA. The NBA makes all contributions and directs the investment of funds.

**Leaving the NBA** (page 57)
When you end your employment with the NBA for any reason—retirement, resignation, termination, disability, or death—you need to know how this affects your coverage under *all* the plans in our benefit program. To save you looking up the information in each separate chapter, we've gathered the facts into one place.

**Important legal information** (page 69)
Here's where you'll find a lot of the administrative and legally required information about your benefit plans.

# The Medical Plan

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Medical benefits aren't as simple as they used to be, and you're encouraged to look through this section and get familiar with where to find the information you may need. To make this as easy as possible, the Plan description is divided into three parts:

- **GETTING STARTED** tells you about eligibility, who can be covered, and when you can make changes.
- **HOW THE PLAN WORKS** (page 6) tells you how the Plan handles most common medical expenses.
- **WHAT'S COVERED** (page 13) tells you more about the services and supplies that are—and aren't—eligible for the Plan.

The Medical Plan gives you a choice between two approaches to medical coverage. Whenever you need medical care, you can go to a doctor, hospital, or another health care provider who participates in a nationwide network called a PPO, which is managed by the insurance company. Or you can go to any health care provider you like.

If you go to a network provider, you get more generous Plan benefits—in fact, your out-of-pocket costs for most treatment are very low. If you go outside the network, you'll pay more yourself, but the Plan will still pay a significant portion of your eligible expenses.

You must enroll to activate your medical coverage.

## GETTING STARTED

### Who's eligible for the Plan?

This Medical Plan is exclusively for referees whose terms and conditions of employment are governed by the Collective Bargaining Agreement between the NBA and the NBRA.

### When does coverage begin?

Your coverage starts on your first day of employment. (If you're disabled on the day coverage is due to start, your coverage won't begin until you return to full-time work.)

You can add or remove dependents from coverage later than the initial enrollment period if you have a qualifying "life event" or other status change. (See page 5 for details.) For example, if you get married, you can add your spouse to your coverage. You must inform the Finance Department of the change within 30 days.

### Who's covered by the Plan?

In addition to you, the Plan can cover:

- Your legal spouse
- Your unmarried dependent children under age 20, or under age 26 if they're enrolled as full-time students in an accredited school. This includes foster children, legally adopted children, and stepchildren for whom you're financially responsible. Coverage ends on the last day of the month in which the child reaches 20 or 26, as appropriate.

A spouse or a child can't be a dependent if he or she is also covered by this Plan as an NBA employee or on active duty in any armed force.

*If you have a dependent disabled child*

You can have Medical Plan coverage for unmarried children of any age if they're permanently and totally physically or mentally disabled and depend mainly upon you for support and maintenance. Both the child's disability and his or her coverage under this Plan must have begun before the Plan's age limit (i.e., before the child reaches 20 or 26, as discussed above).

You'll need to send the insurance company written proof of the child's handicap and dependency within 30 days of the date he or she reaches the regular age limit. The insurance company will ask periodically for proof that the child's condition continues.

*If you're adopting a child*

You can add a child to your coverage from the moment he or she is placed in your home for the purpose of adoption, even if the final adoption order is never issued. Make sure you enroll the child within 30 days of taking on responsibility for his or her medical coverage.

*When a dependent's coverage starts*

Generally, a dependent's coverage will begin when yours begins, or when you enroll the dependent, if this is later.

If you don't enroll your existing dependents within 30 days of your date of hire, they're considered "late enrollees." And if you acquire a dependent after you're a Plan participant—for example, if you get married or if a child is born or adopted—you must enroll him or her within 30 days of the date he or she became an eligible dependent. (In certain circumstances, a dependent can gain coverage outside the usual 30-day window without being regarded as a late enrollee; the insurance company can tell you more.)

A newborn child is *automatically* covered by the Plan from the time of birth, even if you don't have family coverage. But that automatic coverage will end after 30 days if you don't formally enroll the newborn in the Plan (see the next section).

**What if I want to make a change during the year?**

You can't start or stop coverage, or add or remove a dependent unless you have a qualifying change in your family status or personal circumstances.

The qualifying life events that permit changes are:

- marriage
- divorce or legal separation
- birth, adoption, or change in custody of a child
- death of a spouse or child
- a switch between part-time and full-time employment status by you or your spouse
- termination of employment by you or your spouse
- you or your spouse taking an unpaid leave of absence
- an increase or decrease in the cost of benefits for you or your spouse
- significant changes in your health coverage or in the coverage of your spouse/ because of his or her employment.

## HOW THE PLAN WORKS

As you've read, the Medical Plan gives you a choice at any time during the year when you need medical services or supplies.

You can go to a health care provider who participates in the insurance company's network or "preferred provider organization," which is called Private Healthcare Systems (PHCS). In most common cases, your only expense will be a payment of $10 for each office visit. You'll receive a directory of network participants when you first enroll for coverage, and you may also request updated directories at any time.

When you enroll, you'll receive an ID card, which you must present to your health care provider to identify yourself as a PHCS participant. (Make sure your provider is in the network before you incur any charges.) Even if your network doctor sends you outside the network for treatment, provided you receive his or her referral, you'll still be eligible for these "preferred" benefits.

You are also free at any time to go outside the network to see any health care provider you wish. In this case, your eligible expenses will generally be treated as follows. You must pay the first $200 of each year's expenses. Then you have to pay 20% of most expenses until your total out-of-pocket expenses for the year add up to $1,000. After that, the Plan will pay 100% of most eligible expenses. (There are other financial features that limit out-of-pocket expenses for a family of three or more, but there are additional financial penalties, too, for failing to get prior approval for certain procedures.) Naturally, you must pay 100% of any expenses that are not eligible by the Plan for any reason (see the WHAT'S COVERED section, beginning on page 13).

You don't have to pay any contributions toward your medical coverage; the Plan's premiums are paid entirely by the NBA.

The chart on the next page shows you how most common medical expenses are treated, whether you go "in-network" by using the preferred provider organization or go "out-of-network." In all cases, it shows what *you* pay. For example, if you pay 20% of an eligible expense, the Plan pays the remaining 80%.

Please note that the chart assumes all expenses are eligible for the Plan; there's a general section on page 13 that tells you why an expense may *not* be eligible, and you should read it, since you have to pay *all* ineligible medical costs, including those that are above the "reasonable" amounts. If there's a page reference in the "Where to read more" column, it means there's more detailed information about the medical service or provider in the WHAT'S COVERED section. *Read this entire section carefully.*

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**Doctors and nurses**

For all Plan purposes, a "doctor" means a medical practitioner, and a "nurse" means a registered nurse or a licensed practical nurse, including a specialist such as a nurse midwife or a nurse anesthetist.

Both doctors and nurses must be properly licensed or certified to provide medical care under the appropriate laws of the state where they practice. They must provide medical services that are within the scope of this license or certificate and are covered by this Plan.

◀◀◀◀

*"Other eligible expenses" in the chart include drugs prescribed in a hospital setting, durable medical equipment (see page 15), ambulance services (see page 15), anesthetics and oxygen, inhalation therapy, hemodialysis, radiation and chemotherapy, physical therapy by a licensed therapist, casts, splints, surgical dressings, and the initial fitting and purchase (but not repair and replacement) of braces, trusses, orthopedic footwear and crutches. Blood, blood products, and blood transfusions are covered unless blood is donated or replaced on the patient's behalf.

Please note that the Plan will pay the first $500 of any non-hospital treatment you require following an accident, whether you go in- or out-of-network for that treatment

| | If you go in-network | If you go out-of-network | Where to read more |
|---|---|---|---|
| Calendar-year deductible | None | $200 per person but no more than $500 per family | Page 8 |
| Annual limit on your out-of-pocket expenses | None | $1,000 per person but no more than $2,500 per family | Page 8 |
| Lifetime maximum | None, apart from $25,000 combined in- and out-of-network limit for infertility treatment | | Page 17 |
| Penalty for not obtaining approval for a hospital stay | None—your network doctor will take care of this | Employee responsibility—penalty is 50% of the payable benefits up to $500 | Page 9 |
| Penalty for not obtaining approval before surgery | None—your network doctor will take care of this | Employee responsibility—penalty is 50% of the payable benefits up to $500 | Page 9 |
| **TREATMENT FROM A DOCTOR** | | | |
| Office visit (including visits to specialists) | $10 copay | 20% after deductible | |
| Prescription drugs | Covered out of network | 20% after deductible | |
| Prenatal and postnatal maternity care | $10 copay | 20% after deductible | |
| Well-child care (including immunizations) | No charge for scheduled well-child office visits or immunizations | No charge for scheduled well-child office visits or immunizations | Page 18 |
| Chiropractic care (spinal manipulation) | $10 copay (but with a limit of 30 visits per calendar year) | 20% after deductible (but with a limit of 30 visits per calendar year) | Page 19 |
| Medically necessary laboratory and X-ray services | No charge | 20% after deductible | |
| Treatment of disease or deformity of the feet | $10 copay (but with a limit on benefits of $2,500 per calendar year) | 20% after deductible (but with a limit on benefits of $2,500 per calendar year) | |
| Other eligible expenses◄ | Not covered in-network | 20% after deductible | |
| **OUTPATIENT HOSPITAL TREATMENT** | | | |
| Ambulatory surgical center | No charge | 20% after deductible | |
| Outpatient clinic | No charge | 20% after deductible | |
| Emergency room treatment | No charge | 20% after deductible | |
| Other eligible expenses◄ | Not covered in-network | 20% after deductible | |
| **SPECIAL REVIEW PROCEDURES** | | | |
| Second opinion | No charge | No charge | Page 9 |
| **INPATIENT TREATMENT** | | | |
| Hospital pre-admission testing | No charge | No charge | |
| Hospital room and board | No charge | 20% after deductible | Page 17 |
| Doctor's fees (not including surgery), routine nursing care, other medically necessary supplies and services | No charge | 20% after deductible | |
| Surgery | No charge | 20% (no deductible) | |
| Anesthesia | No charge | 20% (no deductible) | |
| Delivery and newborn nursery care | No charge | 20% after deductible | |
| Private duty nursing | Not covered in-network | 20% after deductible. (You must pay an additional 20% of the first $2,000 in charges, which will not apply to your out-of-pocket maximum.) | |
| Other eligible expenses◄ | Not covered in-network | 20% after deductible | |
| Hospital alternatives: | | | |
| *Home health care* | No charge, but limited to 100 visits in a calendar year | 20% (no deductible), but limited to 100 visits in a calendar year | Page 16 |
| *Extended care center* | No charge, but limited to 100 days of inpatient confinement | 20% (no deductible), limited to 100 days of inpatient confinement | Page 16 |
| *Hospice care* | No charge | 20% (no deductible) | Page 16 |
| *Birthing center* | No charge | 20% (no deductible) | Page 17 |
| *Rehabilitation center* | No charge, but limited to 100 days of inpatient confinement | 20% after deductible, limited to 100 days of inpatient confinement | Page 19 |
| **MENTAL HEALTH AND SUBSTANCE ABUSE** | | | |
| Inpatient treatment for mental health problems | No charge, but treatment limited to 30 days per calendar year | 20% after deductible, treatment limited to 30 days per calendar year | Page 18 |
| Inpatient treatment for substance abuse problems | No charge, but treatment limited to 60 days per calendar year | 20% after deductible, treatment limited to 60 days per calendar year | Page 15 |
| Outpatient treatment for mental health problems | $10 copay per visit, benefits are limited to $50 per visit, up to 30 visits per calendar year | 20% after deductible, benefits are limited to $50 per visit, up to 30 visits per calendar year | Page 18 |
| Outpatient treatment for substance abuse problems | $10 copay per visit, but visits are limited to 60 days per calendar year (maximum 20 visits for other family members) | 20% after deductible, but visits are limited to 60 days per calendar year (maximum 20 visits for other family members) | Page 15 |

**The Plan's financial features**

*Copays*

"Copays" (or "copayments") are flat fees that you have to pay for certain forms of treatment, usually a visit to a network doctor's office.

*Deductibles*

Deductibles apply only to out-of-network treatment. It's the amount of eligible expenses, currently $200, that each plan participant must pay *in full* in each calendar year.

Each participant's expenses are tracked separately. Individual deductibles will always apply, no matter what level of coverage you elect. But if you elect coverage for three or more participants, there's an *additional* $500 limit on your combined deductibles. Whenever the family's combined deductible payments reach this amount, they won't have to pay any more deductible expenses in that year, even if nobody has met his or her individual deductible.

◄◄◄◄ Let's take an example of a family of four people. At the beginning of the year, the husband incurs $300 in out-of-network expenses. He pays the first $200 as a deductible, and then only 20% of the remaining $100. Then a week later, each of the other family members incurs a $100 doctor's bill, which comes out of their individual deductibles. At that point, the total paid by the family has reached the cap of $500 ($200 + $100 + $100 + $100). So even though three of them have yet to incur $200 in expenses, they're all considered to have met their deductibles for the year.

In other words, the Plan will pay 80% of out-of-network expenses as soon as you meet your individual deductible or the family meets the family deductible, whichever happens first.

If more than one covered family member is hurt in the same accident, or if covered family members come down with a contagious disease within ten days of each other, then only one deductible amount will be applied to resulting medical expenses.

If a participant hasn't fully met his or her annual deductible before the beginning of October, then any further payments applied to the deductible in the same year will also be applied to the next year's deductible.

◄◄◄◄ For example, suppose you have no expenses applied to your deductible before October. Then you get a small medical bill in November for $40, which you have to pay out of your own pocket. That $40 spent in the last quarter of the year will also bring your next year's deductible down to $160.

*Coinsurance*

"Coinsurance" is your share of eligible expenses for out-of-network treatment—20% after the deductible. Don't confuse coinsurance, which is a percentage of eligible expenses, with a copay, which is a fixed amount.

*Out-of-pocket limits*

The $1,000 "out-of-pocket limit" (or "out-of-pocket maximum") is the most money you'll have to pay in coinsurance in a calendar year. Once you reach your limit, the Plan will pay 100% of most additional expenses. Please note that this limit doesn't include your deductible.

Just like deductibles, limits apply individually to each participant, no matter how many people you elect to cover. But if you elect coverage for three or more people, the limit on your combined out-of-pocket expenses is $2,500. When a family's total out-of-pocket expenses reach this limit, all further covered medical treatment in the year will be paid 100% by the Plan—even if some family members have yet to incur *any* expenses.

There is no out-of-pocket limit for in-network treatment. In-network copays don't count toward the out-of-pocket limit.

**Are there any treatments that require prior approval?**

Yes. If a doctor determines that you need hospital treatment or any form of surgery (inpatient or outpatient) that cannot be performed in the doctor's office, you must obtain a review from PHCS. Your doctor should notify PHCS no later than 48 hours before the surgical procedure or hospital admission. PHCS will review the information and contact your doctor by phone, with a written follow-up. If the procedure or admission is approved, your doctor will also be given details such as the expected length of any hospital stay and whether PHCS recommends an alternative (such as outpatient surgery instead of inpatient surgery).

If you fail to get a required approval, you'll have to pay half the amount that you would have received as a benefit for the treatment out of your own pocket, up to a maximum of $500. These penalty payments won't count toward your deductible or your out-of-pocket maximum.

Please note that inpatient surgery requires *both* a pre-hospital review *and* a pre-surgery review, since these address different aspects of your health care treatment. Your doctor can apply for both reviews at the same time. You'll have to pay a penalty if you fail to obtain either review (and you'll have to pay two penalties if you miss both reviews).

For an emergency admission, either you or your doctor must telephone PHCS no later than the end of the next regular working day and give details of the emergency. Failure to report the emergency will result in the same penalty that you'd pay if you failed to get a pre-hospital review. The doctor must also request a continued stay review at this time, so that PHCS can assess the likely length of the hospital stay.

A continued stay review is also required following a nonemergency hospital admission, if it becomes medically necessary for a patient to stay longer than the time approved in the pre-hospital review. The second review should be requested before the end of the period that was already approved.

If you get an approval, but you don't comply with the details—for example, if you go to a different hospital—you must apply for the approval again. (Of course, if the review shows the treatment not to be medically necessary, you won't receive *any* benefits.)

There is an established appeals process if you or your doctor do not agree with the result of any kind of review. Following an appeal to PHCS—in which your doctor will provide information to support the request for treatment—you may be required to obtain a second opinion from a Board-certified doctor, whom you can select from a list of approved specialists. Naturally, he or she can't have been involved in your case up to this point. The Plan will cover all the costs of these consultations, including tests and X-rays. PHCS will generally accept the opinion of the doctor providing the second opinion as to the medical necessity of the procedure.

**How do I make a claim?**

If you go to a network provider, you won't need to file a claim. Just show your ID card, pay your copay, and the provider will bill the Plan's Claims Administrator directly (see page 71). You'll get an explanation of benefits form, which will show any additional payment you have to make. Call the toll-free number on your ID card if you have any questions.

For out-of-network treatment, you should file a claim with the Claims Administrator as soon as possible by completing the claim form, which you can get from the Finance Department or by requesting a copy from the insurance company. Make copies of all paperwork and then send in the claim form with the original bill for the service to:

The Guardian,
P.O. Box 26015
Lehigh Valley, Pennsylvania 18002-6015.

Generally, the bill should show patient name, diagnosis, date(s) of service, itemized charges, and types of charges. Canceled checks, cash register receipts, and balance due bills (which show only the amount owed) will not be acceptable on their own. However, you should include them so that the Claims Administrator knows how much you've actually paid.

*Hospital bill audit bonus*

The Plan pays a cash bonus if you can show the insurance company that you were overcharged by $10 or more on a hospital bill. (The error must be for a covered charge.) Get a corrected bill and send it with the original to the insurance company. You'll receive half of the amount of the overcharge, up to $500.

*What if a claim is denied?*

You'll be told why in writing. If you want the decision reviewed, first contact the Claims Administrator through the toll-free number on your ID card. If you're still not satisfied with the answer, you may consult the Finance Department. Then there are a series of actions you can take, which apply to any claim for reimbursement from a benefit plan—these are covered in the legal section on page 75. But please note that you can't start any legal action until at least 60 days after your claim is submitted, or any later than three years after the claim is submitted. You should also note that the Plan Administrator has the final say in how the terms of the Plan are interpreted.

**What happens if someone is covered by more than one plan?**

Our Plan has a coordination of benefits provision. This means that if your expenses are payable by another medical plan or by an insurance policy, you can't receive more in benefits from the two plans than the actual cost of the medical treatment. This process is called "coordination of benefits." (Claims that amount to $50 or less for a particular course of treatment won't be coordinated.)

This provision usually applies when you or your dependents are covered by the NBA Medical Plan and also by a medical plan offered by your spouse's employer. But the other plan could also be any of the following:

- any group or blanket health insurance, including Blue Cross, group Blue Shield plans or other service or prepayment plans
- a union welfare plan
- another employer plan or multi-employer plan
- trusteed labor and management plans
- any other plan for members of a group
- Medicare
- mandatory no-fault auto insurance
- a government program.

The coordination between plans with coordination of benefits provisions is easy to understand:

- For each treatment, the Claims Administrator decides which plan is the primary plan. "Primary" means the plan pays benefits first.
- The Claims Administrator for each plan determines what each plan would pay for the eligible expense. Please note that each plan will use its own definition of "eligible expense."
- The primary plan pays benefits as if there's no other coverage.
- If our Plan is primary, then any further amount paid by the secondary plan depends on its own rules.
- If our Plan is secondary, it pays the difference (if any) between the amount paid by the primary plan and the actual

For example, suppose you're charged $500 for out-of-network treatment for a child who's covered by both our plan and your spouse's plan. Assume your spouse's plan is primary, which makes our plan secondary, and you've already met your deductibles. If your spouse's plan pays 70% of covered expenses, then you receive $350. The NBA Plan then pays the remaining $150 of your expenses. (If our plan were primary, you would have received $400 of the original expense.)

expense incurred. However, as the secondary plan, our Plan won't pay any more than it would have paid if it had been primary.

The principle is simple; the complicated part is deciding which plan pays first. Please note:

- If the other plan provides treatment that our Plan specifically excludes as an eligible expense, our Plan won't pay anything. See page 13.
- If the other plan doesn't have a coordination of benefits provision, it pays first.
- If both plans have a coordination of benefits provision, the plan that covers an individual as an employee pays first. For example, if you and your spouse both have family coverage, then our Plan pays first for your individual expenses and your spouse's company plan pays first for his or her expenses.
- A plan that covers an individual or a dependent as a laid-off or retired employee pays second. This rule will not apply if the other plan doesn't have a similar rule.

When a child is covered as a dependent by the NBA Medical Plan and as a dependent by another plan, you can use this flow chart to decide which plan pays first:

You must supply any claim information that's required by our Claims Administrator, who may in turn exchange relevant claim information with the administrators of other plans, if it's necessary for coordination of benefits.

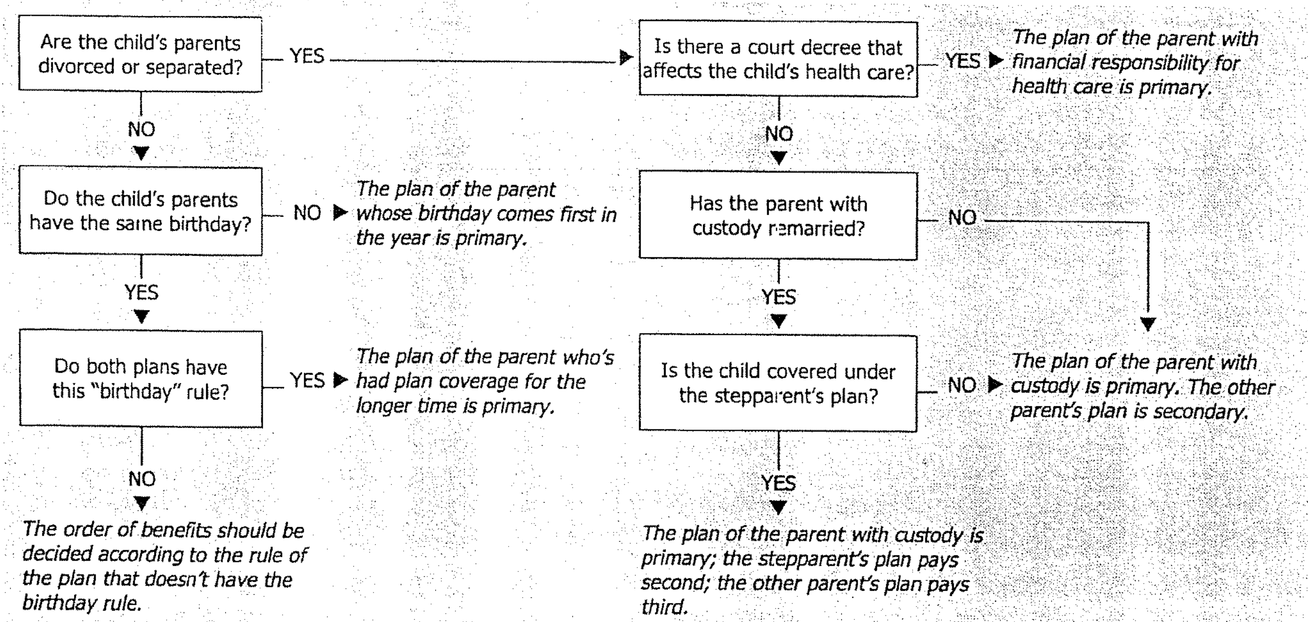
The procedure may also require our Plan to make payments to other plans or recover payments from them. If you receive an overpayment of benefits, you must repay it.

*If the other plan is Medicare*

Our Plan is generally primary over Medicare, if you're still working for the NBA when you become eligible for Medicare because of your age. However, if you qualify for Medicare earlier, as a result of a disability, then Medicare will be primary. (If a covered dependent gets Medicare because of a disability, our Plan will still be primary for him or her.)

When Medicare is primary, we subtract what Medicare pays from what we'd normally pay. You must be covered by both Parts A and B of Medicare, or you must meet the Medicare Alternate Deductible.

This provision doesn't apply if you, your spouse, or another dependent become eligible for Medicare before age 65 because of end-stage renal disease. In this case, our Plan will be primary for all participants.



**What happens to my coverage if I'm away from work?**

All of your benefits coverage will continue while you're on a paid leave of absence, such as vacation or jury duty. Your benefits will also continue if you take leave permitted under the Family and Medical Leave Act, as long as you return to work at the end of your leave.

If you're absent for a long time because of a disability and you're unlikely to return to work, the NBA may make adjustments to your benefits coverage. You can read about this situation in the Leaving the NBA chapter, starting on page 57.

Your benefits coverage may also end if you take an unpaid leave of absence. You'll need to discuss this situation with the Operations Department.

*Service in the uniformed services*

If you need to be absent from employment to serve in one of the uniformed services, you can elect to continue your medical and dental coverage for yourself and your dependent family members while you're away. The continued coverage period extends for the earlier of 18 months or until the date you fail to apply for or return to employment after your service. (See your Plan Administrator for more details concerning this date.)

You'll be charged the full cost of the premium for medical and dental coverage plus an additional 2% for administrative costs. Your notification will tell you how much this is. If your uniformed service period is less than 31 days, you won't be charged for administrative costs.

**When does coverage end?**

Your Medical Plan coverage will stop on the date on which any of the following events takes place:

- your active employment with the NBA ends, including resignation, retirement, layoff, and approved leave of absence (apart from Family and Medical leave and absence because of service in the uniformed services, which are covered in the previous section)
- you cease to meet the eligibility requirements for the Plan
- the Plan is discontinued.

Coverage for your dependents ends when your coverage ends or when the individual ceases to qualify as an eligible dependent.

**What happens if I leave the NBA?**

You or your dependent may be able to continue your medical coverage after you leave the NBA. Because termination of employment affects all your benefits, we have described what happens in a special chapter called "Leaving the NBA," which begins on page 57. This tells you how coverage will change when you retire, if you become totally disabled, if you die while you're still working for the NBA, or if your employment is terminated for another reason.

# WHAT'S COVERED?

The chart on page 7 outlines the main types of medical treatment covered by the Plan and shows you how much of any eligible expenses will be paid. This section specifies some general conditions that decide whether or not an expense is eligible for the Plan. It also gives you more detailed information about certain specific types of coverage, which you should know before you incur any expenses for these services.

### What's an eligible expense?

Generally, to be covered by the Plan, any service, supply, treatment, etc. must meet *all* of the following conditions:

- It must be given by a provider recognized by the Plan as an appropriately qualified health care provider—usually a doctor
- it must be medically necessary for the diagnosis or treatment of a sickness or injury
- it must be accepted by a professional medical society in the U.S. as beneficial for the control or cure of the sickness or injury being treated
- it must be furnished within the framework of generally accepted methods of medical management currently used in the U.S.
- it must be "reasonable," which means it isn't more than the usual local charge for the particular service or supply. (When deciding what's reasonable, the insurance company looks at the patient's condition and how severe it is, as well as at special circumstances.)

"Eligible" means that the expense will be paid by the Plan either in part or in whole, according to the appropriate schedule for in-network or out-of-network care. You have to pay 100% of any amount that's not considered an eligible expense, include any amount that exceeds the reasonable charge for a service or supply.

### What isn't eligible?

You can't assume any medical expense is eligible for the Plan unless it is specifically mentioned in this publication as a covered expense. If you have any questions about eligible expenses, call the toll-free number on your ID card.

In addition to the exclusions addressed in other sections of this chapter, the Plan does not cover:

- services or supplies for which no charge is made, or that you wouldn't have to pay if you didn't have this coverage
- experimental treatment, which means the treatment:
  - hasn't been scientifically proven or fully developed
  - can't be supported in medical literature published by a professional medical society in the U.S.
  - isn't accepted by a professional medical society in the U.S. as beneficial for the control or cure of the sickness or injury being treated
  - isn't furnished within the framework of generally accepted methods of medical management currently used in the U.S.
- any sickness or injury that's the direct or indirect result of a war, whether declared on undeclared, or that occurs while the covered individual is on active duty in any armed forces
- services or supplies provided by a spouse, child, parent, brother, sister, or a member of your household, or by a business or professional associate of you or a family member
- on-the-job or job-related injury, including any sickness or injury for which benefits are payable by Worker's Compensation or similar laws
- any sickness or injury that's suffered, directly or indirectly, by a covered individual taking part in a riot or other civil disorder, or committing a felony

- personal comfort items, such as televisions or phones, or items that are generally useful to a household, such as first aid kits, exercise equipment, and saunas
- custodial care, education or training, or room and board in a rest home, old age home, or any place that's mainly a school (custodial care means care provided only to help a person meet routine daily needs, which can be given by someone without professional health care training or skills)
- eyeglasses, contact lenses, or hearing aids, their prescription and fitting, or vision and hearing visits
- wigs, toupees, hair transplants, hair weaving, or any drug used to restore hair growth
- routine foot care, which is the cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excresences, helomas, hyperkeratosis, hypertrophic nails, noninfected ingrown nails, deratomas, keratosis, onychauxis, oncychocryptosis, tylomas, or symptomatic complaints of the feet
- routine preventive care (including checkups and related X-rays and lab tests) apart from well-child care for a covered dependent and an annual gynecological exam, including a Pap test, and periodic mammograms for female participants
- room and board for a covered individual in any facility when he or she wasn't physically present
- cosmetic surgery unless it's reconstructive surgery needed because of an illness or injury, including functional birth defects in a dependent child and a mastectomy (see page 18)
- ambulance services used to transport a patient to any place other than an inpatient health care facility
- drugs that don't require a prescription, even if a doctor has given you one.
- drugs that aren't approved by the Food and Drug Administration, especially those labeled "Caution—Limited by Federal Law to Investigational Use"
- nurses' aides, home attendants, nutritionists, dieticians, or massage therapists, unless the Plan provides special benefits for services. (For example, if massage therapy is an essential element of rehabilitation following an injury, ordered by a doctor.)

### More information about specific services or supplies

Please look through this section—especially if you know you need a certain type of treatment—and make sure you understand all the information before you incur any charges.

*Alcohol and drug abuse*

The chart on page 7 tells you how both inpatient and outpatient treatment for alcohol and drug abuse are handled. Inpatient care may be given in a hospital, an alcohol abuse center, a drug abuse center, or a residential treatment facility (see page 19). Outpatient treatment must be given by facilities that are certified as medically supervised ambulatory drug abuse programs by, respectively, the Division of Alcoholism and Alcohol Abuse and the Division of Drug Abuse Services. Custodial care, education, and training are not covered by the Plan.

A **drug abuse center** is a facility that mainly provides treatment for people with substance abuse problems. The Plan will recognize such a center if it carries out its stated purpose under all relevant state and local laws and it is either accredited for its purpose by the Joint Commission on the Accreditation of Health Care Facilities or approved by Medicare.

An **alcohol abuse center** is a facility that mainly provides treatment for people with alcohol abuse problems. The Plan will recognize such a center if it carries out its stated purpose under all relevant state and local laws and is either accredited for its purpose by the Joint Commission on the Accreditation of Health Care Facilities or approved by Medicare.

*Ambulance services*

The Plan will cover the medically necessary charges of transporting you to a local hospital for inpatient care or to the nearest hospital where medically necessary inpatient care and treatment can be given, if it's not available at the local hospital. Transportation can be provided by a professional ambulance service, train, or plane, but not a chartered air flight. The travel or communication expenses of doctors, nurses, or family members of the patient aren't covered.

*Dental care*

The Plan does cover limited treatment to the teeth, mouth, and jaw, specifically: diagnosis and treatment of oral tumors and cysts; the surgical removal of impacted teeth; and injuries to natural teeth or the jaw, but only if:

- the injury occurs while the patient is insured by this Plan
- the injury was not caused, directly or indirectly, by biting or chewing
- all treatment is finished within 12 months of the injury.

Other dental treatment is more likely to be covered by the Dental Plan. Under no circumstances can you claim the same expense through both the Medical *and* Dental Plans.

*Diabetes*

The Plan will cover all the common supplies and equipment for the care and treatment of diabetes. It also covers diabetes self-management education programs, if medical necessary because of a change in the individual's symptoms or if reeducation or a refresher is necessary.

The education may be provided by a doctor or other licensed health care provider, or his or her staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietician or registered dietician, upon the referral of a health care provider. This can involve home visits, when medically necessary.

*Durable medical equipment*

This is medical equipment that can withstand repeated use, such as a wheel-chair or breathing equipment. It's suitable for use in the home, but intended only to serve a medical purpose. (For example, air conditioners, hu-

midifiers, and exercise equipment don't qualify.)

The Plan usually covers just the rental of medical equipment, but it may alternatively cover the purchase, maintenance, and repair of equipment if it's either less costly or more practical than rental. All equipment purchase requires advance written approval from the insurance company, or it won't be covered.

*Enteral formulas and modified solid food products*

These are covered if a doctor or other licensed health care provider has given a written order that:

- the enteral formula is effective as a disease-specific regimen for individuals who are or will become malnourished or suffer from disorders that, if untreated, cause chronic physical disability, mental retardation of death
- modified solid food products are necessary for the treatment of certain inherited diseases of amino acid and organic acid metabolism. (Benefits for modified solid food products are limited to $2,500 in any continuous 12- month period.)

*Extended care center*

This is a facility that provides full-time inpatient skilled nursing care for sick or injured people who no longer need to be in a hospital. (It may also be known as a **skilled nursing center.**) Confinement in an extended care center must start within 14 days of your discharge from a hospital.

Benefits are limited to 100 days of confinement in any calendar year. The Plan will cover the lesser of the center's actual daily room and board charge or 50% of the covered room and board charge for semi-private accommodations made by the hospital the patient has just left.

The Plan will recognize such a center if it carries out its stated purpose under all relevant state and local laws and it is either accredited for its purpose by the Joint Commission on the Accreditation of Health Care Facilities or approved by Medicare.

*Home health care*

Home health care is care given in the home of a sick or injured person to reduce or eliminate hospital stays. For home health care to be covered by the Plan, your doctor must certify that it's needed in place of inpatient care in a recognized facility. He or she will set up a written home health care plan within 14 days of the start of the care. The Plan will then cover all home health care services and supplies given or coordinated by a home health care agency in accordance with your doctor's written plan. This home health care plan must be reviewed by your doctor at least once every 60 days.

The Plan will cover medically necessary expenses and supplies, including prescribed drugs, if these would have been covered if you were treated in a hospital. However, the Plan doesn't cover more than 100 home health care visits from a home health aide, nurse, or other authorized provider in a calendar year. (A "visit" can last up to four hours.) Care given to someone other than the patient is also ineligible for the Plan.

A home health care agency is a provider that mainly provides home health care. The Plan will recognize a home health care agency if it carries out its stated purpose under all relevant state and local laws and it is approved by Medicare.

*Hospice care*

A hospice is a facility that mainly provides palliative and supportive care for terminally ill people under a hospice care program. The Plan will cover hospice expenses for a participant who is not expected to live more than six months, for up to 210 days, starting from the first day hospice care is given.

Covered expenses include all required services and supplies given or coordinated by the hospice, including prescription drugs, as long as they're ordered by the patient's physician.

The Plan doesn't pay for services or supplies provided by volunteers or others who don't regularly charge for their services, funeral services and arrangements, legal or financial counseling or services, or services given to anybody other than the patient, apart from bereavement counseling, which may begin before or after the patient's death.

The Plan will recognize a hospice. if it carries out its stated purpose under all relevant state and local laws and it is either accredited for its purpose by the Joint Commission on the Accreditation of Health Care Facilities or the National Hospice Association, or it is approved by Medicare.

*Infertility treatment*

In order to qualify for infertility treatment coverage, the couple must have a medically documented history of unexplained infertility lasting at least two years, or the infertility treatment must be certified by a doctor as medically necessary. All treatment must be on an outpatient basis—no inpatient treatment for infertility is covered.

Treatment must be performed in a facility that's licensed or certified for what it does in the state in which it operates.

The Plan covers hormonal therapy, artificial insemination, sonograms or other treatment that meets the protocol set by the American College of Obstetricians and Gynecologists. But it only covers in-vitro fertilization, in-vivo fertilization, gamete intrafallopian transfer (GIFT), or similar procedures of the couple has not been able to obtain a successful pregnancy through other means.

There is a lifetime maximum of $25,000 per covered family on benefits for the treatment of infertility.

*Inpatient hospital treatment*

Any **pre-admission tests** that are required before admission to a hospital are fully paid by the Plan, both in-network and out-of-network. These tests must be performed within seven days of a planned admission or surgery. (The Plan won't pay for any tests that are repeated after admission, unless they're required because of a significant change in the patient's health.)

The Plan will cover up to the "semi-private" rate for room and board in an inpatient facility. (A semi-private room has two or more beds.) If you want a private room, you'll have to pay the difference. If the facility doesn't have any semi-private rooms, the Plan will pay 90% of its lowest room and board rates for a private room.

However, if you need to be in a **special care unit,** the Plan will pay the full cost of a private room. A special care unit is the part of a hospital set up for the treatment and continuous observation of very sick patients. It must have specially trained staff and special equipment and supplies on hand at all times. Intensive Care Units (ICUs), cardiac care units, neonatal care units, and burn units are all examples of special care units.

The Plan will also pay the full daily room and board rate for a **birthing center.**

When a woman has a baby in a hospital, she's covered by a specific federal law, called the Newborns' and Mothers' Health Protection Act. The mother and her newborn baby can leave the hospital at any time this is decided in consultation with the attending OB/GYN, pediatrician, midwife, or other health care provider, as appropriate. However, while mother and baby remain in the hospital, a medical plan cannot:

- discontinue or reduce hospitalization benefits for the mother or the newborn for at least 48 hours following a vaginal delivery and for at least 96 hours following a C-section
- require the mother's health care provider to get authorization for a hospital stay of up to 48 hours or 96 hours, as appropriate. (Pre-approval for the hospital stay is still required.)

*Mastectomy*

The Plan covers reconstructive surgery following a mastectomy, including breast reconstruction, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses. It also covers treatment for physical complications for all stages of a mastectomy, including lymphedemas.

*Mental and nervous conditions*

These may also be called "psychiatric" conditions. The chart on page 7 tells you how both inpatient and outpatient treatment for mental health problems are handled. Inpatient treatment can be given in a hospital, mental health center, or residential treatment facility (see page 19).

In addition, the Plan will cover outpatient treatment on a crisis intervention basis, if a licensed or certified mental health care provider certifies that a psychiatric emergency situation exists. (A "psychiatric emergency" is a situation in which the patient appears to have a mental or nervous disorder for which immediate observation, care, and treatment are necessary to avoid serious harm to the patient and others.) The services can be provided by any properly licensed or certified doctor, psychologist, or social worker, or by a hospital or mental health center. No more than three outpatient psychiatric emergency visits are covered in a calendar year.

A **mental health center** is a facility that mainly provides treatment for people with psychological problems. The Plan will recognize such a center if it carries out its stated purpose under all relevant state and local laws and it is either accredited for its purpose by the Joint Commission on the Accreditation of Health Care Facilities or approved by Medicare.

*Obesity*

The Plan will cover one course of treatment per covered individual for morbid obesity. The treatment must be provided by a doctor on an outpatient basis, following a written treatment plan that he or she has prepared. If the individual discontinues the treatment plan before it's complete, he or she will not be covered for any later treatment for obesity. Covered services include office visits and related laboratory tests, but not appetite or weight control drugs, dietary supplements, special foods or food supplements, health or weight control centers or resorts, health club memberships, or exercise equipment.

"Morbidly obese" means that the individual weighs at least twice as much as a normal person of the same height, age, and sex.

*Phenylketonuria*

As long as treatment is given under the direction of a doctor, the Plan will cover the nutritional supplements medically necessary to treat phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria.

*Preventive care for children*

The Plan pays 100% of covered charges for preventive and primary care services given to covered dependents up to age 19. This means:

- An initial hospital check-up and well-child visits scheduled in accordance with the current clinical standards of the American Academy of Pediatrics. These services must be provided by a doctor, either in a hospital or in his or her office.
- Services at each well-child visit, again in accordance with the current clinical standards of the American Academy of Pediatrics. These include a medical history, complete physical exam, developmental assessment, anticipatory guidance, appropriate immunizations, and lab tests ordered at the time of the visit, which are done in either the doctor's office or a clinical laboratory.
- Necessary immunizations that meet the standards approved by the United States public health service against diptheria, pertussis, tetanus, polio, measles, rubella, mumps, hemophilus influenzae type B, and hepatitis B.

Other covered medical treatment for dependents under age 19 will be treated as a regular Plan expense.

*Preventive care for women*

The Plan covers an annual Pap test and pelvic exam for female participants age 18 or older, including laboratory and diagnostic services to examine and evaluate the Pap smear.

The Plan also covers periodic mammography screening for female participants, as follows:

- a mammogram at any age if recommended by a doctor for someone with a personal history of breast cancer, or whose mother or sister has a history of the disease
- one baseline mammogram between the ages of 35 and 39
- one mammogram every two years—or more frequently if recommended by a doctor—between the ages of 40 and 49
- an annual mammogram at age 50 or older.

These services are treated like any other office visit or laboratory expenses, as appropriate. No other routine, preventive, or diagnostic care charges are covered by the Plan.

*Prosthetic devices*

The Plan limits its coverage of prosthetics, such as artificial limbs and eyes, which must take the place of a natural part of the patient's body or be needed due to a dependent's functional birth defect. Only the initial fitting and purchase is covered; replacements and repairs aren't covered unless they're functionally necessary. Wigs and dental prosthetics or devices aren't covered.

*Rehabilitation center*

This is a facility that mainly provides therapeutic and restorative services to sick or injured people. It may also be called a **rehabilitation hospital.** The Plan will cover the lesser of the center's actual daily room and board charge or 50% of the covered room and board charge for semi-private accommodations made by the hospital the patient has just left.

The Plan will recognize such a center if it carries out its stated purpose under all relevant state and local laws and it is either accredited for its purpose either by the Joint Commission or the Commission on the Accreditation of Health Care Facilities, or it is approved by Medicare.

*Residential treatment facility*

This is a facility that provides 24-hour treatment for people with drug abuse, alcohol abuse, or mental health problems on an inpatient basis. It must provide at least the following: room and board; medical services; nursing and dietary services; patient diagnosis; assessment, and treatment; individual, family, and group counseling; and educational and support services.

The Plan will recognize such a facility if it carries out its stated purpose under all relevant state and local laws and it is accredited for its purpose either by the Joint Commission on the Accreditation of Health Care Facilities.

*Speech therapy*

The Plan only covers speech therapy if it's needed because of a sickness or injury. It doesn't cover speech therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss that's not medically documented, or similar disorders.

*Spinal manipulation*

This includes the manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive ultrasound, doppler, whirlpool, or hydro therapy, or other treatment of a similar nature. The Plan covers spinal manipulation as a regular medical expense, but only for up to 30 visits in a calendar year, and no more than two modalities per visit.

# The Dental Plan

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The Dental Plan covers most common forms of dental treatment. You can use any dentist you like, but if you use a dentist who participates in the special network, his or her charges will be lower and your benefits may be greater.

For all services, apart from in-network preventive care and orthodontia, each covered individual must pay a deductible. Then the Plan will reimburse a certain percentage of eligible expenses—the amount depends on the type of service—until the Plan's total reimbursements reach a certain amount in any calendar year. At that point, you must pay all further expenses. Orthodontia is available for children under age 19; expenses are tracked separately and are subject to a lifetime maximum per child.

**What's a dentist?**
A dentist is defined as any dental or medical practitioner that the insurance company is required by law to recognize who is properly licensed or certified under the laws of the state where he or she practices and provides services that are within the scope of his or her license or certificate. Dentists who participate in the insurer's network (called a "Preferred Provider Organization" or PPO) are listed in a special directory.

### Who's eligible for Dental Plan coverage?

All referees whose terms and conditions of employment are governed by the Collective Bargaining Agreement between the NBA and the NBRA are eligible for the Dental Plan.

### How do I enroll for coverage for the first time?

Just complete the appropriate section of the new employees' enrollment form, indicating whether you want coverage for yourself alone or for yourself and any number of eligible dependents. For a definition of eligible dependents, please see page 4 of the Medical Plan. You must list your eligible dependents on your form. (You may already have done this, if you have elected dependent coverage under the Medical Plan.)

You must return this form within 30 days of your initial employment date. Otherwise, you and your dependents will have to wait for six months before any "basic" services are covered and 12 months before any "major" services are covered, unless treatment is necessary for an injury. Additionally, your dependents will have to wait 24 months before orthodontia is covered. These categories of services are explained in the section that begins on page 23.

You can add or remove dependents from coverage later than the initial enrollment period if you have a qualifying "change in status." (See page 5 for details.) For example, if you get married, you can add your spouse to your coverage. You must inform the Finance Department of the change within 30 days or the waiting times in the previous paragraph will apply to any newly covered dependents.

You'll receive an ID card shortly after your enrollment is processed by the insurance company.

### When does coverage begin?

Your coverage will begin on your first day at work after you become eligible, providing you return a completed enrollment form.

Coverage for your dependents, if you elect family coverage, will begin when your own coverage begins, unless the dependent is in a hospital or health care facility, confined at home, or unable to carry out normal activities. In these cases, coverage will begin as soon as the dependent is no longer affected by any of these conditions. This doesn't apply to a newborn in a hospital—although he or she is unlikely to need dental care. If the newborn is an adopted child, coverage will also begin at birth, provided you file a petition for adoption within 30 days of the birth and take physical custody of the child upon release from the hospital.

### How are eligible expenses handled by this option?

First, please note that, in order to be considered by this Plan option, any expense must meet the definition of eligibility on page 26. That's what this book means by "eligible expenses."

As you've already read, you can use any dentist you wish under this option, but dentists who participate in the insurer's network—called "DentalGuard Preferred"—have agreed to provide their services at rates that are approximately 30% lower than those generally charged by other dentists in the same area. Just present your ID card to the dentist before you incur any charges.

Here's how your eligible dental expenses are treated.

*Your deductible*

You must pay the first $50 of your eligible expenses in any calendar year. This is called your deductible. Each covered individual has a $50 annual deductible. However, no family will have to pay more than $150 in deductible expenses in any year, which benefits families of four or more. In-network preventive care and orthodontia expenses don't require a deductible.

Here's an example that shows how the family limit works. A family of four goes to a non-PPO dentist for a checkup, before they incur any other dental expenses for the year. The dentist charges them $95 each for the examination and cleaning. The husband, wife, and their older child each pay their $50 deductibles, and the plan reimburses the rest. This means the family has now paid a combined total of $150 in deductible expenses. Therefore, the younger child doesn't have to pay a deductible, and the full eligible cost of his or her checkup is reimbursed by the plan.

*Coinsurance and annual maximum*

After you meet your deductible, the Plan will pay a certain percentage of the remaining eligible expenses—100%, 80% or 50%, depending on the type of service. However, the Plan will not pay more than $2,000 in benefits to any individual during the calendar year.

(Please note that this is different from the out-of-pocket maximum that applies to out-of-network expenses under the Medical Plan. The Medical Plan's maximum is a limit on what *you* pay. The Dental Plan's maximum is a limit on what *the Plan* pays.)

Expenses for orthodontia are tracked separately, and don't apply to the calendar year maximum. Instead there's a $2,000 *lifetime* limit on orthodontia benefits for each person.

So, for example, it's possible for a newly enrolled dependent to receive up to $2,000 in regular dental benefits and up to $2,000 in orthodontia benefit in the same year. In the following year—assuming coverage doesn't change—he or she may receive up to $2,000 in nonorthodontic dental benefits. But the $2,000 orthodontia limit will be reduced by the amount already reimbursed for orthodontia in the previous year.

**What's covered by the Plan?**

Here's how the Plan categorizes your dental services:

| Type of service | Examples of covered treatment | Does the deductible apply? | Your share of eligible expenses (after deductible) | |
|---|---|---|---|---|
| | | | *In-network* | *Out-of-network* |
| Preventive and diagnostic | Checkup, cleaning, X-rays, fluoride treatment | Only to out-of-network charges | 0% | 0% |
| Basic | Fillings, periodontia, extractions, denture repair | Yes | 10% | 20% |
| Major | Crowns, bridges, dentures | Yes | 40% | 50% |
| Orthodontia | | No | 50% | 50% |

*Preventive and diagnostic services*

- Office visits for a checkup and cleaning ("prophylaxis"), limited to one treatment in any six-consecutive-month period. This includes an examination, scaling, and polishing.
- Emergency palliative treatment and other nonroutine, unscheduled visits.
- Full mouth series of X-rays (at least 14 films, including bitewings) if needed, limited to one set in any 36-consecutive-month period.
- Other X-rays, as needed:

  Bitewing X-rays (no more than four films), limited to one set in any six-consecutive-month period.

  Other intraoral periapical or accusal films (one film).

  Extraoral superior or inferior maxillary film.

  Panoramic film, maxilla and mandible, limited to once in any 36-consecutive-month period.
- Fluoride treatment—topical application of fluoride for covered dependents under age 14, limited to one treatment in any six-consecutive-month period. This includes examination and prophylaxis.
- Initial appliance of space maintainers for covered dependents under age 16 and all adjustments in the first six months after installation. (Includes fixed, unilateral, ban or stainless steel crown type; fixed, unilateral, cast type; and removal, bilateral type.)
- Initial fixed or removable appliance to inhibit thumbsucking and other harmful habits for covered dependents under age 16, and all adjustments in the first six months after installation.
- Dental sealants on the unrestored permanent molars of covered dependents under age 14, limited to one treatment in any six-consecutive-month period.

*Basic services*

- Consultation with a dentist other than the one providing treatment, limited to one consultation for each dental specialty in any 12-consecutive-month period. No other service may be rendered during the visit.
- Diagnostic casts, biopsy, and examination or oral tissue.
- Amalgam restorations (i.e., fillings)
- Synthetic restorations (i.e., fillings) using silicate cement, acrylic or plastic, or composite resin.
- Crowns made of acrylic or plastic, without metal, or stainless steel.
- Pins for retention, exclusive of restorative material.
- Recementation—inlay or onlay, crown, and bridge.
- Endodontic services, including routine X-rays and cultures, but not including final restoration:

  Pulp capping, direct

  Remineralization (calcium hydroxide) as a separate procedure

vital pulptomy

apexification and therapeutic apical closure

root canal therapy on nonvital (nerve-dead) teeth—traditional therapy and medicated paste therapy, N2 Sargenti

apicoectomy as a separate procedure or in conjunction with other endodontic processes.

- Periodontic services, including the treatment plan, local anesthetics, and post-surgical care. (Surgical periodontic services are limited to one treatment per area in any 36-month period.) This covers:

  gingivectomy or gingivoplasty, per quadrant

  gingivectomy per tooth, if fewer than three teeth are affected, not incidental to crown preparation.

  periodontal root planing (one treatment per area in any 24-month period)

  osseous surgery, including flap entry and closure, per quadrant, including all recurring associated surgical procedures

  osseous grafts, including flap entry, closure, and donor sites

  muco-gingival surgery

  occlusal adjustment, when done in conjunction with periodontic surgery, per quadrant, limited to four quadrants in any 12-consecutive-month period.

- Oral surgery, including routine X-rays, the treatment plan, local anesthetics, and post-surgical care. This covers:

  uncomplicated extractions of one or more teeth

  surgical removal of erupted teeth, involving tissue flap and bone removal

  surgical removal of impacted teeth

  alveolectomy, per quadrant

  stomaplasty with ridge extension, per arch

  removal of mandibular tori, per quadrant

  excision of hyperplastic tissue

  excision of pericoronal gingiva, per tooth

  removal of palatal torus

  removal of cyst or tumor

  incision and drainage of abscess

  closure of oral fistula or maxillary sinus

  reimplantation of tooth

  frenectomy

  suture of soft tissue injury

  sialolithotomy for removal of salivary calculus

  closure of salivary fistula

  dilation of salivary duct

  sequestrectomy for osteomyelitis or bone abscess, superficial

  maxillary sinustomy for removal of tooth fragment or foreign body.

- Basic prosthodontic services—other prosthodontic services are included under "major services":

  denture repairs, acrylic: repairing dentures, no teeth damaged; repairing dentures and replace one or more broken teeth; and replacing one or more broken teeth, no other damage

  denture repairs, metal: amount of reimbursement based on the extent and nature of damage and on the type of materials involved

  full or partial denture rebase, jump case, limited to once per denture in any 36-consecutive-month period

  denture reline, limited to once per denture in any 12-consecutive-month period: office reline; cold cure; laboratory reline

  denture adjustments, limited to adjustments more than six months after the initial installation, by a dentist other than the one providing the denture

tissue conditioning, limited to two treatments per arch in any 12-consecutive-month period

adding teeth to partial dentures to replace extracted natural teeth

repairs to crowns and bridges, amount of reimbursement based on the extent and nature of damage and the type of materials involved.

- General anesthesia in connection with surgical procedures only.
- Injectable antibiotics needed solely for treatment of a dental condition.

*Major services*

- Cast restorations and crowns, but only when needed because of decay or injury, and only when the tooth cannot be restored with a routine filling material

  inlays

  onlays, in addition to inlay allowance

  crowns and posts: acrylic with metal, porcelain, porcelain with metal, full cast metal (other than stainless steel), ¾-cast metal (other than stainless steel), cast post and core, in addition to crown (not a thimble coping), steel post and composite or amalgam core, in addition to crown, and cast dowel pin (one-piece cast with crown. Amount of reimbursement may depend on the type of crown.

- Prosthodontic services—specialized technique and characterizations are not covered

  fixed bridges: each abutment and each pontic makes up a unit in a bridge

  bridge abutments (see inlays and crowns in the previous bullet point)

  bridge pontics: cast metal, sanitary, plastic or porcelain with metal, slotted facing and slotted pontic

  simple stress breakers, per unit

  full dentures, upper or lower

  partial dentures, including base, all clasps, rests, and teeth

  upper dentures with two chrome clasps and rests, acrylic base

  upper dentures with chrome palatal bar and clasps, acrylic base

  lower with two chrome clasps with rests, acrylic base

  lower with chrome lingual bar and clasps, acrylic base

  stayplate base, upper or lower (anterior teeth only)

  any adjustments to dentures in the first six months after installation, if done by the dentist furnishing the denture.

*Orthodontic services*

Please note that orthodontic services are not covered under any of the other categories and are available only for covered dependents who are under age 19 when the appliance is first placed. Covered orthodontic services include:

- Any treatment listed under preventive and diagnostic services, basic services, or major services if it is given in connection with orthodontic treatment.
- Surgical exposure if impacted or unerupted teeth in connection with orthodontic treatment, including routine X-rays, local anesthetics, and post-surgical care
- All types of active appliance, including diagnostic services, the treatment plan, the fitting, making, and placing of the appliance, and all related office visits including post-treatment stabilization.

The insurance company pays the expenses of orthodontia in equal payments spread out over the course of treatment, according to the treatment plan (or over two years, if this is less). There is no payment if a treatment is discontinued or after a dependent loses coverage for any reason, even if the course of treatment is not yet complete.

**What's an eligible expense?**

In order to be considered for reimbursement as an eligible expense, a charge for a dental service or supply must be incurred while the patient is covered by the Plan. The service or supply must be prescribed by or performed by or under the direct supervision of a dentist. The Plan won't cover treatment that doesn't meet accepted standards of dental practice or that is experimental in nature.

Eligible expenses are limited to the "reasonable and customary" charges for a particular service or supply. You must pay any amount that exceeds these charges, in addition to your deductible and coinsurance.

- A "reasonable" charge is the dentist's usual charge for the service. But if more than one type of service can be used to treat a dental condition, then the insurance company may limit eligible expenses to the lowest cost, providing the treatment still meets accepted standards of dental practice. For example, if you insist on a gold filling, you will probably have to pay the excess over the cost of an amalgam filling.
- A "customary" charge is the charge made for the dental condition by most other dentists with similar training and experience in the same geographic area.

A pretreatment review (see page 27) can tell you the "reasonable and customary" charge for the treatment. (Excess charges may be claimed through the Health Care Reimbursement account.)

The Plan won't pay for a device that replaces any teeth lost before coverage began, unless the device also replaces teeth lost or extracted while you were a Plan participant.

The Plan won't cover charges for:

- oral hygeine, plaque control or diet instruction
- precision attachments
- any appliance or prosthetic device used to change vertical dimension, restore or maintain occlusion (unless covered by the Plan as orthodontic treatment), splint or stabilize teeth for periodontic reasons, replace tooth structure lost as a result of abrasion or attrition, or treat disturbances of the termporomandibular joint
- any cosmetic treatment, including characterizing and personalizing prosthetic devices and making facings on prosthetic devices for any teeth behind the second bicuspid
- replacing an appliance or prosthetic unless it's at least ten years old and can't be made usable, or unless it's irreparably damaged while in the covered person's mouth as a result of an injury that occurred while insured
- replacing a lost, stolen, or missing appliance or prosthetic device
- making a spare appliance or device
- dental treatment required because of an on-the-job or job-related injury or one for which benefits are payable by Worker's Compensation or similar laws

  treatment for which no charge is made, including treatment given by

  a clinic or medical department run by the NBA, a dependent's employer, a labor union or similar group

  a facility owned or run by any government body

  any public program, except for Medicare, paid for or sponsored by a government body.

**How can I know how much a treatment is going to cost?**

If a proposed course of treatment is going to cost at least $200, you're strongly encouraged to submit a treatment plan to the insurance company before you incur any expenses. Ask your dentist to develop a plan, including a list of the services to be performed (using the American Dental Association terminology and codes), the itemized cost of each service, and the estimated length of treatment. X-rays and study models should also be submitted, if needed to evaluate the treatment plan. Any course of orthodontia automatically requires a treatment plan.

The insurance company will then be able to tell your dentist how much of the proposed treatment cost is likely to be eligible, and how much of this eligible expense will actually be reimbursed by the Dental Plan, assuming the treatment goes ahead according to the treatment plan. This information is particularly important if the proposed plan is likely to result in charges that are above the "reasonable and customary" limits described on page 26. It gives your dentist an opportunity to review alternative treatments with you that may be less expensive for you. (If you don't arrange for your dentist to send in a treatment plan, you run the risk that you may get some unexpected out-of-pocket costs when you send in your claims for reimbursement.)

You don't need to send in a treatment plan before any emergency treatment, oral examination, X-rays, or cleaning, even if these become part of a course of treatment.

**What happens if my expenses can be paid by another plan?**

The rules for nonduplication of benefits that apply to medical coverage also apply to dental expenses. See page 10 for information about the way our Plan will coordinate benefits with another plan that offers coverage for the same dental treatment.

Please note that preventive dental care for children up to age 12 is available as an in-network medical benefit. You cannot claim reimbursement from both the Medical and Dental Plans for the same services.

**How do I make a claim?**

There's no need to file a claim if you use a network provider. You pay nothing at the time of your visit. Your dentist will handle the reimbursement and bill you for your portion (if any) after receiving reimbursement from the insurer.

For expenses paid to an out-of-network dentist, complete the Guardian claim form, which you can get from the Finance Department, and send it with the original bill for service. Make copies of all paperwork. It's a good idea to take your claim form with you when you go to the dentist. He or she can probably complete many of the sections for you, including details of the treatment you receive.

Send the claims to:
The Guardian
DentalGuard Preferred
PO Box 2459
Spokane, Washington 99210-2459
Tel: 1-800-541-7846

Submit all bills for eligible expenses, even if you know you must pay some or all of the total as your deductible—otherwise The Guardian will not know how much you've paid toward deductible expenses.

If your claim is denied, you'll be told why in writing. If you want the decision reviewed, first call The Guardian's toll-free customer service number. If you're still not satisfied, you may consult the Finance Department. Then there are a series of actions you can take, which are outlined in the legal section on page 75. But please note that you can't start any legal action until 60 days after your claim is submitted, or any later than three years after it's submitted. The Plan Administrator has the final say in how the terms of the Plan are interpreted.

**What happens if I'm away from work?**
Please see the section of the Medical Plan that covers what happens to your benefits during an absence (page 12).

**When does coverage end?**
Your dental coverage will stop as of the date on which any of the following events takes place:

- your active employment with the NBA ends, including resignation, retirement, layoff, death, and after 29 months of continuous disability
- you cease to meet the eligibility requirements for the plans
- the Plan is discontinued.

Coverage for your dependents ends at the same time as your coverage ends. However, some uncompleted dental treatments may still be eligible for reimbursement if you have not submitted a claim for them before your coverage ends. See page 66.

**What happens if I leave the NBA?**
If you leave the NBA for any reason, you're going to want to know how this change affects all your benefits. To make this easy, we've put all the information in once place, in the chapter called "Leaving the NBA," which begins on page 57.

# The Disability Plans

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An absence for "disability" is any time when you're unable to be at work because of a health condition, such as an illness, injury, or pregnancy. It's important to know how much income you'll receive if you're disabled and how your absence may affect your other benefits.

For an absence that lasts longer than a week, **state-mandated short-term disability** comes into effect. In New York, this benefit is equal to 50% of your weekly salary up to a maximum payment of $170 per week. State short-term disability continues payments for up to 26 weeks of disability.

If you're still disabled after 90 days (which is approximately 13 weeks or three months), you may receive payments from the **Long-Term Disability (LTD) Plan.** This Plan ensures a certain level of income for as long as you remain disabled.

However, if your injury is job-related, the NBA's **salary continuation** policy will make sure your total disability income adds up to your regular salary for up to one year. If you're still unable to work at this time, the LTD Plan will take over.

### Who's eligible for disability coverage?

All referees whose terms and conditions of employment are governed by the Collective Bargaining Agreement between the NBA and the NBRA are eligible for salary continuation and the Long-Term Disability Plan. There is no minimum service requirement.

### How do I enroll for coverage?

Your participation in all of these Plans is automatic, and all coverage is available at no cost to you, except for state-required payroll taxes.

### What if I have a job-related injury?

If you're injured or develop a physical illness or condition in the course of employment and, as a result, you're unable to officiate, your salary will be continued for up to a year. This "salary continuation" provision means the NBA will make sure that your total disability income, including workers' compensation benefits and NBA-provided insurance, will equal the salary you were earning at the time the disability began.

After one year (actually, 365 days) of *continuous* job-related disability, salary continuation will end and the provisions of the LTD Plan will take over. Separate periods of salary continuation for the *same* job-related injury can't add up to more than one year in any five-year period.

### What if I go back to work but become disabled again?

If you return to work after a non-job-related illness or injury, but you have to be absent *for the same disability* within 30 days of your return, the two absences will be treated as if they were continuous. In other words, you'll go back to where you left off in the waiting period for LTD Plan benefits, and state disability will waive any usually applicable waiting period for the second disability.

If your second absence begins more than 30 days after you return to work, or if you have an unrelated disability any time after going back to work, the waiting period for state disability and LTD Plan benefits will begin again.

**When does the Long-Term Disability Plan come into effect?**

The LTD Plan will start to make payments after 90 consecutive days of a disability that occurs off the job. (That's about 13 weeks or three months.) The appropriate form to claim benefits should be completed before the end of the waiting period. Claim forms should be sent to the Finance Department or to the insurance company.

If your injury is job-related, your salary continuation payments will continue for up to 365 days. LTD Plan payments will begin if you're still disabled as a result of the same injury or sickness at the end of this 365-day period.

**What qualifies as a "long-term" disability?**

Clearly, if you claim any disability absence, the condition of your health must mean you're unable to come to work. You will be required to provide medical certification of your disability.

In order to qualify for payments from the LTD Plan, you must meet a more specific definition of disability. You're eligible for Plan benefits for up to 120 months, if, because of an injury or sickness:

- you can't perform each of the material duties of your regular occupation, or
- you can perform at least one (but not all) of the material duties of any occupation on a part-time or full-time basis, but because of your disability, your monthly earnings are at least 20% less than your indexed pre-disability earnings.

After 120 months of Plan benefits, you'll continue to be disabled under the Plan if UNUM determines that, due to the same sickness or injury, you can't perform the duties of *any* gainful occupation for which you are reasonable fitted by education, training, or experience.

Your "indexed pre-disability earnings" are your earnings at the time the disability began, adjusted on an annual basis by either the current annual percentage increase in the Consumer Price Index, or by 10% if this is less.

In all cases of disability, you must be under the regular care of a doctor. The Plan will not pay benefits for a disability due to:

- any act of war, declared or undeclared
- intentionally self-inflicted injuries
- active participation in a riot.

The insurance company may at any time interview an employee who makes a claim and have that employee examined by the company's own choice of doctor, health professional, or vocational expert (at the company's expense).

A "doctor," according to the LTD plan's requirement for medical certification, is a physician who's either licensed to practice medicine and prescribe and administer drugs or to perform surgery, or legally qualified as a medical practitioner and required to be recognized under this policy according to the insurance statutes or insurance regulations of the governing jurisdiction. The doctor must be operating within the scope of his or her license, and cannot be you or a close relative.

*Medical conditions that existed before you started work for the NBA*

The Plan will not cover any disability caused by or contributed to by a sickness or injury for which you received medical treatment in the three months before you started work for the NBA. This restriction doesn't apply to a disability absence that begins more than a year after your first day of employment.

Medical treatment includes consultation, care, or services, including diagnostic measure, or the use of prescribed drugs or medicines.

This exclusion for a pre-existing condition doesn't apply if, in your previous job, you received benefits for the same condition from group long-term disability coverage issued by the same insurance company (First UNUM).

### How much long-term disability income will I receive?

The LTD Plan *supplements* your other sources of disability income, so that your *total* disability income equals a certain amount of money.

The Plan will make sure your total monthly disability income equals 60% of your monthly salary at the time the disability began, not including commissions, bonuses, overtime pay, or any other compensation.

However, the calculation of your total disability income is subject to a maximum of $13,500 a month. This will only affect you if your annual salary when you became disabled was $270,000 or more.

For example, if your basic monthly earnings were $3,000 when you started your disability absence, the LTD Plan will make sure that your total disability income adds up to $1,800 (60% × $3,000). So if your alternative sources of disability income pay you $800 a month, your LTD Plan payment will be $1,000 a month.

*If you are working during disability*

There is an alternative calculation if you are earning income, despite your disability, and your earnings are more than 20% of your indexed pre-disability earnings (see page 31 for a definition). In this case, the benefit will be as follows:

1. For the first 12 months after you begin to earn income, the LTD Plan will generally ignore your earnings. However, your LTD Plan benefit will be adjusted to make sure your total income—earnings *plus* LTD Plan benefits *plus* other disability income—does not exceed 100% of your indexed pre-disability earnings.
2. After 12 months, your LTD Plan benefits, as calculated in step 1, will be multiplied by this factor:

$$\frac{\text{Indexed pre-disability earnings} - \text{Actual earnings received}}{\text{Indexed pre-disability earnings}}$$

Under all circumstances, certain minimum payments apply—see the next section.

You must give the insurance company appropriate proof of your earnings on a quarterly basis. If you have been underpaid or overpaid in the meantime, an adjustment will be made when the company receives the quarterly information.

For example, if your indexed pre-disability earnings are $3,000 a month and you earn $1,500 a month from working, even though you still qualify as "disabled" under the plan, your factor would be 50%.

$$\frac{\$3{,}000 - 1{,}500}{\$3{,}000} = 50\%$$

In other words, you'd receive half as much from the plan in your second year of disability, to reflect the fact that you have other income.

**What other disability income will be counted?**

As you've read, the Plan takes into account your disability income from all sources. The sources of income that will be counted are:

- eligible payments from Workers' or Workmen's Compensation, occupational disease law, or any other act or law of similar intent
- any disability income benefits for which you're eligible under any compulsory benefit act or law, including state disability benefits and Social Security
- any disability income for which you're eligible under any group insurance plan or any governmental retirement system as a result of your job
- any amount you receive as a disability benefit from the NBA's retirement plans, or any other amount you elect to receive from these plans
- any retirement income you receive as a result of reaching a certain age.

Please note that in all cases:

- You must tell the insurance company about all your sources of income, including any changes in regular payments. But you should also note that your LTD Plan benefit will *not* be adjusted downward if your other income increases because of a cost of living adjustment.
- The income must be payable for the same disability that qualifies you as "disabled" under the LTD Plan's definition.
- In all cases, the insurance company will assume that if you are eligible for a payment (for example, from Social Security), then you have actually claimed this payment and you are receiving it. If you are denied a claim for an alternative disability benefit, make sure the insurance company is informed.
- In determining your LTD Plan benefits, any disability payment made in a lump sum will be prorated over the time period for which the sum is given. If no time period is stated, the insurance company will prorate the amount over your expected lifetime.

*Minimum Plan payments*

No matter how much alternative disability income you receive or how much you earn, the LTD Plan will make a minimum monthly payment to you. This is 10% of the largest possible monthly payment under the Plan, but no less than $100. For example, if your pre-disability earnings were $3,000 a month, the largest possible monthly payment—before allowing for other disability income—is 60% of this amount or $1,800. Your minimum benefit from the LTD Plan is therefore $180 a month (10% of $1,800).

**When do long-term disability payments end?**

For employees who become disabled before the age of 60, LTD payments will be paid until you reach age 65. Employees who become disabled at age 60 or older will be paid for up to five years.

LTD benefits will also end if any of the following events occurs:

- You no longer fit the Plan's definition of "disabled," which includes receiving earnings that exceed 80% of your pre-disability earnings. (See page 31.)
- You die (see page 34).
- Benefits become payable under another employer's group long-term disability plan.

*Limitations because of mental illness*

If your disability is due to a mental, nervous, or emotional disease or disorder, LTD benefits are generally payable for a maximum of 24 months.

However, if you're already confined in a hospital or institution for your condition at the end of this 24-month period, benefits will continue while you're confined and for up to

90 days following your discharge. If you go back into a hospital or institution during this 90-day period, benefits will resume after you've been confined for at least 14 consecutive days. You'll get another 90-day recovery period at the end of this confinement.

LTD benefits will also resume if you become confined for at least 14 consecutive days after the end of the 24-month period, provided you have been continuously disabled in the meantime. In this case, benefits will end when you are discharged.

In all cases, the maximum benefit periods described earlier in this section will also apply and take precedence. For example, if you are age 69, your LTD benefits will end after one year, even if you are confined for a mental illness.

### What happens if a disability recurs?

If you return to full-time work and you're able to perform all the material duties of your occupation, then your disability ends. But if you become disabled again at a later date, here's what happens:

- If the second absence begins less than six months after your return to work, and it's caused by the same disability, you'll immediately go back to payments from the LTD Plan—you won't have to go through the 90-day qualifying period.
- If the second absence begins six months or more after your return to work, it will be treated as a new disability, with a new waiting period.
- If the second absence is caused by a disability that's unrelated to your earlier disability, it will be treated as a new disability.

### What happens if I die?

If you die while receiving LTD payments, your benefits end as of the date of your death. The Plan will pay a "survivor benefit" equal to three times your gross monthly benefit, provided that your disability had continued for at least 180 consecutive days (which is about six months) and the insurance company receives appropriate proof of the death.

The payment will be made to a surviving spouse. If there is no living spouse, the payment will be made to your children under age 25 or to a person named by the NBA to receive payment on their behalf (generally if they are minors or incapacitated). If there are no living children, the payment will be made to your estate.

### What about my coverage if I'm away from work?

LTD Plan coverage will continue during a leave of absence. During a temporary layoff, coverage will continue until the end of the calendar month following the month in which the layoff began.

### When does coverage end?

The earlier section "When do long-term disability payments end?" told you what would happen if you were *actually receiving* benefits from the LTD Plan. This section covers the events that will cause you to lose your general coverage under the Plan.

LTD Plan coverage will end on the date that:

- the policy terminates or the Plan is discontinued by the NBA
- you no longer qualify for coverage according to the Plan's terms
- your employment with the NBA terminates, including resignation, retirement, layoff, and death.

### What happens if I leave the NBA?

Basically, your LTD coverage ends as of your last day of employment. But if you leave the NBA for any reason, you're going to want to know how this change affects all your benefits. To make this easy, we've put all the information in one place, in the chapter called "Leaving the NBA," which begins on page 57.

# Life and Accident Insurance

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Your NBA-provided life insurance provides you with coverage equal to $500,000. Payment is made to your named beneficiary if you die.

Your accident insurance pays a additional benefit if you die in an accident or if you suffer certain serious injuries as a result of an accident that leave you permanently disabled. This income may be particularly important when you face unexpected medical and living expenses, and when you may be unable to resume your regular work.

**Who's eligible for coverage?**

All full-time referees whose terms and conditions of employment are governed by the Collective Bargaining Agreement between the NBA and the NBRA. are eligible for insurance coverage. There is no minimum service requirement.

You don't need to enroll for coverage, but you must complete a beneficiary designation form. (See the next section.) Your coverage will be effective on the first day that you are actively at work.

**How do I elect a beneficiary?**

The NBA uses a combined beneficiary designation form for life and accident insurance, but you can choose different beneficiaries for each type of coverage, if you wish. You normally complete this form when you first join the NBA. If you want to change your beneficiary at a later time, just complete, sign, and return a new form. You can get forms from the Finance Department. The change will be effective as soon as the Finance Department receives the form.

The form asks you to name a **primary** beneficiary and a **contingent** beneficiary. A primary beneficiary is the person, trust, or organization that will receive payment from the insurance plans if you die. A contingent beneficiary would receive benefits if (and only if) the primary beneficiary dies before you, and you have not taken the opportunity to change your designation.

There is space for you to name more than one beneficiary in each category, if you wish. (If you want to name more than two, please attach an additional sheet with clear instructions.) The insurance companies will divide any payment evenly between the named beneficiaries. For example, if you name two primary beneficiaries for your life insurance, and they are both alive at the time of your death, the payment would be split 50/50 between them. If you want a different share, please make your instructions clear on the designation form.

If you don't name a beneficiary, then the insurance companies will make payments to the first surviving individual or entity in the following lists:

- Life insurance payments will go to your estate or to a surviving close relative: your spouse first, then your parents, your children, or your brothers and sisters, as required by law.
- Accident insurance payments on your life will go to your spouse first, then your surviving children, your surviving parents, your surviving brothers and sisters, or—if no relatives survive—your estate.

You receive any accident insurance payments that are made because of an injury to your or your family, or because a family member dies in an accident.

**What's my life insurance coverage?**

If you were to die while you're employed by the NBA, your beneficiary would receive a payment equal to $500,000. If your death was the result of an accident, you'd receive an additional $500,000 from your life insurance coverage.

**What's my accident insurance coverage?**

Your accident insurance covers you at all times, whether or not you're actively at work as an NBA referee. (You may hear accident insurance referred to as "AD&D," which stands for accidental death and dismember-

ment insurance—this common term isn't quite accurate for your accident coverage, which includes injuries in addition to actual loss of limb.)

*If you die in an accident*

If you die as a direct result of an accident, your beneficiary would receive a payment equal to $500,000 *in addition* to your life insurance payment.

The accident must have taken place while you were covered by the Plan, and no more than 90 days before the date of your death. (Please note that some accidents may not be covered—see the section called "What activities are not covered?" for a list of exclusions.)

An insured individual will be presumed dead if he or she is still missing one year after a conveyance in which he or she was traveling was involved in an accident that might reasonably prevent the recovery of remains.

*If you're injured in an accident*

Your insurance covers other accidental injuries as well. You'll receive the same amount as your accidental life insurance coverage if you suffer any of the following losses:

- Speech
- Hearing
- Physical loss or loss of use of a hand
- Physical loss or loss of use of a foot
- Sight of one eye
- Thumb and index finger of the same hand

Please note that for referees, the Plan makes no difference between physical loss, which in the case of a hand or foot means actual severance, and loss *of use* of a limb, which means permanent inability to function without actual severance. For example, if you lose the use of an arm, you automatically lose the use of a hand.

Your life coverage is the most you'll receive from any accident, even if you suffer multiple losses.

In all cases, an appropriate doctor is a licensed medical doctor or doctor of osteopathy who is qualified to provide diagnosis and medical treatment, and who is not a member of the employee's family, a social worker, a physical therapist, or an intern.

*Coverage for your dependents*

Accident insurance coverage for loss of life is also available for your spouse and your dependent children, if they are traveling with you for business purposes or if you're relocating at the NBA's request. To qualify, the travel must be approved and paid for by the NBA.

The coverage for loss of life is $50,000 for your spouse and $25,000 for each child.

Coverage for your family will begin when you leave your home for the business trip (or when you leave your regular place of work, if this is later). Coverage ends when you reach your home—your new home, in the case of a relocation—or you reach your place of work, whichever happens first. Unlike you, your family members are not covered during regular commutation.

A dependent child, in this case, is your unmarried child under the age of 19 (or under 25 if enrolled as a full-time student) who is primarily dependent on you for support. It also includes a child of any age who is physically or mentally incapable of self-support.

Loss of use of a hand means inability to function below the knuckle joints of at least four fingers on the same hand or at least three fingers and the thumb. Physical loss of the hand means complete severance through or above these joints, even if the fingers and/or thumb are surgically reattached.

Loss of use of a foot means inability to function below the ankle joint. Physical loss of the foot means complete severance through or above the ankle joint, even if the foot is surgically reattached.

Loss of hearing means permanent and irrecoverable loss in both ears, as determined by an appropriate doctor.

Loss of sight in an eye means permanent and irrecoverable loss of vision in one eye; remaining vision must be no better than 20/20 using a corrective aid or device as determined by an appropriate doctor.

Loss of speech means permanent and irrecoverable total loss of the capability of speech without the aid of mechanical devices, as determined by an appropriate doctor.