Burlington Northern Santa Fe Medical Program Burlington Northern Pre-65 Retiree Program

Summary Plan Description

Effective January 1, 2006

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BNSF Medical Program
for Burlington Northern Pre-65 Retirees

Pre-65 Retirees who meet BNSF eligibility requirements have the opportunity to continue Medical Program coverage beginning with the first day of the month in which their early retirement benefit commences.

Medical Program options from which you can choose include:

- The Aetna Select EPO where available;
- The Blue Cross Blue Shield Preferred Provider Organization (BCBS PPO) Base;
- The Build Your Own Option (BYO) with Blue Cross Blue Shield or Aetna; or
- Aetna High Deductible Health Program (Aetna HDHP)

However, because you are no longer actively employed, there will be some changes in the Medical Program rules for early Retirees. This Summary Plan Description (SPD) covers benefits available under all the options for Burlington Northern Pre-65 Retirees only.

The BCBS PPO Base Plan and the Build Your Own and the Aetna EPO and Build Your Own medical options feature a Health Reimbursement Account (HRA). This **BNSF-funded** account is yours to use for qualified medical expenses during the year that aren't paid by the plan (for example, deductibles or copays for office visits or prescriptions). Any unused balance remaining at year-end can be carried forward to the next year. More details can be found beginning on page 90.

You may choose from the following coverage level options under the Pre-65 Retiree Medical Program:

- Retiree only;
- Retiree plus family, which includes coverage for you, your dependent children and your spouse.

Your contributions will be withheld from your pension check unless you make arrangement with Your Benefits Resources (YBR) for direct bill and payment. You are no longer eligible for a pre-tax contribution election under the BNSF Internal Revenue Code Section 125 cafeteria plan.

If you have questions regarding your benefits, call Your Benefits Resource at 877-847-2436.

Eligibility and Enrollment

Your Eligibility for Coverage

You are eligible to enroll for early Retiree coverage if you meet the eligibility requirements for the Pre-65 Retiree Medical Program. You must have been a full-time regularly assigned active salaried employee of Burlington Northern, Inc. or its affiliates participating in the Program prior to September 22, 1995 and have remained in a salaried position continuously up to your early retirement date. In addition you must meet all of the following requirements:

- you terminate salaried employment with the Company due to retirement prior to reaching age 65;
- if you retire after June 1, 1994, you have 10 or more years of service with the Company after reaching age 45;
- you are immediately eligible and elect to begin receiving benefits under the BNSF Retirement Plan; and
- you are a U.S. resident at the time of your early retirement and you continue to be a U.S. resident after retirement.

Employees who enter salaried employment with Burlington Northern Santa Fe as a result of a transfer, initial hire or rehire after September 22, 1995, are not eligible for benefits under the Pre-65 Retiree Medical Program. In addition, coverage is not available to other employees or service providers, such as leased employees or independent contractors.

In the case of salaried employees (1) whose employment is terminated for reasons other than cause as a result of the transaction described in the Comprehensive Outsourcing Agreement between The Burlington Northern and Santa Fe Railway Company and International Business Machines Corporation ("IBM") dated August 12, 2002, (ii) who have attained age 40 at the date of such termination of employment, (iii) who are employed by IBM or an affiliate of IBM after such termination of employment, and (iv) who timely execute an appropriate release in the form prepared by the Company or an affiliate of the Company, then for purposes of meeting the above eligibility requirements, service with IBM or its affiliates shall be treated as service with the Company, and termination of employment with IBM shall be treated as termination of employment with the Company.

Dependent Eligibility

Family members you may cover as eligible dependents under the Pre-65 Retiree Medical Program include:

• Your legal spouse who is under age 65, unless you are legally separated or divorced.

• Your unmarried children under age 19 (or under age 23 if the child is a full-time student at an accredited institution) and dependent primarily on you for financial support. Eligible children must live with you in a parent-child relationship and include:

– your unmarried natural children;

– your stepchildren, legally adopted children, children placed for adoption, or children placed under the full legal guardianship of you or your spouse; and

– children related to you by blood or marriage, including grandchildren who live with you in a parent child relationship (for grandchildren, a parent-child relationship does not exist if the child's natural parent lives in the same home).

• A child who is the subject of a Qualified Medical Child Support Order (QMCSO) issued under ERISA Section 609, as determined by BNSF. You may request copies of the BNSF QMCSO policies and procedures free of charge through the Benefits Department in Fort Worth or you may contact YBR.

Your children are considered to depend primarily on you for financial support if you provide more than 50% of their support and they are eligible to be claimed as dependents on your federal income tax return. Coverage ends on the first to occur of the following:

• the end of the month in which a child who is not a full-time student turns 19;

• the date that the child over 19 graduates or ceases to be a full-time student;

• the end of the month in which a child who is a full-time student reaches age 23;

• the child's marriage; or

• the date the child ceases to be a dependent for income tax purposes.

To be considered a full-time student at an accredited institution, your child must be registered as a full-time student in a high school, college, university, trade school, professional school, school in a foreign country or remedial education facility. The Benefits Administrator, Your Benefits Resources (YBR), will require proof of whether a child qualifies as a full-time student.

Eligible enrolled children who are mentally or physically disabled may retain coverage beyond age 19 (or age 23, if they are full-time students when they become disabled) if their disability occurred before reaching the Pre-65 Retiree Medical Program's maximum age. To be eligible for continued coverage, the child must be unmarried, legally reside with you, must be incapable of self-sustaining employment and must be primarily dependent on you for financial support. To continue coverage for a disabled child, you must contact your carrier with proof of the disability within 60 days of the date the child turns age 19 (or age 23 if the child is a full-time student) and as requested from time to time thereafter.

Enrollment

If you are eligible for the Pre-65 Retiree Medical Program, you may enroll in the Medical Plan of your choice. You also may enroll your spouse and those dependents that meet the eligibility requirements listed on page 2. ***You must enroll within 31 days after the date you first become eligible for coverage under the Pre-65 Retiree Medical Program.***

If you are enrolled in early Retiree coverage, you cannot change your coverage election during the year unless one of the following Family Status Events should occur:

- Your marriage, divorce, legal separation or annulment;
- Death of your spouse or other covered dependent;
- Birth, adoption, placement for adoption, or marriage of a dependent;
- A dependent satisfies or ceases to satisfy eligibility requirements;

- The termination or commencement of your spouse's employment, a change in hours worked, or an unpaid leave of absence taken by you or your spouse resulting in a change in eligibility for medical coverage;
- A Qualified Medical Child Support Order under ERISA Section 609, as determined by the Program Administrator; or
- A significant change or loss of spouse or dependent coverage under another group health plan for reason other than your failure to pay premium.

If you experience one of the qualifying family status change events noted above, any changes to your benefit selections will be based on the type of event you experience. You can make only those changes that directly relate to the event and are consistent with the event.

Opting Out of Early Retiree Coverage

If you choose not to elect or continue Pre-65 Retiree Medical coverage for yourself and your dependents, you should be certain you have other group or individual medical coverage in place to cover yourself and your dependents at the time you opt out. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows you to carry over credit from coverage under another medical plan (whether the coverage is individual coverage or group coverage) and to apply it to a new group medical plan's pre-existing condition exclusion period. Under HIPAA, if you have a break in coverage that is greater than 62 days, you may not be able to carry over credit for any prior medical coverage to any new medical coverage.

Although this Pre-65 Retiree Medical Program does not have a pre-existing condition exclusion period, you should still familiarize yourself with HIPAA's coverage credit carryover rules. You may want to purchase medical coverage that does have a pre-existing exclusion period at some future date.

HIPAA Special Enrollment Rules

If you do not elect Pre-65 Retiree Medical coverage for yourself or an eligible dependent when first eligible or in any subsequent year, you may not re-enroll for coverage unless you have the following Special Enrollment Event:

• You waive Pre-65 Retiree coverage because you had other group medical plan coverage and that group medical plan terminates, or the employer sponsoring the other group medical plan ceases to make employer contributions. You should know that failure to pay the required premium for the other group medical coverage is not a termination of the other plan under the HIPAA Special Enrollment Event rules. You will need to provide evidence of the other group coverage, including information on the reasons it has ended; or

• Termination of eligibility for other group medical coverage due to termination of employment of you or your spouse in the event that you are enrolled as a dependent.

You must notify YBR within 31 days of the termination of your other group medical plan coverage to re-enroll in the Pre-65 Retiree coverage.

Giving Notice of a Family Status Event

You must notify YBR within 31 days of one of these events in order to change your election. If you have a Family Status Event or if you want to enroll under the HIPAA Special Enrollment Rules, you can log on to www.ybr.com/benefits to make the changes. If you prefer to use the phone, you can call the YBR Resource Line by dialing 1-877-847-2436. Except as noted below (under "Effective Date of Revised Coverage"), if you do not notify YBR within 31 days, you will have to wait until the next Annual

Enrollment unless you have a subsequent Family Status Event or otherwise qualify for HIPAA Special Enrollment, and you give notice within 31 days.

Effective Date of Revised Coverage

Generally, all changes due to Family Status Events and HIPAA Special Enrollment Rules must be made within 31 days of the event. In those cases, the effective date of the new coverage will be the date of the event. However, there are some *limited* exceptions to the 31-day rule as indicated below:

- If your request is to add a newly eligible dependent, and the request is made after 31 days of the Family Status Event, the new dependent's coverage will be effective on the date of the request; or

- If the request is to add a newly eligible dependent, and you already have "family coverage", the new dependent's coverage will be retroactive to the date of eligibility.

If the above exceptions do not apply, and your request is more than 31 days after the event, you must wait until the next Annual Enrollment period to make the change. Therefore, it is always best to request the change as soon as possible.

The BCBS PPO Option

The BCBS PPO is a national PPO. This means BCBS has a national network of hospitals and other health care providers who have agreed to provide services covered under the Program at a pre-determined rate. The BCBS PPO option offers two plans—the Base Plan and the Build Your Own (BYO) Plan.

BCBS PPO Base Plan

This option, designed for those who require a basic level of medical coverage, has the highest annual deductible and out-of-pocket maximum, and pays the lowest percentage of medical costs through coinsurance. Additionally, you pay a percentage of your prescription drug costs rather than a specific copay amount. (See Outpatient Prescription Drug Benefit on page 30.)

BCBS PPO Build Your Own (BYO) Plan

This option provides you with numerous combinations of coverage levels to design a plan that is best for you and your family. You choose how much you want your deductible to be for the year, the coinsurance percentage you want and the prescription drug coverage level you want.

Choosing an In-Network Provider

With both the BCBS PPO Base and the BCBS PPO BYO Plan, you may see any physician you wish. However, if you want to take advantage of Program benefits at a lower cost, you should consider using a BCBS PPO network provider. You and your enrolled dependents can find a BCBS PPO network provider by using the YBR web site at **www.ybr.com/benefits**. If you do not have access to the web site, you can contact YBR by phone at 1-877-847-2436. The YBR information is regularly updated. However, once you select a PPO provider, you should always check with the provider to be certain the provider is in the BCBS PPO network.

Under both the Base and BYO Options, you can go to any physician or health care professional at any time. Each time, you can decide whether to go to an in-network PPO provider or an out-of-network provider. Benefits are greater when you use a PPO in-network provider. If you decide to use an out-of-network provider, you will pay a greater share of the cost of service. You will also be responsible for that part of the out-of-network provider's bill that does not meet the BCBS definition of a "reasonable and customary" charge.

If you decide to rely exclusively on the PPO network providers for your care throughout the calendar year, you will reduce your health care expenses in several ways. For example:

• You will have a lower calendar-year deductible.

• The individual calendar-year out-of-pocket maximum is lower than the out-of-network option.

• You will pay a set dollar copayment for PPO in-network provider office visits.

• You and your covered family members will never incur a charge for PPO in-network services that exceeds “reasonable and customary” levels. (You are required to pay for that portion of out-of-network charges that are not “reasonable and customary” under Program terms.)

In most cases, you will not be required to file a claim form for services provided by PPO in-network providers. Your claim will be submitted automatically to the Claims Administrator by the PPO provider.

You will be responsible for paying the annual deductible, individual out-of-pocket amounts and other PPO copayments, however. There is no lifetime dollar limit on the services provided to covered persons by PPO network providers. However, for example, there are dollar limits that apply to certain benefits such as substance abuse benefits.

Out-of-Network Providers

You are not required to use the PPO network providers. You may choose to use out-of-network providers, but you will pay more for their services. You and your dependents will be required to pay a higher calendar-year deductible and a higher out-of- pocket maximum. **Also, preventive care services by out-of-network providers are not covered.** There is a lifetime $750,000 limit on out-of-network services for each covered person. Certain limits also apply to specific benefits. Each January 1, if you have used at least $1,000 of the lifetime limit in the prior year, $1,000 will be restored to the limit. See the chart on page 8 for a comparison of out-of-pocket expenses for network and out-of-network services.

BCBS PPO Base Schedule of Benefits

LIFETIME MEDICAL PROGRAM LIFETIME MAXIMUM	**No limit**	**$750,000 all benefits are subject to Reasonable and Customary**
BENEFITS	**In Network Coverage** **Base Plan Pays**	**Out-of-Network Coverage** **Base Plan Pays**
Deductible: (per individual)	$1,000	$2,000
Family Deductible Limit:	$2,000	$4,000
Out-of-pocket Expense Limitation: The amount of money an individual pays toward covered hospital and medical services during any 1 calendar year, **excluding the deductible**. Office visit, emergency room and prescription drug copays, pre-certification penalties and charges in excess of the BCBS fee schedule do not apply to any out-of-pocket limit.	Individual $2,000 Family $4,000	Individual $4,000 Family $8,000
Inpatient Hospital Services: Room allowance based on the hospital's most common semi-private room rate; Skilled Nursing Facility, Hospice and Coordinated Home Care are paid on the same basis; Pre-admission testing paid as part of the subsequent Inpatient Hospital surgical stay.	80% After Deductible	60% After Deductible
Outpatient Surgery & Diagnostic Tests:	80% After Deductible	60% After Deductible
Outpatient Emergency: (Hospital & Physician) Emergency Medical and Emergency Accident -- Initial treatment of accidental injuries or sudden and unexpected medical conditions with severe life threatening symptoms. Subject to $50 copay, waived if admitted.	100% after $50 Copayment	Same as Network
Physician Office Visit: Payments are based on the BCBS fee schedule. Network providers have agreed to accept the BCBS fee schedule as payment in full for covered services, excluding your deductible and any coinsurance.	Primary Care – 100% after $15 Copayment Specialist Care –- 100% after $25 Copayment	60% After Deductible
Well Child & Adult Routine Care: Subject to Office Visit copay.	100% after Office Visit Copayment	Not Covered
Chiropractor: limited to 60 visits per year.	100% after $25 Copayment	60% After Deductible
Durable Medical Equipment (DME):	80% After Deductible	60% After Deductible
Occupational / Physical / Speech Therapy: 60 visits per calendar year per therapy.	$25 Copayment	60% After Deductible
Other Covered Services: Blood and blood components; leg, arm, and neck braces; private duty nursing; ambulance services; oxygen and its administration; surgical dressings, casts and splints.	80% After Deductible	60% After Deductible
Prescription Coverage: See Outpatient Prescription Drug Coverage section on page 30	Retail and Mail - 75% (with minimums based on type of drug, maximum $100 retail and $200 mail)	Retail - reimbursement limited to payment made for in-network; Mail – Not covered

- Pre-certification is required for Inpatient Hospital, Skilled Nursing Facilities, Coordinated Home Health Care, and Private Duty Nursing. Failure to pre-certify will result in a penalty of $500.
- Mental health and substance abuse are subject to limits. See Schedule of Benefits Substance Abuse and Mental Health section of SPD on page 26
- Penalties for not requesting pre-certification and charges in excess of reasonable and customary can not be credited toward the deductible and out-of-pocket maximum.

- Some benefits are subject to limits. Examples of limited benefits include infertility treatment, chiropractic treatment, occupational, speech and physical therapies and home health care. See Medical Care Services section of this SPD for details on all limitations that apply.

The Schedule of Benefits above applies to the PPO Base Plan. However, the Build Your Own Options differ only in the deductibles, out-of-pocket limits, coinsurance levels, and prescription coverage. These are listed below for each BYO option.

BCBS Build Your Own Options
Level of Coverage

BCBS BYO Option 1	In Network	Out of Network
Deductible (Individual/Family)	$500 / $1,000	$1,000 / $2,000
Coinsurance	85%	65%
Out-of-pocket Maximum (Individual/Family)	$2,000 / $4,000	$4,000 / $8,000
Prescription Coverage	Copay	Copay

BCBS BYO Option 2	In Network	Out of Network
Deductible (Individual/Family)	$500 / $1,000	$1,000 / $2,000
Coinsurance	85%	65%
Out-of-pocket Maximum (Individual/Family)	$2,000 / $4,000	$4,000 / $8,000
Prescription Coverage	Coinsurance	Coinsurance

BCBS BYO Option 3	In Network	Out of Network
Deductible (Individual/Family)	$500 / $1,000	$1,000 / $2,000
Coinsurance	70%	50%
Out-of-pocket Maximum (Individual/Family)	$3,000 / $6,000	$6,000 / $12,000
Prescription Coverage	Copay	Copay

BCBS BYO Option 4	In Network	Out of Network
Deductible (Individual/Family)	$500 / $1,000	$1,000 / $2,000
Coinsurance	70%	50%
Out-of-pocket Maximum (Individual/Family)	$3,000 / $6,000	$6,000 / $12,000
Prescription Coverage	Coinsurance	Coinsurance

BCBS BYO Option 5	In Network	Out of Network
Deductible (Individual/Family)	$1,000 / $2,000	$2,000 / $4,000
Coinsurance	85%	65%
Out-of-pocket Maximum (Individual/Family)	$2,000 / $4,000	$4,000 / $8,000
Prescription Coverage	Copay	Copay

BCBS BYO Option 6	In Network	Out of Network
Deductible (Individual/Family)	$1,000 / $2,000	$2,000 / $4,000
Coinsurance	85%	65%
Out-of-pocket Maximum (Individual/Family)	$2,000 / $4,000	$4,000 / $8,000
Prescription Coverage	Coinsurance	Coinsurance

Continued

BCBS BYO Option 7	In Network	Out of Network
Deductible (Individual/Family)	$1,000 / $2,000	$2,000 / $4,000
Coinsurance	70%	50%
Out-of-pocket Maximum (Individual/Family)	$3,000 / $6,000	$6,000 / $12,000
Prescription Coverage	Copay	Copay

BCBS BYO Option 8	In Network	Out of Network
Deductible (Individual/Family)	$1,000 / $2,000	$2,000 / $4,000
Coinsurance	70%	50%
Out-of-pocket Maximum (Individual/Family)	$3,000 / $6,000	$6,000 / $12,000
Prescription Coverage	Coinsurance	Coinsurance

BCBS BYO Option 9	In Network	Out of Network
Deductible (Individual/Family)	$1,500 / $3,000	$3,000 / $6,000
Coinsurance	85%	65%
Out-of-pocket Maximum (Individual/Family)	$2,000 / $4,000	$4,000 / $8,000
Prescription Coverage	Copay	Copay

BCBS BYO Option 10	In Network	Out of Network
Deductible (Individual/Family)	$1,500 / $3,000	$3,000 / $6,000
Coinsurance	85%	65%
Out-of-pocket Maximum (Individual/Family)	$2,000 / $4,000	$4,000 / $8,000
prescription Coverage	Coinsurance	Coinsurance

BCBS BYO Option 11	In Network	Out of Network
Deductible (Individual/Family)	$1,500 / $3,000	$3,000 / $6,000
Coinsurance	70%	50%
Out-of-pocket Maximum (Individual/Family)	$3,000 / $6,000	$6,000 / $12,000
Prescription Coverage	Copay	Copay

BCBS BYO Option 12	In Network	Out of Network
Deductible (Individual/Family)	$1,500 / $3,000	$3,000 / $6,000
Coinsurance	70%	50%
Out-of-pocket Maximum (Individual/Family)	$3,000 / $6,000	$6,000 / $12,000
Prescription Coverage	Coinsurance	Coinsurance

Understanding Deductibles, Coinsurance and Copayments

Certain rules apply to deductibles and copayments for the PPO (Base and BYO Plans) in-network and out-of-network options. No matter whether you choose a PPO provider or an out-of-network provider, you and your covered dependent(s) must pay part of the expenses for services and supplies received. Depending on the type of expenses, you will be required to pay a copayment or a deductible and a percentage of the charge. When you pay a percentage (rather than a specific dollar amount) it is called *coinsurance*.

A *copayment* is a specific dollar payment required under the PPO option when you or a dependent visits a network physician, or receives emergency care in your physician's office or the emergency room of a hospital. For example, if you visit an in-network primary care doctor, you pay $15 at the time of service. There is no additional fee to pay or a deductible to meet. The PPO network coinsurance and copayments are shown in the Schedule of Benefits on pages 8.

A *deductible* is money you must spend each calendar year for eligible expenses, other than for office visits, emergency care, or prescriptions, before the Program pays benefits. There are individual and family deductibles under the BCBS PPO Base and BYO Plans for both in network and out-of-network coverage. All options have individual and family maximum deductibles. Before benefits are paid, you must meet the deductible for the type of provider you have visited, a BCBS in network provider or an out-of-network provider. The deductibles are shown in the BCBS PPO Schedule of Benefits on page 8.. Each PPO and non-PPO deductible is separate; however, the non-PPO deductible applies to the PPO deductible.

When you look at the Schedule of Benefits, you will see the maximum family deductible is equal to two individual deductibles. This means that when two or more family members incur eligible expenses totaling the family deductible, the Program will begin paying the appropriate percentage for additional expenses for the family for that year. Please note that no more than an individual deductible will be taken from any one family member.

Coinsurance is the percentage of eligible expenses (except office visits and emergency care) the plan pays, after you have met your deductible. For example, if you are covered under the BCBS PPO Base option, the coinsurance is 80%.

Both the in-network and out-of-network options have calendar-year coinsurance maximums, also called "out-of-pocket" expense maximums. *Out-of-pocket expenses* are your portion of the charges made by network and out-of-network providers. Out-of-pocket expenses include only your portion of coinsurance; they do not include any deductibles, or any network copayments (including prescription copayments). Under either the network or the out-of-network options, the Program will pay 100% of the eligible expenses that are subject to coinsurance for the remainder of that calendar year after a Covered Person has met the out-of-pocket maximum. See the BCBS PPO Schedule of Benefits on page 8. for details.

Special limits apply to mental health/substance abuse benefits under the Medical Program. See page 26 for the Mental Health and Substance Abuse Schedule of Benefits.

The following charges will **not** count toward the annual deductible or out-of-pocket maximums for the in-network or out-of-network benefit options.

• Charges in excess of the BCBS reasonable and customary charges.

• Charges for services and supplies not covered under the BCBS option.

• Charges that exceed the applicable lifetime or calendar year dollar maximums.

• Any penalties paid because the covered person failed to comply with the Program's pre-certification requirements.

• Charges for inpatient admissions and additional inpatient days that have not been certified on review by the pre-certification reviewer.

• Copayments or coinsurance for prescription drugs and office visits.

What You Should Know About Covered Charges

The Program reimburses only those covered charges that are medically necessary and not otherwise excluded or limited under Program terms. If you use the PPO network your charges will be submitted directly to the network Claims Administrator and you will never pay more than the applicable individual out-of-pocket maximum and any required copayment or coinsurance. If you use out-of-network providers, you will need to file a claim with the Claims Administrator for most out-of-network provider charges. You will also pay an out-of-network deductible and the applicable co-insurance up to the out-of-pocket maximum. Only those medically necessary out-of-network covered charges that meet the BCBS definition of reasonable and customary will be paid or reimbursed by the Claims Administrator.

Certain medical services are subject to pre-admission certification. Failure to comply with the BCBS option's pre-admission certification requirement could result in your paying a $500 penalty that will not be included as part of the calendar-year deductible or out-of-pocket maximum. You also will be responsible for paying the penalty for covered medical services that should have been, but were not, pre-certified under the BCBS option. The pre-certification requirements apply to both in-network and out-of-network medical services.

Special rules apply to covered charges for mental health and substance abuse services. See page 26 for the Mental Health and Substance Abuse Schedule of Benefits.

Medically Necessary Charges

A service or supply is *medically necessary* when, in the Claims Administrator's determination, it meets all of the following criteria:

1. It must be provided by a physician, hospital or other covered provider under the BCBS option.

2. It must be commonly and customarily recognized with respect to the standards of good medical practice as appropriate and effective in the identification or treatment of a patient's diagnosed injury or illness.

3. It must be consistent with the symptoms on which the diagnosis and treatment of the illness or injury is based.

4. It must be the appropriate supply or level of service that can safely be provided to a patient. With regard to a person who is an inpatient, it must mean the patient's illness or injury requires that the service or supply cannot be safely provided to that person on an outpatient basis.

5. It must not be primarily for the convenience of the patient, physician, hospital or other covered provider under the Program. It must not be for the purpose of custodial care, convalescent care, rest cures, or domiciliary care.

6. It must not be scholastic, educational or developmental in nature, used for vocational training, or experimental or investigational.

7. It must not be provided primarily for the purpose of medical or other research.

8. It must not be an inpatient admission primarily for diagnostic studies like x-rays, laboratory services or other machine diagnostic tests. If these procedures can be provided safely and adequately on an outpatient basis or in the physician's office, inpatient testing is not medically necessary under the Program.

The Program Administrator has delegated the discretionary authority to determine medical necessity under the Program to the Claims Administrator. The fact that a patient's physician has ordered a particular treatment or supply does not make it medically necessary under the Program. Even if your physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary, the Program will only reimburse services and supplies determined medically necessary by BCBS.

Among the factors the Claims Administrator may consider in determining medical necessity are (1) approval by the U.S. Food and Drug Administration (FDA), if applicable; or (2) whether a service or supply is commonly and customarily recognized by physicians in a particular medical specialty as appropriate for the diagnosis or treatment of the illness or injury. The presence of these or other factors will not automatically result in a determination of medical necessity if the Claims Administrator determines one or more of the eight requirements listed above has not been met.

Reasonable and Customary Charges

Only reasonable and customary charges are paid under the Program. If you use a PPO network provider, the charges from the network provider are subject to a scheduled reimbursement allowance and are not subject to a reasonable and customary determination by the Claims Administrator. Out-of-network provider charges are reasonable and customary if they are within the normal range of charges made by most physicians, hospitals and other providers in the same geographical area. The Claims Administrator has the discretionary authority to determine reasonable and customary amounts under the Program, and will take into consideration the nature and severity of the condition treated, and any complications or unusual circumstances that may require additional time, skill or experience.

Pre-admission Certification and Continued Stay Review

Pre-admission certification and continued stay review refer to the process used to certify the medical necessity and length of inpatient hospital stays during a course of treatment. These reviews are part of the BCBS Medical Services Advisory Program, which is called "MSA". MSA review applies to the PPO network and out-of-network Program options. You, your dependents or your treating physician should request MSA review prior to an inpatient hospital admission. If MSA certification is not obtained prior to an inpatient admission, you will be charged a $500 penalty. If the penalty applies, it will not be counted as part of any calendar-year deductible or out-of-pocket maximum.

Pre-admission Review is not a guarantee of Program benefits. Payment of benefits is subject to the general terms, limitations, and exclusions under the Program.

If your treating physician is in the PPO network, the network provider usually will make certain the MSA review is obtained prior to any inpatient stay in a network hospital. If you have an out-of-network physician and/or are preparing for inpatient admission to an out-of- network hospital, you are responsible for obtaining an MSA review. **Whether care is received from a PPO provider or an out-of-network provider, it is your responsibility to make sure MSA review has been obtained.**

When you contact the MSA be prepared to give the following information:

1. the name of the attending or admitting physician;

2. the name of the hospital where admission is scheduled;

3. the scheduled admission date; and

4. a preliminary diagnosis or reason for the admission.

Under federal law, hospital length of stay in connection with childbirth for the mother or newborn child may not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. The attending physician is not required to obtain pre-certification for a length of stay that does not exceed the federal requirements.

To obtain an MSA review for any inpatient hospital admission or to find out if MSA review is required, call the toll-free number shown on your BCBS PPO option identification card.

When you receive MSA certification or review, your treating physician and the hospital will be advised of the length of stay certified by the MSA reviewer. Continued stay review should be requested by you or your treating physician prior to the end of the certified length of stay if additional inpatient days may be needed.

To obtain MSA certification for additional inpatient days, call the toll-free number shown on your BCBS PPO identification card.

If you and your physician decide to extend your inpatient stay when the MSA reviewer has indicated the Pre-65 Retiree Medical Program will not pay for additional days, you will be responsible for paying for the added days. You may not count your payment toward the calendar year deductible or out-of-pocket maximum. You may appeal the MSA reviewer's denial of additional days under the rules outlined in the "If Your Claim Is Denied" section of the SPD beginning on page 40. All medical decisions regarding your treatment are between you and your physician. The MSA reviewer is responsible for determining only whether the Program will pay for extra inpatient days.

When to Request Pre-admission Certification

Non-emergency or non-maternity admissions: If you or a dependent is planning elective surgery, you, your physician, or anyone on your or your dependent's behalf should *call the MSA toll-free number on your BCBS PPO identification card* to certify the hospital stay within one (1) business day before the inpatient admission.

The Hospital or your physician will be advised by telephone of the MSA review decision. There will be a follow-up notification letter sent first class mail. This letter may not be received prior to your date of admission.

Emergency admissions: If you or a dependent is admitted to the hospital due to a sudden sickness or injury that may result in serious medical complications, loss of life or permanent impairment of bodily functions, you, your treating physician or a friend or relative should *call the MSA toll-free number on your BCBS PPO identification card* within two (2) business days of the emergency admission, or as soon as reasonably possible.

Pregnancy: Although you are not required to call for an MSA review prior to your maternity admission, you should call MSA as soon as you find out that you or your spouse is pregnant but no later than the first trimester of pregnancy in the normal course. The MSA reviewer will monitor the pregnancy and provide educational materials that will help you ask your physician the right questions. Your physician will receive a letter stating you have contacted MSA.

You or your physician should contact MSA within two (2) days after a maternity admission. Under federal law, neither you nor your physician is required to obtain MSA pre-authorization on entering the Hospital to deliver your baby. However, you or your physician must contact the MSA reviewer if the mother is not going to be released within 48 hours of a normal vaginal delivery. If the baby is delivered by Cesarean section and the mother is not going to be released 96 hours after the baby is delivered, then

you or your physician must contact MSA. *Call the MSA reviewer toll free number on your BCBS PPO identification card.*

Special Rules for Mental Health and Substance Abuse Inpatient Care

Emergency Mental Health/Substance Abuse Care: In the event of an emergency mental illness or substance abuse admission, you, or someone on your behalf, must call the Mental Health Unit (MHU) reviewer no later than 48 hours after the emergency admission has occurred. *The MHU reviewer can be reached 24 hours a day, 7 days a week at the toll free number 1-800-851-7498.*

Inpatient Mental Health/Substance Abuse Care: The MHU reviewer must be called if you are requesting non-emergency inpatient Hospital admission. The inpatient admission must be recommended by your physician. You or your physician must call the MHU reviewer one (1) day prior to the inpatient admission. If there are going to be pre-admission tests, then the MHU reviewer must be called one (1) day prior to those tests. *The MHU reviewer can be reached 24 hours a day, 7 days a week at the toll free number 1-800-851-7498.* You or your physician must seek MHU reviewer approval of any extension of the original approved stay. If you or your physician decide to extend inpatient days when the MHU review has indicated the Program will not pay for additional days, you will be responsible for the added days. You may appeal the MHU reviewer's denial of additional days under the rules for Expedited and Written Appeals on SPD page 28.

Mental Health/Substance Abuse Partial Hospitalization: The term "partial hospitalization" means an approved program of a Hospital or Substance Abuse Treatment Facility for the rehabilitation treatment of mental illness or substance abuse, in which the patient spends days only or nights only. If your physician recommends a partial hospitalization treatment program, you must call the MHU reviewer one (1) day prior to scheduling admission. *The MHU reviewer can be reached 24 hours a day, 7 days a week at the toll free number 1-800-851-7498.*

MHU does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and the required services is between you and the physician. MHU determines whether benefits are paid under the BCBS definition of medically necessary. The fact that your physician or health care provider determines a treatment is medically necessary does not mean the Program will cover the treatment.

When you contact MHU you should be able to give the information listed on page 28 of this SPD.

Case Management

In the event you or your dependent needs continuing treatment beyond the acute care setting of the hospital, you will be contacted by a Case Manager. The Case Manager helps to ensure that patients receive care in the most effective setting possible whether at home, as an outpatient or as an inpatient in a specialized facility. The Case Manager will work closely with the patient, the family and the treating physician to determine treatment options and to keep costs manageable. Case Managers also are available to answer questions and provide ongoing support for the family in times of medical crisis.

You, a friend or relative, or the treating physician can request case management by *calling the toll-free number on your BCBS PPO identification car*d. Participation in the case management program is voluntary. There is no penalty if you do not want to participate in case management.

Organ Transplants

Charges made for or in connection with certain organ transplant services that are not determined to be experimental and investigational and that are approved by BCBS are covered the same as benefits for other medical conditions under the Program. *If you or a dependent is or may become a candidate for an*

organ transplant, call the toll-free number on your BCBS PPO identification card. Only the following human organ or tissue transplants are covered under Program terms.

- cornea
- heart valve
- heart
- liver
- kidney
- muscular-skeletal
- lung
- pancreas
- bone marrow
- parathyroid
- heart/lung
- pancreas/kidney

You must call the toll-free number on your BCBS PPO identification card before scheduling any heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant. The Program only covers benefits for these transplants at Hospitals operating a BCBS approved Human Organ Transplant Program. No benefits will be provided for these transplants at any hospital that does not have a BCBS approved Human Organ Transplant Program.

Benefits are available to both the recipient and donor under the following rules:

• If both donor and recipient have their own insurance coverage, each will have their benefits paid by their own insurance.

• If you are a recipient and the donor has no insurance from any source, the benefits described in this SPD will apply to the donor for transplant purposes only. In this case, payments made for the donor will be charged against any BNSF Pre-65 Retiree Medical Program benefit limits that apply to you.

• If you are the donor and no coverage is available to you from any other source, you will be covered under the BNSF Pre-65 Retiree Medical Program. No benefits will be provided for the recipient under the Program.

Transplant benefits begin no earlier than five (5) days prior to transplant surgery and extend no longer than 365 days from date of surgery. Only U.S. or Canadian transportation of a donor organ is covered.

No benefits are provided for transportation by an ambulance for a donor or recipient, or for travel time and related expenses of a medical Provider. No benefits are paid for cardiac rehabilitation if provided after three (3) days after Hospital discharge. No benefits are paid for drugs or treatments that are investigational, as determined by BCBS.

All transplants are subject to MSA reviewer pre-certification and continued stay review. You or your physician must call the MSA reviewer number on your BCBS identification card.

Medical Care Services

The following medically necessary services are covered under the Program subject to the copayments, deductibles and co-insurance maximums that apply to the Program option (in-network or out-of-network) you have elected. Reimbursement of medical expenses is subject to BCBS reasonable and customary limits, and some benefits are subject to annual maximums, as shown on the "Schedule of Benefits chart and the "Substance Abuse and Mental Health" chart on pages 8 and 26. The fact that an annual or lifetime maximum is not listed in the following summary does not mean one or more of the limits have been removed. All Program limits and exclusions apply to all covered charges unless otherwise specified.

Hospital Charges

• Inpatient bed, board and general nursing care when the covered person is in a semi-private room, private room or an intensive care unit.

• Ancillary services (such as operating rooms, drugs, surgical dressings and lab work).

• Inpatient services of a surgeon, radiologist, pathologist and anesthesiologist.

• Pre-admission testing for preoperative tests on an outpatient basis in preparation for scheduled inpatient surgery. Benefits will not be provided for canceled or postponed surgery.

• Emergency care received in the hospital as an outpatient due to accidental injury or the onset of a medical emergency, provided the care is under the order of a physician and, in the case of an accident, is received within 72 hours of the accidental injury. Each time you receive covered services in an emergency room, you must pay a $50.00 copayment. Benefits for emergency accident care and emergency medical care are covered at 100 percent after the $50 copayment and are not subject to the Program deductible. Covered services received for emergency accident care and emergency medical care resulting from criminal sexual assault or abuse will be paid at 100% of the eligible charge, and the emergency room copayment of $50.00 will not apply.

• Outpatient renal dialysis treatments if received in a hospital, a dialysis facility or in the covered person's home under the supervision of a hospital or dialysis facility.

• Outpatient surgical services, including related diagnostic charges, physicians' fees, anesthesia and facility charges, ordered by the treating physician and all furnished by a hospital on the day the procedure is performed.

• Charges for anesthetics and their administration; outpatient diagnostic x-ray and laboratory examinations; x-ray, radium and radioactive isotope treatment; chemotherapy, shock therapy treatments, blood transfusions and blood not donated or replaced; and oxygen and other gases and their administration. Experimental and investigational treatments, as determined by BCBS, in any of these categories are not reimbursable under the Program.

• Charges for rehabilitative therapy by a licensed physical, occupational or speech therapist; prosthetic appliances; dressings; and drugs and medicines lawfully dispensed upon the written prescription of a physician while confined in a hospital.

• Other services and supplies provided they are medically necessary as determined by BCBS.

A *hospital* means an institution that is accredited by the Joint Commission on Accreditation of Healthcare Organizations and/or meets one of the following requirements:

• An institution licensed as a hospital that maintains on its premises all facilities necessary for medical and surgical treatment. The hospital must have the capacity to provide treatment on an inpatient basis, providing 24-hour service by registered graduate nurses under the supervision of physicians licensed to practice medicine.

• An institution that qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals.

• An institution that specializes in treatment of mental illness, alcohol or drug abuse, or other related illness; provides a residential treatment program; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term *hospital* does not include an institution that is primarily a place for rest or a nursing home, convalescent home, skilled nursing facility, or custodial home for the aged or similar institutions.

A *physician* is a licensed medical practitioner who is practicing within the scope of his or her license and who is licensed to prescribe and administer drugs or to perform surgery. Other health care providers whose services are covered subject to the Program's limitations and exclusions are as follows:

• a licensed podiatrist;

• a registered clinical psychologist with a Ph.D. who meets the criteria established by BCBS;

• a certified nurse-midwife who (a) practices under the standards of the American College of Nurse-Midwives; (b) has an arrangement with a physician for obtaining medical consultation and hospital referral, and (c) has a current license as a registered nurse and is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives, or its predecessor;

• a licensed chiropractor;

• a licensed clinical social worker;

• a certified registered nurse anesthetist;

• a licensed physical therapist;

• a licensed occupational therapist; or

• a licensed speech therapist.

Physician Charges

Benefits are available for surgery performed by a physician, dentist, or podiatrist when medically necessary as determined by BCBS. Surgery performed by a dentist or podiatrist is limited to surgical procedures the practitioners are legally qualified to perform and which the Program would otherwise pay if the surgery is performed by a physician. Oral surgery benefits are limited to the following:

1. surgical removal of complete bony impacted teeth;

2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth;

3. surgical procedures to correct accidental injuries to the same areas described in item 2. above;

4. excision of exostoses of the jaws and hard palate (where not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of celluletes; incision of accessory sinuses, salivary glands or ducts; reduction or dislocation of, or excision of, the temporomandibular joints.

Surgical benefits include:

1. sterilization procedures, even if elective;

2. anesthesia services if administered during a surgical procedure in a hospital or ambulatory surgical facility. Anesthesia services provided by oral and maxillofacial surgeons in the surgeon's office are also covered;

3. assistant surgeon (physician, dentist or podiatrist) to the operating surgeon.

Additional surgical opinion following a recommendation for elective surgery is covered at 100% of reasonable and customary. Benefits are limited to one second-opinion with related diagnostic services. The deductible will not apply. You may request coverage for a third opinion if the second opinion does not resolve the question of surgery. BCBS must approve the request for a third opinion.

Coordinated Home Care Program Charges

A Home Care Program must be an organized skilled patient care program provided in the home. The home care can be provided by a hospital's licensed home health department or by any licensed home health agency. The patient must be unable to leave home without assistance and require supportive medical devices or special transportation. Home Care services must be necessary on an intermittent basis under the direction of the patient's physician and MUST be pre-approved by the BCBS Medical Services Advisory Program (MSA). To obtain approval, call the Member Services toll-free telephone number on your BCBS identification card. Failure to obtain pre-certification may result in a $500 penalty even if the services are deemed appropriate and otherwise covered by the Program.

The Home Care Program benefit includes:

- Skilled Nursing Service by or under the direction of a registered professional nurse;
- Services of physical therapists;
- Hospital laboratories; and
- Necessary medical supplies.

The Home Care Program does not include and is not intended to provide benefits for private duty nursing service.

The BCBS Medical options cover PPO-based Coordinated Home Care Programs at the coinsurance percentage as shown in the schedule of benefits on page 8, 10, or 11 subject to the deductible and limited to 40 visits per calendar year. Non-PPO Coordinated Home Care Programs are covered at the coinsurance percentage for out-of-network care for your level of coverage subject to the deductible, and limited to 40 visits per calendar year.,

Hospice Care Charges

A *hospice care program* is a program that provides supportive medical, nursing and other health service through home or inpatient care for a patient who is expected to live six months or less, as determined by a physician.

Hospice care services include any services provided by a hospital, a skilled nursing facility, a home health care agency, a hospice facility or any other licensed facility or agency under a hospice care program.

A *hospice facility* is a facility that primarily provides care for dying patients, is accredited by the National Hospice Organization, and meets any state or local licensing requirements.

Hospice care programs meet the physical, psychological, spiritual and social needs of a dying patient and family members. Hospice care must be given under the direction of the treating physician. In order to be eligible for the hospice care benefit, the patient must have been diagnosed as having six months or less to live. The care is meant to keep the patient as comfortable as possible. Charges for room and board are paid at the contract rate subject to BCBS reasonable and customary limits. Other covered charges include:

• Services provided by a hospice facility on an outpatient basis.

• Services of a hospice ordered home health care agency for part-time or intermittent nursing care by or under the supervision of a nurse or home health aid, as necessary.

• Physical, occupational and speech therapy.

• Medical supplies, drugs and medicines lawfully dispensed on the written prescription of a physician; and laboratory services (but only if otherwise payable if the patient was confined in the hospital).

Hospice care charges will **not** be reimbursed for the following:

• Services of a person who is a member of your family or your dependent's family or who normally lives with you or your dependent.

• Services for any period of time when the patient is not under the care of a physician.

• Services for any curative or life-prolonging procedures.

• Services and supplies used primarily to aid you or your dependent in daily living.

The BCBS Medical options cover hospice care at the coinsurance level for your plan as described in the Schedule of Benefits (page 8, 10 and 11), subject to the deductible.

Skilled Nursing Facility Charges

A *skilled nursing facility* is a licensed institution (other than a hospital) that specializes in physical rehabilitation on an inpatient basis, or inpatient skilled nursing and medical care. The institution must have all facilities necessary for medical treatment on the premises. It must provide treatment under the supervision of physicians and a full-time nursing staff. Admission to a skilled nursing facility MUST be pre-approved by the BCBS Medical Services Advisory Program (MSA). You may contact the MSA unit by calling Member Services at the toll-free telephone number on your BCBS identification card. Failure to pre-certify may result in a penalty of $500 even if the admission is deemed appropriate and otherwise covered by the Program.

If a patient should need physical rehabilitation or skilled nursing and medical care on an inpatient basis, but no longer needs to be hospitalized for an illness or injury, the Program pays charges for a skilled nursing facility at the coinsurance level for your plan as described in the Schedule of Benefits (page 8, 10 and 11), subject to the deductible. (All non-administrator facility services are paid at 50%.) Reimbursement is limited to 60 days per calendar year for both PPO and non-PPO facilities combined. No prior hospitalization is required. Charges for room and board, general nursing care and drugs and surgical dressings or supplies are paid subject to the Program's reasonable and customary limits as determined by BCBS.

Infertility Treatment Charges

Benefits for the treatment of infertility and all related services and supplies are subject to a lifetime maximum of $2,500. There is a separate lifetime maximum for prescription drugs. This lifetime maximum is not applied on an individual basis. It is a single lifetime maximum whether you have employee only coverage, employee plus spouse coverage, or any form of family coverage. Infertility means the inability to conceive a child after one year of unprotected sexual intercourse, or the inability to sustain a successful pregnancy.

Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures are provided only when:

1. you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments; and

2. you have not undergone four (4) completed oocyte retrievals, except if a live birth followed a completed oocyte retrieval, two (2) more completed oocyte retrievals are covered.

Benefits are not provided for childbirth services rendered to a surrogate mother; cryo-preservation and storage of sperm, eggs, embryos, except for procedures using a cryo-preserved substance; non-medical costs of an egg or sperm donor.

Procedures must be performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for in-vitro fertilization programs.

Other Covered Charges

• Emergency licensed ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided. No benefits will be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.

• Independent lab and x-ray services rendered by a provider other than a hospital.

• Private duty nursing service for a patient in a hospital or other health care facility only when BCBS determines the services provided are so complex they could not have been provided by the regular nursing staff of the hospital or other health care facility. Only BCBS can make this decision based on the nature of the case. Private duty nursing services at the patient's home will be covered under the Program only when BCBS determines the services could not have been provided by non-professional personnel. No private duty nursing benefits are provided when a nurse resides in the home, or is a member of the patient's or the employee's immediate family.

• Physical therapy from a registered professional physical therapist supervised by a physician. There must be a written plan from the physician and it must be regularly reviewed by the therapist and the physician. The plan must be established before treatment starts. It must specify the type, amount, frequency and length of the therapy and indicate a diagnosis with specific goals for improvement. Benefits for outpatient physical therapy are limited to a maximum of $5,000 each calendar year, PPO and non-PPO providers combined.

• Chiropractic benefits limited to a maximum of 60 visits, for PPO and non-PPO services combined each calendar year.

• Occupational therapy from a registered occupational therapist supervised by a physician. There must be a written plan from the physician and it must be regularly reviewed by the physician and therapist. The plan must be established before the treatment starts. It must specify the type, amount, frequency and length of therapy and indicate a diagnosis with specific goals for improvement. Benefits for outpatient occupational therapy will be limited to 60 visits per calendar year, PPO and non-PPO providers combined.

• Speech therapy benefits from a licensed speech therapist or a speech therapist certified by the American Speech and Hearing Association. Inpatient speech therapy benefits will be provided only if speech therapy is not the only reason for admission. Outpatient speech therapy benefits will be limited to 60 visits per calendar year, PPO and non-PPO services combined.

• Family planning office visits including tests, counseling, and surgical sterilization procedures for vasectomy and tubal ligation. Reversals of surgical sterilization are not covered.

• Durable medical equipment that can withstand repeated use in the home, is primarily used to serve a medical purpose, and is generally not useful in the absence of sickness or injury. The Claims Administrator will determine whether the Program will pay for rental or purchase of durable medical equipment. Diabetic supplies are not classified as durable medical equipment. Diabetic supplies are covered under the Pre-65 Retiree Medical Program prescription drug benefit.

• Temporomandibular Joint (TMJ) Treatment and related disorders.

• Wellness care from a BCBS network provider. Wellness care includes immunizations; routine mammograms; routine diagnostic tests; routine physical examinations; routine pap smear tests. You will pay an office visit copay and the benefits will be provided at 100% of the BCBS PPO provider's contracted rate. The Program does not reimburse for wellness care from a non-PPO provider.

• Maternity, including initial visit to determine pregnancy, subsequent prenatal visits, postnatal visits and delivery in a hospital or birthing center. The Program does not restrict benefits for any hospital length stay in connection with childbirth for mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section, or require that a provider obtain authorization for prescribing a length of stay not in excess of the above periods.

• Certain services rendered to the newborn are covered including routine inpatient hospital nursery charges; and one routine inpatient exam as long as the exam is by a physician other than the one who delivered the child or administered anesthesia during delivery. **Be certain to enroll your newborn in the BNSF Pre-65 Retiree Medical Program within 31 days of the date of birth by calling YBR at 877-847-2436.**

• Coverage includes benefits for elective abortions if legal where performed.

• Charges for the purchase, maintenance or repair of internal prosthetic medical appliances consisting of permanent or temporary internal aids and supports for defective body parts, specifically interocular lenses, artificial heart valves, cardiac pacemakers, artificial joints, intrauterine devices and other surgical materials such as screws, nails, sutures and wire mesh, and exclude all other prostheses.

• Surgical benefits for a mastectomy include coverage for

– reconstruction of the breast on which the mastectomy has been performed;

– surgery and reconstruction of the other breast to produce a symmetrical appearance; and

– prostheses and coverage for any complications on all stages of mastectomy, including lymphedema.

• Prosthetic appliances, special appliances and surgical implants if (a) required to replace all or part of an organ or tissue of the human body; or (b) required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue. These benefits include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances). Call the toll free number on your BCBS identification card to find out what intra-oral devices used to treat TMJ and related disorders may be covered.

• Allergy testing, treatment and immunizations.

• Radiation therapy treatment, provided it is not experimental or investigational in nature, as determined by BCBS.

• Chemotherapy, provided it is not experimental or investigational in nature, as determined by BCBS.

• Shock therapy treatments.

• Wigs/hairpieces after radiation or chemotherapy (limited to a lifetime maximum of $500).

• Cardiac rehabilitation services in BCBS approved programs when received within a 6-month period following a covered inpatient hospital admission for myocardial infarction, coronary artery bypass surgery, or percutaneous trans-luminal coronary angioplasty. Benefits are limited to 36 outpatient treatment sessions within the 6-month period.

Remember that all covered charges must be medically necessary as determined by BCBS. Non-PPO medically necessary charges will be reimbursed at the Program's reasonable and customary level as determined by BCBS.

Special Rules for Mental Health and Substance Abuse Benefits

The Pre-65 Medical Program option includes Mental Health and Substance Abuse Benefits that may be subject to certain rules and some limitations. The deductible, copayments, and other information are shown on the Schedule of Benefits for Mental Health and Substance Abuse chart on page 27.

Pre-Certification Required

Mental health and substance abuse benefits are available under the Program. You may choose a network or out-of-network medical care provider. **Whatever medical care provider you choose, you will need to have all inpatient mental health and substance abuse treatment pre-certified through the MHU reviewer.**

You must call the MHU reviewer for pre-certification at this toll-free number: 1-800-851-7498. You can call twenty-four (24) hours a day, seven (7) days a week. If you do not pre-certify inpatient treatment, you will be responsible for the first $500 of cost in addition to all deductibles, co-payments, coinsurance and out-of-pocket expense limits.

Benefits for Mental Illness, Alcohol and Drug Abuse

If you or a covered dependent incurs covered expenses for treatment of mental illness, alcohol or drug abuse, the Program provides the following benefits subject to the limits in the Schedule of Benefits for Mental Health and Substance Abuse on page 27 of this SPD.

• Covered expenses incurred during inpatient confinement in a BCBS PPO network hospital due to mental illness.

• Covered expenses incurred during inpatient confinement in a BCBS PPO network hospital due to alcohol or drug abuse.

• Covered expenses for outpatient treatment in a network facility or by a PPO network provider for mental illness, or drug or alcohol abuse after meeting the deductible.

• Covered expenses for a MHU approved out-of-network hospital confinement due to mental illness or alcohol or drug abuse, or for outpatient treatment, after meeting the deductible.

Special Outpatient Limits and Exclusions

Outpatient benefits for the treatment in a non-PPO hospital or facility will be reimbursed at 60% of reasonable and customary to the extent the benefits are covered expenses under the Program and are subject to 25 visits per year maximum combined for mental health and chemical dependency.

Covered Expenses

Covered expenses must be medically necessary and pre-certified by the MHU reviewer. Benefits are subject to the limits in the Schedule of Benefits for Mental Health and Substance Abuse Treatment on page 27 of this SPD and the Special Limits on this page and include the following medical services and supplies:

• Hospital room and board and medically necessary services and supplies while an inpatient.

• Licensed ambulance service to or from the nearest hospital where needed medical care and treatment can be provided.

• Outpatient hospital charges for medical care and treatment.

• Outpatient charges by a facility licensed to furnish mental health services for care and treatment of mental illness.

• Physician or psychologist charges for professional services.

• Charges for anesthetics and their administration, diagnostic x-ray and laboratory examinations, blood transfusions and blood not donated or replaced, and oxygen and other gases and their administration.

Schedule of Benefits for Mental Health and Substance Abuse for BCBS Base Plan*

Service	**In-Network** (Percentage of medically necessary covered expense paid by the Program with no deductible)	**Out-of-Network** (Percentage of medically necessary covered expense paid by Program with no deductible)
Inpatient treatment in a hospital	80%	60% of reasonable and customary rates
Inpatient treatment in a residential facility other than a hospital	80%	60% of reasonable and customary rates
Partial hospitalization	80%	60% of reasonable and customary rates
Maximum length of patient stay per calendar year	45 days per year — for mental health and substance abuse combined —minus any days of treatment that are not authorized	10 days per year for mental health and substance abuse combined
Outpatient treatment	80% No limit to the number of visits;	60% Mental health care treatment must be provided by a Ph.D., MD or MSW 25 visit limit
Maximum Benefits Mental health treatment	No separate lifetime dollar maximum; subject to overall program lifetime maximum. [1]	
Maximum Benefits Substance abuse treatments	$25,000 per person combined lifetime maximum for inpatient and outpatient treatment from a network provider. $5,000 per person lifetime maximum if you receive care from an out-of-network provider. This applies to inpatient or outpatient services. No annual out-of-pocket maximum.	
Pre-authorization and review	Pre-authorization is required for all inpatient care; failure to obtain pre-authorization will result in a $500 penalty. All coverage is subject to medical necessity determination.	

* The Schedule of Benefits above applies to the Build Your Own Options except the appropriate coinsurance levels as defined on pages 10 and 11 will be applied for each option.

[1] The Lifetime Maximum can be found on SPD page 8.

Procedure for MHU Pre-Authorization

When you contact the MHU reviewer, you, a family member, or the attending physician or Provider should have the following information:

• name of the attending physician or of the admitting physician or Provider;

• name of the hospital or facility where the admission or service has been scheduled;

• the type of scheduled admission or the date of the proposed service;

• a diagnosis or reason for the admission or service.

The MHU reviewer will follow-up with the physician or Provider. If the MHU reviewer determines the services are not medically necessary, you or your physician may ask for an expedited appeal.

Expedited Appeal for MHU Denial

If you or your physician or Provider do not agree with the MHU reviewer prior to or while receiving services or treatment, you have the right to ask for an expedited appeal. You or the physician or Provider must contact the MHU reviewer and request an expedited appeal. You and/or your physician or Provider will be notified by the MHU of its determination within twenty-four (24) hours, or in the case of inpatient treatment before the last MHU approved day. If you and/or your physician or Provider do not agree with the decision, you may ask for a further appeal as described below.

Written Appeal of Expedited Appeal Denial

You and your physician or Provider is responsible for making medical decisions regarding your treatment. In some cases, the written appeal process will not be completed until you are no longer an inpatient, or until your treatment has been completed. If you disagree with an expedited appeal denial, or if you disagree with a denial of a claim that you have submitted after treatment has ended, you or your physician or Provider may submit a written request for appeal within 180 days of the denial to the following:

Appeals Coordinator
Health Care Service Corporation
Mental Health Unit
P.O. Box 2307
Chicago, Illinois 60690-2307

A person who did not make the initial decision shall decide your appeal. The review on appeal will not give any deference to the initial decision and will take into account all information submitted by you, regardless of whether it was submitted or considered in the initial decision.

You may submit additional information or comments with your appeal. You should also include any clinical documentation from your physician that would substantiate coverage of the denied claim.

Upon request, you or your representative will be provided reasonable access to and copies of all documents, records and other information relevant to your claim, free of charge, including:

- information relied upon in making the benefit determination;
- information submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon in making the benefit determination;
- descriptions of the administrative processes and safeguards used in making the benefit determination;
- records of any independent reviews conducted by the Claims Administrator;

- if the claim was based on a medical judgment, including determinations about whether a particular service is experimental, investigational or not medically necessary or appropriate, an explanation of the scientific or clinical judgment for the decision applying the term of the Program, or an explanation for the denial; and
- expert advice and consultation obtained by the Claims Administrator in connection with your denied claim, whether or not the advice was relied upon in making the benefit determination.

Within 60 days of receiving your request for review, the Claims Administrator will send you its final decision on the Claim.

The Claims Administrator's decision on appeal is final and binding. Benefits under this Program will be paid only if the Claims Administrator decides, in its sole discretion, that you are entitled to them. If you continue to disagree, you may exercise "Your Rights under ERISA" as explained beginning on SPD page 154.

Expenses Not Covered

Covered expenses for mental illness or substance abuse treatment will not include, and no payment will be made for, expenses incurred:

• For conditions that are (1) within the scope of usual medical practice; and (2) normally handled by non-mental health and substance abuse clinicians;

• In excess of the amount that the provider has agreed to accept for the service; or

• For services or supplies for which benefits are not payable under the section titled “What the Program Does Not Cover” beginning on SPD page 33.

Outpatient Prescription Drug Benefit

Your prescription drug benefit is administered by Caremark Inc. Under the Caremark program, you can fill prescriptions at network retail pharmacies or through one of Caremark's Mail Service pharmacies. Your prescription drug copayments or coinsurance amounts do not apply toward your Pre-65 Retiree Medical Program deductible or out-pocket maximums.

Included in your prescription drug benefit program is a "Primary Drug List" (formulary). A Primary Drug List, or formulary, is a list of preferred prescription medications that are proven to be effective in meeting the patient's clinical needs. These drugs are generally lower in cost than other available drugs. For a list of prescription drugs included in the Primary Drug List refer to Caremark's web site at www.caremark.com or call their toll free number at 800-378-7559.

Participating Pharmacy Benefit

You may fill a prescription for up to a 34-day supply at any participating pharmacy by showing your Caremark Identification card and paying the applicable charge.

Retail prescription costs are as follows:

Prescription Drug Type	**Coinsurance**	**Copayment**
Applies to Plan:	**BCBS Base Plan & BYO 2,4,6,8,10 & 12**	**BYO 1,3,5,7,9,11**
Generic	25%* (Minimum $10; Maximum $100)	$10
Formulary Brand	25%* (Minimum $25; Maximum $100)	$25
Non-Formulary Brand	25%* (Minimum $40; Maximum $100)	$40

**Of total prescription cost up to maximum listed.*

For a list of participating pharmacies refer to Caremark's web site at www.caremark.com or call 800-378-7559.

If you use a non-participating pharmacy, you will pay **100 percent of the prescription price**. You will then need to submit a paper claim form, along with the original prescription receipt(s) to Caremark for reimbursement of covered expenses. In most cases this option will cost you more. The time limit to file a paper claim with Caremark is 365 days from the prescription fill date.

Mail Order Pharmacy Benefit

Caremark's Mail Service Program provides a way for you to order up to a 90-day supply of maintenance or long-term medication for direct delivery to your home.

For prescriptions received from one of the Caremark Mail Service pharmacies you will pay:

Prescription Drug Type	**Coinsurance**	**Copayment**
Applies to Plan:	**BCBS Base Plan & BYO 2,4,6,8,10 & 12**	**BYO 1,3,5,7,9,11**
Generic	25% (Minimum $20; Maximum $200)	$20
Formulary Brand	25%* (Minimum $50; Maximum $200)	$50
Non-Formulary Brand	25%* (Minimum $80; Maximum $200)	$80

**Of total prescription cost up to maximum listed.*

Information on how to use the mail order pharmacy benefit is included in the packet with your Caremark Identification Card.

For questions about mail order prescriptions, call 1-800-378-7559 or visit Caremark's web site at *www.caremark.com*.

Covered Prescription Drugs

The term *covered prescription drug* means:

• A Prescription Legend Drug for which a written prescription is required;

• Oral or injectable insulin dispensed only upon the written prescription of a physician;

• Insulin needles and syringes;

• A compound medication of which at least one ingredient is a Prescription Legend Drug;

• Tretinoin for individuals through age 26;

• Any other drug that, under the applicable state law, may be dispensed only upon the written prescription of a physician;

• Oral contraceptives;

• Prenatal vitamins, upon written prescription;

• An injectable drug, excluding injectable infertility drugs, for which a prescription is required, including needles and syringes;

• Oral infertility drugs (up to a $2,500 lifetime maximum);

• Glucose test strips;

• Growth hormones (managed through Caremark's Specialty Pharmacy and Services) and anabolic steroids (available only through Caremark's Mail Service Program); and

• A drug that has been prescribed for a particular use for which it has not been approved by the Food and Drug Administration (FDA) **only** if it meets the following criteria:

– The drug is recognized for the specific use in any one of the following established reference compendia: the United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluation, the American Hospital Formulary Service, or any peer-reviewed national professional medical journal;

– The drug has been otherwise approved by the FDA; and

– The drug has not been contraindicated by the FDA for the use prescribed.

Limitations

No payment will be made under the Program for the following expenses:

• For non-legend drugs, other than those specified above under “Covered Prescription Drugs”;

• To the extent that payment is unlawful where the person resides when expenses are incurred;

• For charges that the person is not legally required to pay;

• For charges that would not have been made if the person was not covered under the Program;

• For experimental drugs or for drugs labeled "Caution —limited by federal law to investigational use";

• For drugs that are not considered essential for the necessary care and treatment of an injury or sickness, as determined by the Claims Administrator for the Program or by the retail pharmacy administrator;

• For drugs obtained from a non-participating mail order pharmacy;

• For any prescription filled in excess of the number specified by the physician or dispensed more than one year from the date of the physician's order;

• For more than a 34-day supply when dispensed in any one prescription order through a retail pharmacy;

• For more than a 90-day supply when dispensed in any one prescription order through a participating mail order pharmacy;

• For indications not approved by the Food and Drug Administration;

• To the extent that the person is covered under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law (any adjustment option chosen under such part will be taken into account);

• For immunization agents, biological sera, blood or blood plasma;

• For therapeutic devices or appliances, including support garments and other non-medicinal substances, excluding insulin syringes;

• For drugs used for cosmetic purposes;

• For tretinoin for individuals age 27 or over;

• For administration of any drug;

• For medication that is taken or administered — in whole or in part — at the place where it is dispensed, or while a person is a patient in an institution that operates — or allows to be operated on its premises — a facility for dispensing pharmaceuticals;

• For prescriptions that an eligible person is entitled to receive without charge from any Workers' Compensation or similar law or any public program other than Medicaid;

• For nutritional or dietary supplements, anti-obesity drugs or anorexiants;

• For contraceptive devices, including implantable contraceptive devices;

• For vitamins, excluding prenatal vitamins, upon written prescription;

• For oral infertility drugs after the $2,500 dollar lifetime maximum has been exhausted; or

• For smoking cessation products.

What the Program Does Not Cover

In addition to the limitations and exclusions described under the specific benefits listed in this SPD, the Program will **not** reimburse charges for the following:

• Services that are not medically necessary as determined by BCBS.

• Services or supplies that are not specifically mentioned in this benefit booklet.

• Custodial care services.

• Services or supplies received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental illness.

• Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

• Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned as covered in this SPD.

• Blood derivatives which are not classified as drugs in the official formularies.

• Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

• Routine foot care.

• Hearing aids or examinations for the prescription or fitting of hearing aids.

• Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or surgical treatment for correction of refractive errors, including radial keratotomy. Any exceptions must be specifically identified as a BCBS PPO option benefit. If you enrolled in the Vision Care Plan which is a separate plan and not part of the BCBS PPO option, refer to the SPD for the Vision Plan that gives information on Vision Care Plan benefits.

• Routine preventive care received from out-of-network providers.

• Diagnostic services as part of routine physical examinations or check-ups, premarital examinations, determination of auditory problems, surveys, case finding, research studies, screening, or similar procedures or tests which are investigational, unless specifically mentioned as covered in this SPD.

• Services and supplies for human organ or tissue transplants other than those specifically named as covered in this SPD.

• Plastic or cosmetic surgery, reconstructive surgery, or other services or supplies that improve, alter or enhance appearance except where requested due to injury while covered under the Program, or to repair a congenital birth defect, or as otherwise stated as a covered benefit in this SPD.

• Charges that a person is not legally required to pay.

• Confinement in a hospital operated by the U.S. government or any of its agencies, except care of a non-military service-related illness or injury received by an employee at a Veterans Administration facility.

• Procedures, services or supplies (including drugs) that BCBS determines to be *experimental or investigational* using one or more of the following criteria:

– The medical or surgical procedure or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include, but are not limited to, Phase I, II and III clinical trials.

– The prevailing opinion within the appropriate specialty of the United States medical profession is that the medical or surgical procedure or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. BCBS will determine if this item is true based on:

1. Published reports in authoritative medical literature.

2. Regulations, reports, publications and evaluations issued by government agencies, such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.

– A drug, medical supply, or medical device that is subject to FDA approval may be determined experimental or investigational if:

1. It does not have FDA approval.

2. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation.

3. It has FDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use. BCBS will determine if a use is an accepted off-label use based on published reports in authoritative medical literature and entries in the following drug compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, and The United States Pharmacopeia Dispensing Information.

– A hospital's institutional review board acknowledges that the use of the medical or surgical procedure or supply is experimental or investigational and subject to that board's approval.

– A hospital's institutional review board requires that the patient, parent or guardian give an informed consent stating that the medical or surgical procedure or supply is experimental or investigational or part of a research project or study; or federal law requires such consent.

BCBS has the discretionary authority to interpret and apply the definition of experimental and investigational in determining whether medical services and supplies are covered charges under Program.

• Any injury resulting from, or in the course of, any employment for wage or profit, except for exempt employees injured while performing duties for BNSF or a BNSF affiliate.

• Any injury or sickness covered under any Workers' Compensation or similar law, except for exempt employees injured while performing duties for BNSF or a BNSF affiliate.

• Custodial services not intended primarily to treat a specific injury or sickness, or any education or training.

• Reports, evaluations, examinations or hospitalizations not required for health reasons as determined by BCBS.

• Reversal of voluntary sterilization procedures and certain infertility services not specifically listed as covered under the Program.

• Transsexual surgery and related medical or psychological services.

• Amniocentesis, ultrasound or any other procedures requested solely for sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder.

• Over-the-counter disposable or consumable supplies, including orthotic devices, unless the latter are determined to be medically necessary by BCBS.

• The following drugs and medicines: diet pills, minoxidil, Retin-A after age 26 unless medically necessary, and non-prescription drugs of any kind.

• Speech therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.

• Charges in excess of reasonable and customary as determined by BCBS.

• Treatment of teeth/peridontium except for emergency dental work to stabilize teeth due to injury to sound natural teeth.

• Treatment that is not medically necessary, even if it is prescribed, recommended or approved by a physician. BCBS has the discretionary authority to determine whether hospitalization or other health care services or supplies are medically necessary.

• Expenses for which benefits are payable under another benefit plan or under insurance provided by an employer, or for which an employer pays all or part of the cost.

• Services or supplies furnished before coverage under the Program became effective.

• Care, treatment, services or supplies that are not recommended or approved by your physician.

• Services and supplies furnished, paid for, or for which benefits are provided or required under any law of a government (for example, Medicare) whether or not that payment or benefits are received, except a government plan for its own employees, Medicaid or similar legislation of any state.

• Room and board, education or training while you or a dependent is confined in a facility that is primarily a school, a place of rest, a place for the aged or a nursing home.

• Expenses for permanent property improvements, even if they are directly related to medical care (such as central air conditioning, a swimming pool or wheelchair ramp).

• Care designed primarily to assist a patient in meeting the activities of daily living.

• Services or supplies furnished to you or a dependent as an inpatient on a day when the patient's physical or mental condition could be safely diagnosed or treated on an outpatient basis.

• Counseling services including marriage, family, child, career, social adjustment, pastoral or financial counseling, except as specifically described in the Program.

• Missed appointments or the completion of claim forms.

• Treatment of injuries sustained during the commission of a felony or other criminal act.

• Treatment of injuries sustained as the result of war or any act of war or international armed conflict.

• Services or supplies for medical care paid for or expected to be paid for by any persons (or the insurers of such persons) considered to be responsible for the condition giving rise to the charges as a result of a judgment, settlement or otherwise. See page 150 under "Right of Reimbursement".

• Charges made by any provider who is a member of your family or your dependent's family.

• Expenses incurred by you or your dependents to the extent that amounts are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. The Claims Administrator will take into account any adjustment option chosen under such part by you or any one of your dependents.

• Charges to the extent that payment is unlawful where the person resides when the expenses are incurred.

• Occupational Therapy, Physical Therapy and Speech Therapy that is considered "maintenance" by BCBS.

Claims Procedures

In general, health services and benefits must be medically necessary to be covered under the Medical Benefit Program. Medical necessity determinations are made on either a pre-service, concurrent, or post-service basis, as described below. Under Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Medical Benefit Program. The procedures described on pages 37 -40 are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

The Company has delegated the discretionary authority to interpret BNSF Pre-65 Retiree Medical Program terms and to make both initial claim determinations and final claim review decisions on ERISA appeals to Blue Cross and Blue Shield (Claims Administrator) and to Caremark, Inc. as Claims Administrator for outpatient prescription drug benefits**.** The BNSF Employee Benefits Committee retains the discretionary authority to determine whether you and/or your dependents are eligible to enroll for coverage and/or to continue coverage under Program terms.

Definitions

Claim--A claim is any request for a Program benefit made in accordance with these claims procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures.

Claimant--As an individual covered by the Pre-65 Medical Benefit Program, you become a claimant when you make a request for a Program benefit or benefits in accordance with these claims procedures.

Incorrectly Filed Claim--Any request for benefits that is not made in accordance with these claims procedures is considered an incorrectly filed claim.

Authorized Representative--Means an individual who has been identified in writing as the representative of an individual covered by the Pre-65 Retiree Medical Benefit Program and signed by the Claimant; however, in the case of a claim involving urgent care, a health care professional with knowledge of the Claimant's medical condition will be permitted to act as the Authorized Representative of the individual covered by the Medical Benefit Program. An Authorized Representative may act on behalf of a Claimant with respect to a benefit claim or appeal under these procedures. An assignment for purposes of payment does not constitute appointment of an Authorized Representative under these claims procedures. Unless the Claimant indicates otherwise in the authorization, all information and notifications regarding the claim will be sent to the Authorized Representative and not to the Claimant.

No individual may receive "protected health information" without the Program having received an "authorization" from the Claimant to the extent required by the Health Insurance Portability and Accountability Act of 1996, and its applicable regulations ("HIPAA").

Pre-Service Claim (pre-certification/ pre-authorization)--A claim is a pre-service claim if benefits under the Program are conditional on receiving approval in advance of obtaining the medical care.

Urgent Care Claim--A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods that otherwise apply (1) could seriously jeopardize the claimant's life or health or ability to regain maximum function or (2) would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. On receipt of a claim, the Claims Administrator will make a determination of whether it involves urgent care, provided that, if a

physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim will be treated as an urgent care claim. If the requested medical care has already been provided, the claim will be considered a post-service claim.

Concurrent Care Claims--A concurrent care decision occurs when the Program approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (1) where reconsideration of the approval results in a reduction or termination of the initially-approved period of time or number of treatments; and (2) where an extension is requested beyond the initially-approved period of time or number of treatments.

Post-Service Claim--A post-service claim is any claim for a benefit under this Program that is not a pre-service claim or an urgent care claim. Post-service claims are claims that involve only the payment or reimbursement of the cost for medical care that has already been provided.

How to File a Claim

No claim forms are necessary when you or a dependent uses a BCBS PPO network provider. However, at the start of each calendar year, the Claims Administrator may ask you to complete a claim form to update personal data.

If you or a dependent uses an out-of-network provider, you must submit a completed claim form before benefits can be paid. You may obtain a claim form from BCBS or call the Benefits Help Line at 800-234-1283 to request a claim form.

Complete and sign the form and submit your claim to the Claims Administrator. When you submit your claim, include with it a copy of your medical bill showing the following:

• Employee's name and subscriber identification number with alpha prefix as shown on your identification card;

• Patient's full name;

• Nature of the sickness or injury;

• Type of service or supply furnished;

• Date or dates the service was rendered or the purchase was made;

• Itemized charges for each service or supply; and

• Provider of service with address and tax ID number.

You must submit separate claims for yourself and each of your covered dependents who have incurred medical expenses. Incomplete claim forms will not be processed.

All PPO network and out-of-network claims must be filed no later than two (2) years after the date a service is received. Claims not filed within two (2) years from the date a service is received will not be eligible for payment under Program terms.

Timeframe for Deciding Initial Benefit Claims

Pre-Service Claims--Your benefit Program requires that you pre-certify for inpatient care, skilled nursing, coordinated home care and private duty nursing. The Claims Administrator will notify you or your representative of the determination within 15 days after receipt of the claim. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Administrator will notify you or your representative within 15 days after receiving the claim. This notice

will include the date a determination can be expected, which will be no more than 30 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed and you or your representative must provide the specified information within 45 days after receiving the notice. The timeframe for deciding the claim will be suspended from the date the extension notice is sent until the date the missing necessary information is provided to the Claims Administrator.

Urgent Care Claim--The Claims Administrator will decide an initial urgent care claim within 72 hours after receiving the claim. However, if necessary information is missing from the request, you or your representative will be notified within 24 hours after receiving the claim to specify what information is needed. The specified information must be provided to the Claims Administrator within 48 hours after receiving the notice. The Claims Administrator will decide the claim within 48 hours after the receipt of the specified information.

Concurrent Care Claims--When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request the extension at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, the Claims Administrator will notify you or your representative of the determination within 24 hours after receiving the claim.

Post-Service Claim--The Claims Administrator will notify you or your representative of the determination within 30 days after receiving the claim. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Administrator will notify you or your representative within 30 days after receiving the claim. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed and you or your representative must provide the specified information within 45 days after receiving the notice. The timeframe for deciding the claim will be suspended from the date the extension notice is sent until the date the missing necessary information is provided to the Claims Administrator.

Notification of Initial Benefit Determination

Each time a claim is submitted, you or your representative will receive a written Explanation of Benefits form that will explain how much was paid towards the claim or whether the claim was denied, in whole or in part. If a claim is denied, in whole or in part, the Claims Administrator will give you or your representative a written notice of the denial and the reason for the denial. The Claim Denial Notice will include the following:

- explain the specific reason(s) for the denial;
- provide the specific reference to pertinent Program provisions on which the denial was based;
- provide a description of any additional information necessary to reverse the denial, or in the case of an incomplete claim to perfect the claim;
- provide an explanation of the Program's claim review procedures and applicable time limits; and
- if the Claim Administrator used or relied on internal guidelines, protocols, or other criteria, the letter will specify the criterion; and a copy of such rule, guideline, protocol or other criteria, and reasonable access to relevant documents, records and other information relevant to the Claim will be provided free of charge on request.

If Your Claim is Denied

The Pre-65 Retiree Medical Benefit Program is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA has special rules that must be followed when you or your representative chooses to appeal an adverse benefit decision (denied claim).

You have a right to appeal any claim denial, including any denial at the pre-service (pre-certification/ pre-authorization) level. It does not make any difference whether the denial is a complete denial or a partial denial. You or your representative should file a written request for appeal as soon as you receive a denial of benefits that you believe should be covered under the Medical Benefit Program but no later than **180** days from the date you receive notice that your claim has been denied. Failure to comply with this important deadline may cause you to forfeit any right to appeal the denial. If the claim is an Urgent Care Claim, you may appeal the decision and receive an expedited decision, please see below.

A person who did not make the initial decision shall decide your appeal. The review on appeal will not give any deference to the initial decision and will take into account all information submitted by you, regardless of whether it was submitted or considered in the initial decision.

If you are appealing a denial of a mental illness or substance abuse benefit under the Medical Benefits Program, there are special procedures. You will find those procedures in the Mental Health and Substance Abuse section of this SPD. See page 27.

Along with your written request for a review, you may submit any additional documents and written issues and comments you believe should be considered during the review. You should also include any clinical documentation from your physician that would substantiate coverage of the denied claim.

Upon request, you or your representative will be provided reasonable access to and copies of all documents, records and other information relevant to your claim, free of charge, including:

- information relied upon in making the benefit determination;
- information submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon in making the benefit determination;
- descriptions of the administrative processes and safeguards used in making the benefit determination;
- records of any independent reviews conducted by the Claims Administrator;
- if the claim was based on a medical judgment, including determinations about whether a particular service is experimental, investigational or not medically necessary or appropriate, an explanation of the scientific or clinical judgment for the decision applying the term of the Program, or an explanation for the denial; and
- expert advice and consultation obtained by the Claims Administrator in connection with your denied claim, whether or not the advice was relied upon in making the benefit determination.

Your request for an appeal should be addressed to:

Blue Cross and Blue Shield of Illinois (BCBSIL)
Claim Review Section
P.O. Box 2401
Chicago, Illinois 60690

Outpatient Prescription Drug Benefit Claims

Caremark, Inc. is the Claims Administrator for the Outpatient Prescription Drug Benefit. If there is a denial of an outpatient prescription drug benefit, you should address your request for an appeal to the following:

Caremark, Inc.
2211 Sanders Road
Northbrook, Illinois 60062

Timeframes for Deciding Benefits Appeals

Pre-Service Claims--The Claims Administrator will provide a written decision on the appeal of a pre-service claim within 30 days after receipt of the appeal.

Urgent Care Claims--The Claims Administrator will decide the appeal of an urgent care claim within 72 hours after receipt of the appeal.

Post-Service Claims--The Claims Administrator will decide the appeal of a post-service claim within 60 days after receipt of the appeal.

Concurrent Care Claims--The Claims Administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. Appeal of a denied request to extend a concurrent care decision will be decided in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

Notification of Decision on Appeal

The Claims Administrator will notify you, in writing, of its final decision and will include the following:

- the specific reasons for the appeal decision;
- a reference to the specific Medical Benefit Program provision(s) on which the decision was based;
- a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to or copies of all documents, records, and other information relevant to the determination (see prior page for a list of such documents); and
- a statement indicating entitlement to receive, upon request and without charge, a copy of any internal rule, guideline, protocol or similar criterion relied on in making the adverse decision regarding your appeal, and/or an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

The Claims Administrator's decision on appeal is final and binding. Benefits under this Program will be paid only if the Claims Administrator decides, in its sole discretion, that you are entitled to them. If you continue to disagree with the decision, you may exercise "Your Rights under ERISA" as explained beginning on page 154 of this SPD.

BCBS Separate Financial Arrangements with Providers

BCBS of Illinois, acting as claims administrator for the Program, has its own contracts with certain Providers ("Administrator Providers") in the BCBS service area to provide and pay for health care services to all persons enrolled under BCBS health policies and contracts. Under certain circumstances described in BCBS contracts with Administrator Providers, BCBS may:

• receive substantial payments from Administrator Providers with respect to services rendered to you for which BCBS was obligated to pay the Administrator Provider, or

• pay Administrator Providers substantially less than their claim charges for services, by discount or otherwise, or

• receive from Administrator Providers other substantial allowances under the BCBS contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable under the BNSF Pre-65 Retiree Medical Program, and the calculation of all required deductible and coinsurance amounts payable by you are based on the eligible chart or provider's claim charge for covered services you receive, reduced by the Average Discount Percentage ("ADP") as determined by BCBS, applicable to your claim. BNSF has been advised that BCBS may receive such payments, discounts and/or other allowances during the term of the agreement between BNSF and BCBS. Neither BNSF nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the BCBS determined ADP.

To help you understand how BCBS's separate financial arrangements with the Administrator Providers work, please consider the following example:

a. Assume you go into the hospital for one night and the normal, full amount the hospital bills for covered services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the BNSF Pre-65 Retiree Medical Program deductible and coinsurance amounts.

c. However, for purposes of calculating your deductible and coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the hospital's eligible charge would be reduced by the ADP applicable to your claim. In this example, if the applicable ADP were 30%, the $1,000 hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the coinsurance portion of the $1,000 hospital bill after it has been reduced by the ADP. In this example, if you coinsurance obligation is 20%, you personally will have to pay 20% of $700 or $140. You should note that your 20% coinsurance is based on the full $1,000 hospital bill, after it is reduced by the applicable ADP.

e. After taking into account the deductible and coinsurance amounts, BCBS will satisfy its portion of the hospital bill. In most cases, BCBS has a contract with hospitals that allows BCBS to pay less, and requires the hospital to accept less, than the amount of money BCBS would be required to pay if it did not have a contract with the hospital.

Therefore, in the example above, since the full hospital bill is $1,000, your deductible has already been satisfied, and your coinsurance is $140, then BCBS has to satisfy the rest of the hospital bill, or $860. Assuming BCBS has a contract with the hospital, BCBS will usually be able to satisfy the $860 bill that remains after your deductible and copayment by paying less, often substantially less, than $860 to the hospital. BCBS receives, and keeps for its own account, the difference between the $860 bill and whatever BCBS ultimately pays under its contracts with Administrator Providers, and neither you nor BNSF are entitled to any part of these savings.

Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers

BCBS must inform you that other Blue Cross and Blue Shield plans outside of Illinois ("Host Plan Providers") may have contracts similar to the contracts described above with certain Providers ("Host Plan Providers") in their service area.

When you receive health care services from a BCBS Host Plan Provider that does not have a direct contract with BCBS of Illinois, the BCBS Host Plan will process your claim in accordance with its applicable contract, if any, with the Host Plan Provider. Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums under the BNSF Pre-65 Retiree Medical Program will be calculated on the basis of the Host Plan Provider's eligible charge for covered services rendered to you or the agreed upon cost between the BCBS Host Plan and BCBS of Illinois for covered services that the Host Plan passes to BCBS of Illinois, whichever is lower. Keep in mind that the term "Host Plan" does not apply to the BNSF Program in which you are enrolled. The term Host Plan just refers to the local BCBS administrator in the region the medical services are provided.

Often, the agreed upon cost between the Host Plan and BCBS of Illinois is a simple discount. Sometimes, however, the agreed upon cost may be in the form of an estimated discount or an average discount received or expected by the BCBS Host Plan based on separate financial arrangements or other non-claims transactions between BCBS of Illinois and the BCBS Host Plan Providers.

The estimated or average discount may be adjusted in the future to correct for over or under estimation of past determinations of the agreed upon cost.

In other instances, laws in a small number of states dictate the basis upon which your deductible and out-of-pocket maximum, or any other BNSF Pre-65 Retiree Medical Program benefit maximum will be determined, using the state's statutory method.

In some instances, BCBS of Illinois has entered into agreements with other BCBS plans ("Servicing Plans") to provide on behalf of BCBS of Illinois, claim payments and certain administrative services for you. Under these agreements, BCBS of Illinois will reimburse each BCBS Servicing Plan for all claim payments made on behalf of BCBS for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Servicing Plan Providers in their region. The Servicing Plan will process your claim in accordance with the Servicing Plan's applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by BCBS for claim payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required deductible and out-of-pocket maximum under the BNSF Program will be calculated on the basis of the Servicing Plan Provider's eligible charge for covered services rendered to you or the cost agreed on between the Servicing Plan and BCBS of Illinois for covered services, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis on which your coinsurance is calculated. When covered services are rendered in those states, the coinsurance amount will be calculated using the state's statutory method.

Aetna Select EPO and Build Your Own Plan

This Program will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

Your Primary Care Physician

Consult your Primary Care Physician whenever you have questions about your health. He or she provides basic and routine care, and can refer you to specialists and facilities in the network, when medically necessary.

Primary and Preventive Care

Your selected Primary Care Physician can provide preventive care and treat you for illnesses and injuries. Coverage for out-of-network care is limited to emergency situations. Refer to the “Schedule of Benefits” for details.

Schedule of Benefits – Aetna Select EPO

LIFETIME MEDICAL PROGRAM LIFETIME MAXIMUM	Unlimited
Deductible (per calendar year)* (Individual/Family)	$500 / $1,000
Program Coinsurance	100% after deductible
Coinsurance limit (Out-of-pocket Maximum)*	Not Applicable
Inpatient Hospital Services (pre-certification required; $500 penalty if pre-certification not received)	100% after deductible
Outpatient Surgery & Diagnostic Tests (pre-certification required on certain procedures and treatments [see page 57]; $200 penalty if pre-certification not received)	100% after deductible
Outpatient Emergency (Hospital & Physician - - Initial treatment of accidental injuries or sudden and unexpected medical conditions with severe life threatening symptoms. Non-emergency use of emergency room is not covered.)	$50 copayment (waived if admitted)
Physician Office Visit	Primary Care Physician: $15 Copay Specialist: $25 Copay
Well Child & Adult Routine Care	100% (no deductible and no coinsurance)
Chiropractor (limited to 60 visits per calendar year)	80% after deductible
Durable Medical Equipment (DME)	80% after deductible
Occupational / Physical / Speech Therapy (limited to 60 visits per therapy per calendar year)	80% after deductible
Other Covered Services	80% after deductible
Prescription Drugs (Retail) **See page 83 for prescription drug coverage details**	Generic $10 copay Formulary $25 copay Non-Formulary $40 copay
Prescription Drugs (Mail Order) **See page 83 for prescription drug coverage details**	Generic $20 copay Formulary $50 copay Non-Formulary $80 copay
Inpatient Mental Health Services	100% after deductible (limited to 60 days per calendar year)
Outpatient Mental Health Services	100% after deductible
Inpatient Chemical Dependency	100% after deductible (limited to 60 days per calendar year)
Outpatient Chemical Dependency	100% after deductible
Medical Management /Aetna Healthline: • **Notification required before all elective inpatient admissions. Emergency a Obstetric admission notification required within 48 hours of admittance. $ penalty applied if pre-certification not received.** **Notification required before certain outpatient procedures and treatments. $200 penalty applied if pre-certification not received**	

*Penalties for not requesting pre-authorization and charges in excess of reasonable and customary for out-of-network providers are not credited toward the deductible or out-of-pocket maximum.

AETNA Build Your Own Options
Level of Coverage

AETNA BYO Option 1	In Network	AETNA BYO Option 2	In Network
Deductible (Individual/Family)	$500 / $1,000	**Deductible** (Individual/Family)	$500 / $1,000
Coinsurance	85%	**Coinsurance**	85%
Out-of-pocket Maximum (Individual/Family)	$2,000 / $4,000	**Out-of-pocket Maximum** (Individual/Family)	$2,000 / $4,000
Prescription Coverage	Copay	**Prescription Coverage**	Coinsurance

AETNA BYO Option 3	In Network	AETNA BYO Option 4	In Network
Deductible (Individual/Family)	$500 / $1,000	**Deductible** (Individual/Family)	$500 / $1,000
Coinsurance	70%	**Coinsurance**	70%
Out-of-pocket Maximum (Individual/Family)	$3,000 / $6,000	**Out-of-pocket Maximum** (Individual/Family)	$3,000 / $6,000
Prescription Coverage	Copay	**Prescription Coverage**	Coinsurance

AETNA BYO Option 5	In Network	AETNA BYO Option 6	In Network
Deductible (Individual/Family)	$1,000 / $2,000	**Deductible** (Individual/Family)	$1,000 / $2,000
Coinsurance	85%	**Coinsurance**	85%
Out-of-pocket Maximum (Individual/Family)	$2,000 / $4,000	**Out-of-pocket Maximum** (Individual/Family)	$2,000 / $4,000
Prescription Coverage	Copay	**Prescription Coverage**	Coinsurance

Continued

AETNA BYO Option 7	In Network	AETNA BYO Option 8	In Network
Deductible (Individual/Family)	$1,000 / $2,000	**Deductible** (Individual/Family)	$1,000 / $2,000
Coinsurance	70%	**Coinsurance**	70%
Out-of-pocket Maximum (Individual/Family)	$3,000 / $6,000	**Out-of-pocket Maximum** (Individual/Family)	$3,000 / $6,000
Prescription Coverage	Copay	**Prescription Coverage**	Coinsurance

AETNA BYO Option 9	In Network	AETNA BYO Option 10	In Network
Deductible (Individual/Family)	$1,500 / $3,000	**Deductible** (Individual/Family)	$1,500 / $3,000
Coinsurance	85%	**Coinsurance**	85%
Out-of-pocket Maximum (Individual/Family)	$2,000 / $4,000	**Out-of-pocket Maximum** (Individual/Family)	$2,000 / $4,000
Prescription Coverage	Copay	**prescription Coverage**	Coinsurance

AETNA BYO Option 11	In Network	AETNA BYO Option 12	In Network
Deductible (Individual/Family)	$1,500 / $3,000	**Deductible** (Individual/Family)	$1,500 / $3,000
Coinsurance	70%	**Coinsurance**	70%
Out-of-pocket Maximum (Individual/Family)	$3,000 / $6,000	**Out-of-pocket Maximum** (Individual/Family)	$3,000 / $6,000
Prescription Coverage	Copay	**Prescription Coverage**	Coinsurance

Special Comprehensive Medical Coverage

Although a specific service may be listed as a covered expense, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of an illness or condition. The Schedule of Benefits outlines the Payment Percentages that apply to the Covered Medical Expenses described below. There are exclusions, deductibles and stated maximum benefit amounts. Covered Medical Expenses include expenses for certain **hospital** and other medical services and supplies and must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses

Hospital Expenses

Inpatient Hospital Expenses
Charges made by a **hospital** for giving **board and room** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.
For **Preferred Care**:

- If a private room is used, the daily **board and room** charge will be covered if:
  the person's **Preferred Care Provider** requests the private room; and
  the request is approved by Aetna.
- If the above procedures are not met, any part of the daily **board and room** charge which is more than the **semiprivate rate** is not covered.

Outpatient Hospital Expenses
Charges made by a **hospital** for **hospital** services and supplies which are given to a person who is not confined as a full-time inpatient.

Outpatient Surgical Expenses

Covered Medical Expenses include charges for outpatient surgical expenses to the extent shown below.
Covered Medical Expenses include charges made:

- in its own behalf by:
  a **surgery center**;
  the outpatient department of a **hospital**; or
  an office based surgical facility of a **physician** or a **dentist**.
- by a **physician**;
- on behalf of a salaried staff **physician** by the outpatient department of a **hospital**.
- for Outpatient Services and Supplies furnished in connection with a surgical procedure performed in the center or in a hospital. The procedure must meet these tests:
- It is not expected to:
  result in extensive blood loss;
  require major or prolonged invasion of a body cavity; or
  involve any major blood vessels.
- It can safely and adequately be performed only in a **surgical center** or in a **hospital** o r
  in an office based surgical facility of a **physician** or a **dentist**.
- It is not normally performed in the office of a **physician** or a **dentist**.

Outpatient Services and Supplies
These are:

- Services and supplies furnished by the **surgery center** or by a **hospital** on the day of the procedure.
- Services of the operating **physician** for performing the procedure and for:
  related pre and postoperative care; and
  the administering of an anesthetic.
- Services of any other **physician** for related postoperative care and for the administering of an anesthetic. This does not include a local anesthetic.

Limitations:
No benefit is paid for charges incurred:
- For the services of a **physician** who renders technical assistance to the operating **physician**.
- While the person is confined as a full-time inpatient in a **hospital**.

Convalescent Facility Expenses

Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury.

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a private room over the **semiprivate rate**.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a **convalescent facility**. This does not include private or special nursing, or **physician's** services.
- Medical Supplies.

Benefits will be paid for no more than 60 days, the Convalescent Days Maximum, during any one calendar year.

Limitations to Convalescent Facility Expenses
This section does not cover charges made for treatment of:
- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

Home Health Care Expenses

Home health care expenses are covered if:
- the charge is made by a **home health care agency**; and
- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:
- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Program if the person had been confined in a **hospital** or **convalescent facility**:
  medical supplies;
  drugs and medicines prescribed by a **physician**; and
  lab services provided by or for a **home health care agency**.

There is a maximum of 40 visits covered in a plan year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Limitations To Home Health Care Expenses
This section does not cover charges made for:

- Services or supplies that are not a part of the **home health care plan**.
- Services of a person who usually lives with you or who is a member of your or your wife's or husband's family.
- Services of a social worker.
- Transportation.

Routine Physical Exam Expenses

The charges for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included are:
- X-rays, laboratory and other tests including a Pap Smear given in connection with the exam; and
- materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For a dependent child:
- To qualify as a covered physical exam, the **physician's** exam must include at least:
- a review and written record of the patient's complete medical history;
- a check of all body systems; and
- a review and discussion of the exam results with the patient or with the parent or guardian.

For all exams given to your child under age 7, Covered Medical Expenses will not include charges for:
- More than 7 exams in the first year of the child's life.
- More than 2 exams in the second year of the child's life; or
- More than one exam per year during the next 5 years of the child's life.

For all exams given to your child age 7 up to age 18, Covered Medical Expenses will not include charges for more than one exam every 12 months in a row.

For all exams given to your child age 18 and over, Covered Medical Expenses will not include charges for more than one exam in 24 months in a row.

For you and your spouse:

For all exams given to you or your spouse, Covered Medical Expenses will not include charges for more than:

one exam in 24 months in a row for a person under age 65; and
one exam in 12 months in a row for a person age 65 and over;

Also included as Covered Medical Expenses are charges made by a physician for one annual routine gynecological exam. Included as part of the exam is a routine Pap smear.

Not covered are charges for:
- services which are covered to any extent under any other part of this Program or any other group plan sponsored by BNSF;
- services which are for diagnosis or treatment of a suspected or identified injury or disease;
- exams given while the person is confined in a **hospital** or other place for medical care;
- services not given by a **physician** or under his or her direction;
- medicines, drugs, appliances, equipment or supplies;
- psychiatric, psychological, personality or emotional testing or exams;
- exams in any way related to employment;
- premarital exams;
- vision, hearing or dental exams;
- a **physician's** office visit in connection with immunization or testing for tuberculosis.

Skilled Nursing Care Expenses

The charges made by a **R.N.** or **L.P.N.** or a nursing agency for "skilled nursing services" are included as Covered Medical Expenses. No other charges made by a **R.N.** or **L.P.N.** or a nursing agency are covered. As used here, "skilled nursing services" means these services:

- Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by a **R. N.** or **L.P.N.** if the person's condition requires skilled nursing care and visiting nursing care is not adequate.

Benefits will not be paid during a plan year for private duty nursing for any shifts in excess of the60 day Private Duty Nursing Care Maximum Shifts or a maximum of $10,000. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Not included as "skilled nursing services" is:

- that part or all of any nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs and companionship activities; or
- any private duty nursing care, given while the person is an inpatient in a **hospital** or other health care facility; or
- care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
- care provided solely for skilled observation except as follows:
  for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:
  change in patient medication;

  need for treatment of an **emergency condition** by a **physician**, or the onset of symptoms indicating the likely need for such services;

  surgery; or

  release from inpatient confinement; or

- any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a **R.N.** or **L.P.N.**

Hospice Care Expenses

Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

Facility Expenses

The charges made in its own behalf by a:

- **hospice facility**;
- **hospital**; or
- **convalescent facility**;

which are for:

Inpatient Care

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:
  pain control; and
  other acute and chronic symptom management.

- Not included is any charge for daily board and room in a private room over the Private Room Limit. Also not included is the charge for any day of confinement in excess of the Maximum Number of Days for all confinements for **Hospice Care**.

Outpatient Care

- Services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses For Outpatient Care

Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours in any one day.
- Medical social services under the direction of a **physician**. These include:
  assessment of the person's:
  social, emotional, and medical needs; and
  the home and family situation;
  identification of the community resources which are available to the person; and
  assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a **physician**.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a **physician**.

Charges made by the providers below for Outpatient Care, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant or case management services.
- A physical or occupational therapist.
- A **Home Health Care Agency** for:
  physical and occupational therapy;

  part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;

  medical supplies;

  drugs and medicines prescribed by a **physician**; and

  psychological and dietary counseling.

Not included are charges made:

- For bereavement counseling.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Contraception Expenses

Covered Medical Expenses include:

- charges incurred for contraceptive drugs that by law need a physician’s prescription; and that have been approved by the FDA.
- related outpatient contraceptive services such as:

consultations;
exams;
procedures; and
other medical services and supplies.

Not covered are:
- charges for services which are covered to any extent under any other part of this Program or any other group plan sponsored by your Employer; and
- charges incurred for contraceptive services while confined as an inpatient.

Infertility Services Expenses

The following infertility services expenses are not Covered Medical Expenses and are not payable by the Program:

- Ovulation induction with ovulatory stimulant drugs;
- Artificial insemination.
- Purchase of donor sperm or storage of sperm.
- Care of donor egg retrievals or transfers.
- Cryopreservation or storage of cryopreserved embryos.
- Gestational carrier programs.
- Home ovulation prediction kits.
- In vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and intracytoplasmic sperm injection.
- Frozen embryo transfers, including thawing.
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Care associated with a donor IVF program, including fertilization and culture.
- Injectable infertility medications.

Even though not incurred for treatment of a disease or injury, Covered Medical Expenses will include expenses incurred by a covered female for the diagnosis and treatment of the underlying medical condition for infertility. Contact member services for additional information on covered expenses.

Outpatient Short-Term Rehabilitation Expense Coverage

The charges made by:
- a **physician**; or
- a licensed or certified physical, occupational or speech therapist;

for the following services for treatment of acute conditions are Covered Medical Expenses.

Short-term rehabilitation is therapy which is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to:
- an injury;
- a disease; or
- congenital defect.

Short-term rehabilitation services consist of:
- physical therapy;
- occupational therapy,
- speech therapy; or
- spinal manipulation,

furnished to a person who is not confined as an inpatient in a **hospital** or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

Not covered are charges for:
- Services which are covered to any extent under any other part of this Program.

- Any services which are covered expenses in whole or in part under any other group plan sponsored by BNSF.
- Services received while the person is confined in a **hospital** or other facility for medical care.
- Services not performed by a **physician** or under his or her direct supervision.
- Services rendered by a physical, occupational, or speech therapist who resides in the person's home or who is a part of the family of either the person or the person's spouse.
- Services rendered for the treatment of delays in speech development, unless resulting from:
  - disease;
  - injury; or
  - congenital defect.
- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired to function without that ability.
- Treatment for which a benefit is or would be provided under the Spinal Manipulation Expenses section, whether or not benefits for the maximum number of visits under that section have been paid.

Also, not covered are any services unless they are provided in accordance with a specific treatment plan which:
- details the treatment to be rendered and the frequency and duration of the treatment.
- provides for ongoing reviews and is renewed only if therapy is still necessary.

Spinal Manipulation Expenses

Covered Medical Expenses include charges for treatment of spinal subluxation or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the Spinal Manipulation maximum visits will be payable in any one calendar year.

The maximum does not apply to expenses incurred:
- while the person is a full-time inpatient in a **hospital**;
- for treatment of scoliosis;
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating physician.

Durable Medical And Surgical Equipment Expenses

Covered Expenses

Covered Medical Expenses are the following:
- The rental of **durable medical and surgical equipment**.
- The initial purchase of **durable medical and surgical equipment** and accessories needed to operate it only if Aetna is shown that:
  - long term use is planned; and
  - the equipment cannot be rented; or
  - it is likely to cost less to buy it than to rent it.
- The repair or replacement of purchased **durable medical and surgical equipment** and accessories. Replacement will be covered only if Aetna is shown that:
  - it is needed due to a change in the person's physical condition; or
  - it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.
- Charges for oxygen

Limitations

Covered Medical Expenses do not include:
- more than one item of equipment for the same or similar purpose;
- equipment that is:
  - normally of use to persons who do not have a disease or injury;
  - for use in altering air quality or temperature; or
  - for exercise or training.

Complex Imaging Services

Covered Medical Expenses include charges for Complex Imaging Services received by a covered person on an outpatient basis when performed in:

- a physician's office
- a Hospital outpatient department or emergency room; or
- a licensed radiological facility

Complex Imaging Services include:

- C.A.T. Scans;
- Magnetic Resonance Imaging (MRIs);
- Positron Emmision Tomography (PET Scans); and
- any other outpatient diagnostic imaging service costing over $ 500.

Deductibles, copayments, coinsurance and other cost sharing features; maximum benefit amounts; and exclusions apply.

Other Medical Expenses

These include:

- Charges made by a **physician**.
- Charges for the following:
  - Drugs and medicines which by law need a **physician's** prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.
  - Diagnostic lab work and X-rays.
  - X-rays, radium, and radioactive isotope therapy.
  - Anesthetics and oxygen.
  - Rental of **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

    The initial purchase of such equipment if Aetna is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.

    Repair of purchased equipment.

    Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.
- Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given.
- Charges for orthopedic shoes, foot orthotics, or other devices to support the feet.
- Artificial limbs and eyes. Not included are charges for:

  eyeglasses;
  vision aids;
  hearing aids;
  communication aids; and
  orthopedic shoes, foot orthotics, or other devices to support the feet, unless **necessary** to prevent complications of diabetes.

National Medical Excellence Program ® (NME)

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Program will pay a benefit for Travel and Lodging Expenses, but only to the extent described below. The maximum Lodging expense is $50.00 per person per night and the Travel and Lodging Maximum is $10,000 per type of procedure.

Travel Expenses

These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

Lodging Expenses
These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:
- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

Travel and Lodging Benefit Maximum
For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:
- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:
  one year after the day the procedure is performed; and
  the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Benefits paid for Travel Expenses and Lodging Expenses do not count against any person's Maximum Benefit.

Limitations
Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Program.

Travel Expenses do not include expenses incurred by more than one **Companion** who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one **Companion** per night.

Family Planning
The charges made by:
- a **physician**; or
- a **hospital**;

for the following even though they are not incurred in connection with the diagnosis or treatment of a disease or injury, are Covered Medical Expenses.

Benefits will be payable for:
- a vasectomy for voluntary sterilization; and
- a tubal ligation for voluntary sterilization.

Not covered are charges for the reversal of a sterilization procedure.

Emergency Room Treatment

Emergency Care

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is **emergency care**;

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Payment Percentage.

Non-Emergency Care

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is not **emergency care**;

no benefits will be payable.

Treatment by an Urgent Care Provider

*You should not seek medical care or treatment from an **Urgent Care Provider** if your illness; injury; or condition; is an **emergency condition**. Please go directly to the emergency room of a **hospital** or call 911 (or the local equivalent) for ambulance and medical assistance.*

Urgent Care

This Program pays for the charges made by an **Urgent Care Provider** to evaluate and treat an urgent condition.

When travel to an Urgent Care Provider for treatment of an urgent condition is not feasible, such treatment may be paid at the Preferred level of benefits

Non-Urgent Care

No coverage is provided for covered medical expenses for charges made by an Urgent Care Provider to treat a non-urgent condition.

Non-urgent care includes, but is not limited to, the following:

- routine or preventive care (this includes immunizations);
- follow-up care;
- physical therapy;
- elective surgical procedures; and
- any lab and radiologic exams which are not related to the treatment of the urgent condition.

Certification For Hospital Admissions

This certification section applies to Out-of-network admissions other than those for the treatment of alcoholism, drug abuse, or **mental disorders**. A separate section below applies to such admissions.

If:

- a person becomes confined in a **hospital** as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by:
  your **Primary Care Physician**; or a **Preferred Care Provider**;

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

- As to Hospital Expenses incurred during the confinement:
  If certification has been requested and denied:

  No benefits will be paid for Hospital Expenses incurred for board and room.

Benefits for all other Hospital Expenses will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:
No benefits will be paid for Hospital Expenses incurred for board and room.

As to all other Hospital Expenses:
Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.
Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:
Hospital Expenses incurred for board and room, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.
Benefits for all other Hospital Expenses will be payable at the Payment Percentage.

- As to other Covered Medical Expenses:
  Benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Program; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not **necessary** will not be applied.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency admission** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card.
This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission**; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. (In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.)

If, in the opinion of the person's **physician**, it is necessary for the person to be confined for a longer time than already certified, you, the **physician** or the **hospital** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital**. A copy will be sent to you and to the **physician**.

Certification for Convalescent Facility Admissions, Home Health Care, Hospice Care, and Skilled Nursing Care (This applies to Out-of-Network only)

If a person incurs Covered Medical Expenses:

- while confined in a **convalescent facility** or a **hospice facility**; or
- for a service or a supply for home health care or **hospice care** while not confined as an inpatient or skilled nursing care; and

it has not been certified that:

- such confinement or any day of it is **necessary**; or
- such other services or supplies (either specifically or as a part of a planned program of care) are **necessary**, and

- the confinement or service or supply has not been ordered or prescribed by:
  your **Physician**; or
  a **Preferred Care Provider**;

such Covered Medical expenses will be paid only as follows:

- As to Convalescent Facility Expenses and Hospice Care Facility Expenses incurred while confined in a **convalescent facility** or a **hospice facility**:

  If certification has been requested and denied:
  No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.
  Benefits for all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:
  No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

  As to all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement:
  Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for all other such expenses will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:
  Convalescent Facility Expenses or Hospice Care Facility Expenses, incurred during the confinement, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for all other such expenses, incurred during the confinement, will be paid at the Payment Percentage.

  As to all other Covered Medical Expenses incurred during the confinement, benefits will be paid at the Payment Percentage.

- As to Covered Medical Expenses incurred for services or supplies either as stated or as a part of a planned program of care for home health care, **hospice care** while not confined as an inpatient, or skilled nursing care:

  If certification for a service or supply has been requested and denied or if certification has not been requested and the service or supply is not **necessary**, no benefits will be paid for the denied or unnecessary service or supply.

  If certification has not been requested for a service or supply and the service or supply is **necessary**, benefits for the **necessary** service or supply will be paid as follows:

  Expenses incurred for the service or supply, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for all other Covered Medical Expenses incurred for the service or supply will be paid at the Payment Percentage.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Program; except that:

- To the extent that a day of confinement has been certified, the exclusion of services and supplies because they are not **necessary** will not apply to:
  Convalescent Facility Expenses for room and board; or

Hospice Care Facility Expenses for room and board.

- To the extent that such service or supply has been certified for home health care, **hospice care**, or skilled nursing care, the exclusion of services or supplies because they are not **necessary** will not apply to such service or supply.

To get certification you must call the number shown on your ID card. Such certification must be obtained before an expense is incurred.

If a person's **physician** believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you must call to certify more days of confinement or services or supplies. Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.

If:
- services and supplies for **hospice care** provided to a person have been certified; and
- the person later requires confinement in a **hospital** for pain control or acute symptom management;

any other certification requirement in this Program will be waived for any such day of confinement in a **hospital.**

Certification For Certain Procedures and Treatments

Certification of the necessity of certain Out-of-Network procedures and treatments is required:
before the procedure is performed; or
before the treatment starts; unless

such procedure or treatment has been ordered and prescribed by:

- your **Primary Care Physician**; or
- a **Preferred Care Provider**.

When any of the procedures or treatments shown below are to be performed on an inpatient or outpatient basis, Covered Medical Expenses incurred in connection with the performance of the procedure or treatment will be payable as follows:

- If the procedure or treatment is not **necessary**:
  No benefits will be payable whether or not certification has been requested.
- If certification has been requested and the procedure or treatment is **necessary**:
  Benefits will be payable at the Payment Percentage.
- If certification has not been requested and the procedure or treatment is **necessary**:
  Expenses incurred in connection with its performance, up to the Excluded Amount, will not be considered to be Covered Medical Expenses.

  Benefits for Covered Medical Expenses in excess of the Excluded Amount will be payable at the Payment Percentage.

List of Procedures and Treatments
The following procedures or treatments require certification before the procedure or treatment is performed. Even though the procedures or treatments are most often done on an outpatient basis, certification is required whether the procedure or treatment will be performed:
- on an inpatient basis; or
- on an outpatient basis.

  Allergy Immunotherapy
  Bunionectomy
  Carpal Tunnel Surgery

Colonoscopy
Computerized Axial Tomography
(CAT Scan)-Spine
Coronary Angiography
Dilation/Curettage
Hemorrhoidectomy
Knee Arthroscopy
Laparoscopy (pelvic)
Magnetic Resonance Imaging (MRI)-Knee
Magnetic Resonance Imaging (MRI)-Spine
Septorhinoplasty
Tympanostomy Tube
Upper GI Endoscopy

You or the provider performing the procedure or treatment, must call the number shown on your ID card to request certification.

If the procedure or treatment is performed due to an **emergency condition**, the call must be made:

- before the procedure or treatment is performed; or
- not later than 48 hours after the procedure or treatment is performed; unless the call cannot be made within that time. In that case, the call must be made as soon as it is reasonably possible. In the event the procedure or treatment is performed on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.

If the procedure or treatment is performed for any condition other than an **emergency condition**, the call must be made at least 14 days before the date the procedure is to be performed or the treatment is to start. If it is not possible to make the call during the specified time, it must be made as soon as reasonably possible before the date the procedure or treatment is to be performed.

Written notice of the certification decision will be sent promptly to you and the provider performing the procedure or treatment. This decision will be valid for 60 days from the date you receive the notice. If the procedure or treatment is to be performed after this 60 day period, certification must again be requested, as described above.

Certification For Hospital and Treatment Facility Admissions for Alcoholism, Drug Abuse, or Mental Disorders

If, in connection with the treatment of alcoholism, drug abuse, or a **mental disorder**, a person incurs Covered Medical Expenses while confined in a **hospital** or **treatment facility**; and it has not been certified that such confinement (or any day of such confinement) is **necessary**; and

- the confinement has not been ordered and prescribed by:
  the BHCC; or
- a **Preferred Care Provider** upon referral by the BHCC:

Covered Medical Expenses incurred on any day not certified during the confinement will be paid only as follows:

With respect to expenses for **hospital** and **treatment facility** board and room:

If certification has been requested and denied, or if certification has not been requested and the confinement (or any day of it) is not **necessary**, no benefits will be paid.

If certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

With respect to all other **hospital** and **treatment facility** expenses:

If certification has been requested and denied, or if certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

If certification has not been requested and the confinement is not **necessary**, no benefits will be paid.

Whether or not a day of confinement is certified, no benefits will be payable for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Program; except that, if certification has been given for any day of confinement, the exclusions of services and supplies because they are not **necessary** will not be applied to **hospital** and **treatment facility** board and room.

To get the days certified, you must call the number shown on your ID card. Such certification must be obtained before confinement as a full-time inpatient, or in the case of an **emergency admission**, within 48 hours after the start of a confinement as a fulltime inpatient or as soon as reasonably possible.

If the person's **physician** believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified. This must be done no later than on the last day that has already been certified.

Treatment of Alcoholism, Drug Abuse, or Mental Disorders

Certain expenses for the treatment shown below are Covered Medical Expenses.

Inpatient Treatment

If a person is a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Hospital

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- **Effective treatment of alcoholism or drug abuse**.
- Treatment of **mental disorders**.

Treatment Facility

Certain expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered. The expenses covered are those for:

- Board and room. Not covered is any **charge** for daily **board and room** in a private room over the **semiprivate rate**.
- Other **necessary** services and supplies.

Calendar Year Maximum Benefit

A Special Inpatient Calendar Year Maximum Days applies to the **hospital** and **treatment facility** expenses described above.

Outpatient Treatment

If a person is not a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered.

For such treatment given by a **hospital**, **treatment facility** or **physician**, benefits will not be payable for more than the Special Outpatient Calendar Year Maximum Visits in any one plan year.

Explanation of Some Important Program Provisions

Calendar Year Deductible
This is the amount of Covered Medical Expenses you pay each plan year before benefits are paid

Lifetime Maximum Benefit
Unlimited.

Routine Mammogram
Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred by a female age 40 or over for one mammogram each calendar year.

Routine Screening for Cancer
Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred for:
- a digital rectal exam and a prostate specific antigen (PSA) test for a male age 40 or over; and
- colorectal cancer screening for persons age 50 or over, for routine screening for cancer.

Mouth, Jaws and Teeth
Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:
- services rendered; and
- supplies needed;

for the following treatment of or related to conditions of the:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, "**physician**" includes a **dentist**.

Surgery needed to:
- Treat a fracture, dislocation, or wound.
- Cut out:
  - teeth partly or completely impacted in the bone of the jaw;
  - teeth that will not erupt through the gum;
  - other teeth that cannot be removed without cutting into bone;
  - the roots of a tooth without removing the entire tooth;
  - cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, replace, restore or reposition:
- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut

due to injury.

Any such teeth must have been:
- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the plan year of the accident or the next one.

If:
- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical Expenses include only charges for:

- the first denture or fixed bridgework to replace lost teeth;
- the first crown needed to repair each damaged tooth; and
- an in-mouth appliance used in the first course of **orthodontic treatment** after the injury.

Except as provided for injury, not included are charges:
- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- for root canal therapy;
- for routine tooth removal (not needing cutting of bone).

Not included are charges:
- to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures or bridgework;
- for non-surgical periodontal treatment;
- for dental cleaning, in-mouth scaling, planing or scraping;
- for myofunctional therapy; this is:
  muscle training therapy; or
  training to correct or control harmful habits.

General Exclusions

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.

- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.

- Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

  there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

  if required by the FDA, approval has not been granted for marketing; or

a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

the disease can be expected to cause death within one year, in the absence of effective treatment; and

the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.
- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for **custodial care**.
- Those for services and supplies:

  Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

  Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically listed as covered.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.

- Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically listed as covered.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Program.
- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
- Those for weight control services including: surgical procedures; medical treatments; weight control/loss programs; dietary regimens and supplements; appetite suppressants and other medications; food or food supplements; exercise programs; exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **morbid obesity**, or for the purpose of weight reduction**,** regardless of the existence of comorbid conditions. Certain surgical procedures may be covered subject to meeting the Aetnas selection criteria.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

  Improve the function of a part of the body that:

  is not a tooth or structure that supports the teeth; and
  is malformed:
  as a result of a severe birth defect; including cleft lip, webbed fingers, or toes; or

  as a direct result of:
  disease; or
  surgery performed to treat a disease or injury.

  Repair an injury. Surgery must be performed:

  in the calendar year of the accident which causes the injury; or
  in the next calendar year.
- Those to the extent they are not **reasonable charges**, as determined by Aetna.
- Those for the reversal of a sterilization procedure.
- Those for a service or supply furnished by a **Preferred Care Provider** in excess of such provider's **Negotiated Charge** for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Effect of Benefits Under Other Plans

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   c. If there is not such a court decree:

      If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

      If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the

stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:
   The benefits of a plan which covers the person on whose expenses claim is based as a:

   - laid-off or retired employee; or
   - the dependent of such person;

   shall be determined after the benefits of any other plan which covers such person as:

   - an employee who is not laid-off or retired; or
   - a dependent of such person.

   If the other plan does not have a provision:

   - regarding laid-off or retired employees; and
   - as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

   The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

   If the other plan does not have a provision:

   - regarding right of continuation pursuant to federal or state law; and
   - as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses incurred in a calendar year will be reduced by all "other plan" benefits payable for those expenses. When the coordination of benefits rules of this Plan and an "other plan" both agree that this Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Effect On Benefits Of This Program

When this Program is secondary, the maximum benefits payable under this Program, when combined with benefits already paid by coordinating plans, will not be more than what this Program would have paid had it been the only plan responsible for coverage. In other words, the total benefits normally payable under this Program will be reduced by the amount of benefits paid by all other plans for the same services and supplies. Benefits payable under other plans include benefits that would have been payable had proper claim been made for them.

Right To Receive And Release Needed Information.
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this Program and other plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility Of Payment.
Any payment made under another Plan may include an amount which should have been paid under This Program. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under This Program. Aetna will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Effect of Medicare

Health Expense Coverage under this Plan will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

  having refused it;

  having dropped it;

  having failed to make proper request for it.

These are the changes:

- The amount of "regular benefits" under all Health Expense Benefits will be figured. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount Medicare provides for the expenses involved, this Plan will pay the difference. Otherwise, this Plan will pay no benefits. This will be done for each claim.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

Subrogation and Right of Recovery Provision

Definitions

As used throughout this provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness, or condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a "Covered Person" includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation

Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness, or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury**,** illness, or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitutes such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury, or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that this plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for

the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The plan reserves the right to notify responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Exclusion

This plan does not cover services and supplies, in the opinion of the Claims Administrator or its authorized representative, that are associated with injuries, illness, or conditions suffered due to the acts or omissions of a third party.

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Program has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this Program may have with respect to such overpayment.

Reporting of Claims

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. Your Employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received.

All benefits are payable to Preferred Care Providers or to you. However, this Program has the right to pay any health benefits to the service provider.

This Program may pay up to $ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

Names of **physicians**, **dentists** and others who furnish services.
Dates expenses are incurred.
Copies of all bills and receipts.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Board and Room Charges

Charges made by an institution for board and room and other **necessary** services and supplies. They must be regularly made at a daily or weekly rate.

Body Mass Index:

This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand Name Drug

A **prescription drug** which is protected by trademark registration.

Companion

This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Custodial Care

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Directory

This is a listing of **Preferred Care Providers** in the **Service Area** covered under this Program. A current list of participating providers is available through Aetna's online provider directory, DocFind, at www.aetna.com.

Durable Medical and Surgical Equipment
This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:
- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

Effective Treatment of Alcoholism Or Drug Abuse
This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:
- has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:
- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

Emergency Admission
One where the **physician** admits the person to the **hospital** or **treatment facility** right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:
- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by Aetna,
  reasonably be expected to result in:
  placing the person's health in serious jeopardy; or
  serious impairment to bodily function; or
  serious dysfunction of a body part or organ; or
  in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Care
This means the treatment given in a **hospital's** emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Condition
This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Generic Drug
A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Home Health Care Agency
This is an agency that:
- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one **physician** and one **R.N.**; and
- has full-time supervision by a **physician** or a **R.N**.; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

Home Health Care Plan
This is a plan that provides for care and treatment of a disease or injury.
The care and treatment must be:
- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital** or **convalescent facility**.

Hospice Care
This is care given to a **terminally ill** person by or under arrangements with a **Hospice Care Agency**. The care must be part of a **Hospice Care Program**.

Hospice Care Agency
This is an agency or organization which:
- Has **Hospice Care** available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:
  skilled nursing services; and
  medical social services; and
  psychological and dietary counseling.
- Provides or arranges for other services which will include:
  services of a **physician**; and
  physical and occupational therapy; and
  part-time home health aide services which mainly consist of caring for **terminally ill** persons; and
  inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:
  one **physician**; and
  one **R.N.**; and
  one licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of **Hospice Care**.
- Assesses the patient's medical and social needs.
- Develops a **Hospice Care Program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program
This is a written plan of **Hospice Care**, which:
- Is established by and reviewed from time to time by:
  a **physician** attending the person; and
  appropriate personnel of a **Hospice Care Agency**.
- Is designed to provide:
  palliative and supportive care to **terminally ill** persons; and
  supportive care to their families.
- Includes:
  an assessment of the person's medical and social needs; and
  a description of the care to be given to meet those needs.

Hospice Facility
This is a facility, or distinct part of one, which:
- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**; at least one such **physician** must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a **R.N.**
- Has a full-time administrator.

Hospital
This is a place that:
- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

L.P.N.
This means a licensed practical nurse.

Mail Order Pharmacy
An establishment where **prescription drugs** are legally dispensed by mail.

Mental Disorder
This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:
- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

For the purposes of benefits under this Program, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

Morbid Obesity:
This means a **Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

NME Patient
This is a person who:
- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

Necessary
A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:
- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:
- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:
- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge
This is the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Program.

Non-Occupational Disease
A non-occupational disease is a disease that does not:
- arise out of (or in the course of) any work for pay or profit; or

- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:
- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not:
- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

Non-Specialist
A **physician** who is not a **specialist**.

Non-urgent Admission
One which is not an **emergency admission** or an **urgent admission**.

Orthodontic Treatment
This is any:
- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:
- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:
- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Pharmacy
An establishment where **prescription drugs** are legally dispensed.

Physician
This means a legally qualified physician.

Preferred Care
This is a health care service or supply furnished by:
- A person's **Primary Care Physician** or any other **Preferred Care Provider**.
- A **Non-Preferred Care Provider** on the referral of the person's **Primary Care Physician** and if approved by Aetna.
- Any health care provider for an **emergency condition** when travel to a **Preferred Care Provider** or referral by a person's **Primary Care Physician** prior to treatment is not feasible and
- A Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible.

Preferred Care is also care which is recommended and approved by the BHCC.

Preferred Care Provider
This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:
- the service or supply involved; and

- the class of employees of which you are member.

Prescriber
Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order of a **prescriber** for a **prescription drug**. If it is an oral order, it must promptly be put in writing by the **pharmacy**.

Prescription Drugs
Any of the following:
- A drug, biological, compounded **prescription** or contraceptive device which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable contraceptive drug prescribed to be administered by a paid healthcare professional.
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.
- Disposable diabetic supplies.

Primary Care Physician
This is the **Preferred Care Provider** who is:
- selected by a person from the list of Primary Care Physicians in the **Directory**;
- responsible for the person's on-going health care; and
- shown on Aetna's records as the person's Primary Care Physician.

Psychiatric Physician
This is a **physician** who:
- specializes in psychiatry; or
- has the training or experience to do the required evaluation and treatment of mental illness.

R.N.
This means a registered nurse.

Reasonable Charge
Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:
- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:
- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:
- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the prevailing charge in other areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the reasonable charge is the rate established in such agreement.

Semiprivate Rate

This is the **charge** for **board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Service Area

This is the geographic area, as determined by Aetna in which **Preferred Care Providers** for this Program are located.

Specialist

A **physician** who:

practices in any generally accepted medical or surgical sub-specialty; and
is providing other than routine medical care.

A **physician** who:

practices in such a sub-specialty; and
is providing routine medical care (such as could be given by a **primary care physician**),

will not be considered a Specialist for purposes of applying this Program's provisions.

Surgery Center

This is a freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  physicians who practice surgery in an area hospital; and
  dentists who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a **R.N.**
- Is equipped and has trained staff to handle medical emergencies.
- It must have:
  a **physician** trained in cardiopulmonary resuscitation; and
  a defibrillator; and
  a tracheotomy set; and
  a blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

Terminally Ill
This is a medical prognosis of 6 months or less to live.

Treatment Facility (Alcoholism Or Drug Abuse)
This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and **effective treatment of alcoholism or drug abuse**.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a **physician**.
- Provides, on the premises, 24 hours a day:

  Detoxification services needed with its effective treatment program.

  Infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical services that may be required.

  Supervision by a staff of **physicians**.

  Skilled nursing care by licensed nurses who are directed by a full-time **R.N.**

Treatment Facility (Mental Disorder)
This is an institution that:

- Mainly provides a program for the diagnosis, evaluation, and effective treatment of **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing care by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

Urgent Admission
One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider
This is:

- A freestanding medical facility which:

  Provides unscheduled medical services to treat an urgent condition if the person's **physician** is not reasonably available.

  Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.

Makes charges.

Is licensed and certified as required by any state or federal law or regulation.

Keeps a medical record on each patient.

Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.

Is run by a staff of **physicians**. At least one **physician** must be on call at all times.

Has a full-time administrator who is a licensed **physician**.

- A **physician's** office, but only one that:
  has contracted with Aetna to provide urgent care; and is, with Aetna's consent, included in the **Directory** as a Preferred Urgent Care Provider.

It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition

This means a sudden illness; injury; or condition; that:

- is severe enough to require prompt medical attention to avoid serious deterioration of the covered person's health;
- includes a condition which would subject the covered person to severe pain that could not be adequately managed without urgent care or treatment;
- does not require the level of care provided in the emergency room of a **hospital**; and
- requires immediate outpatient medical care that cannot be postponed until the covered person's **physician** becomes reasonably available.

Outpatient Prescription Drug Benefit

Your prescription drug benefit is administered by Caremark Inc. Under the Caremark program, you can fill prescriptions at network retail pharmacies or through one of Caremark's Mail Service pharmacies. Your prescription drug copayments or coinsurance amounts do not apply toward your medical program deductible or out-pocket maximum.

Included in your prescription drug benefit program is a "Primary Drug List" (formulary). A Primary Drug List, or formulary, is a list of preferred prescription medications that are proven to be effective in meeting the patient's clinical needs. These drugs are generally lower in cost than other available drugs. For a list of prescription drugs included in the Primary Drug List refer to Caremark's web site at www.caremark.com or call their toll free number at 1-800-378-7559.

Participating Pharmacy Benefit

You may fill a prescription for up to a 34-day supply at any participating pharmacy by showing your Caremark Identification card and paying the applicable charge.

Retail prescription costs are as follows:

Prescription Drug Type	**Coinsurance**	**Copayment**
Applies to Plan:	**BYO 2,4,6,8,10 & 12**	**Aetna EPO & BYO 1,3,5,7,9,11**
Generic	25%* (Minimum $10; Maximum $100)	$10
Formulary Brand	25%* (Minimum $25; Maximum $100)	$25
Non-Formulary Brand	25%* (Minimum $40; Maximum $100)	$40

**Of total prescription cost up to maximum listed*.

For a list of participating pharmacies refer to Caremark's web site at www.caremark.com or call 800-378-7559.

If you use a non-participating pharmacy, you will pay **100 percent of the prescription price**. You will then need to submit a paper claim form, along with the original prescription receipt(s) to Caremark for reimbursement of covered expenses. In most cases this option will cost you more. The time limit to file a paper claim with Caremark is 365 days from the prescription fill date.

Mail Order Pharmacy Benefit

Caremark's Mail Service Program provides a way for you to order up to a 90-day supply of maintenance or long-term medication for direct delivery to your home.

For prescriptions received from Caremark Mail Service you will pay:

Prescription Drug Type	**Coinsurance**	**Copayment**
Applies to Plan:	**BYO 2,4,6,8,10 & 12**	**Aetna EPO & BYO 1,3,5,7,9,11**
Generic	25% (Minimum $20; Maximum $200)	$20
Formulary Brand	25%* (Minimum $50; Maximum $200)	$50
Non-Formulary Brand	25%* (Minimum $80; Maximum $200)	$80

*Of total prescription cost up to maximum listed.

Information on how to use the mail order pharmacy benefit is included in the packet with your Caremark Identification Card.

For questions about mail order prescriptions, call 1-800-378-7559 or visit Caremark's web site at www.caremark.com.

Covered Prescription Drugs

The term covered prescription drug means:

• A Prescription Legend Drug for which a written prescription is required;

• Oral or injectable insulin dispensed only upon the written prescription of a physician;

• Insulin needles and syringes;

• A compound medication of which at least one ingredient is a Prescription Legend Drug;

• Tretinoin for individuals through age 26;

• Any other drug that, under the applicable state law, may be dispensed only upon the written prescription of a physician;

• Oral contraceptives;

• Prenatal vitamins, upon written prescription;

• An injectable drug, excluding injectable infertility drugs, for which a prescription is required, including needles and syringes;

• Oral infertility drugs (up to a $2,500 lifetime maximum);

• Glucose test strips;

• Growth hormones (managed through Caremark's Specialty Pharmacy and Services) and anabolic steroids (available only through Caremark's Mail Service Program); and

• A drug that has been prescribed for a particular use for which it has not been approved by the Food and Drug Administration (FDA) only if it meets the following criteria:

– The drug is recognized for the specific use in any one of the following established reference compendia: the United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluation, the American Hospital Formulary Service, or any peer-reviewed national professional medical journal;

– The drug has been otherwise approved by the FDA; and

– The drug has not been contraindicated by the FDA for the use prescribed.

Limitations

No payment will be made under the Program for the following expenses:

• For non-legend drugs, other than those specified above under “Covered Prescription Drugs”;

• To the extent that payment is unlawful where the person resides when expenses are incurred;

• For charges that the person is not legally required to pay;

• For charges that would not have been made if the person was not covered under the Program;

• For experimental drugs or for drugs labeled “Caution —limited by federal law to investigational use”;

• For drugs that are not considered essential for the necessary care and treatment of an injury or sickness, as determined by the Claims Administrator for the Program or by the retail pharmacy administrator;

• For drugs obtained from a non-participating mail order pharmacy;

• For any prescription filled in excess of the number specified by the physician or dispensed more than one year from the date of the physician’s order;

• For more than a 34-day supply when dispensed in any one prescription order through a retail pharmacy;

• For more than a 90-day supply when dispensed in any one prescription order through a participating mail order pharmacy;

• For indications not approved by the Food and Drug Administration;

• To the extent that the person is covered under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law (any adjustment option chosen under such part will be taken into account);

• For immunization agents, biological sera, blood or blood plasma;

• For therapeutic devices or appliances, including support garments and other non-medicinal substances, excluding insulin syringes;

• For drugs used for cosmetic purposes;

• For tretinoin (Retin-A) for individuals after age 26;

• For administration of any drug;

• For medication that is taken or administered — in whole or in part — at the place where it is dispensed, or while a person is a patient in an institution that operates — or allows to be operated on its premises — a facility for dispensing pharmaceuticals;

• For prescriptions that an eligible person is entitled to receive without charge from any Workers' Compensation or similar law or any public program other than Medicaid;

• For nutritional or dietary supplements, anti-obesity drugs or anorexiants;

• For contraceptive devices, including implantable contraceptive devices;

• For vitamins, excluding prenatal vitamins, upon written prescription;

• For oral infertility drugs after the $2,500 dollar lifetime maximum has been exhausted; or

• For smoking cessation products.

Claims Procedures

In general, health services and benefits must be medically necessary to be covered under the Medical Benefit Program. Medical necessity determinations are made on either a pre-service, concurrent, or post-service basis, as described below. Under Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Medical Benefit Program. The procedures described on pages 85-89 are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

The Company has delegated the discretionary authority to interpret BNSF Medical Program terms and to make both initial claim determinations and final claim review decisions on ERISA appeals to Aetna (Claims Administrator). The BNSF Employee Benefits Committee retains the discretionary authority to determine whether you and/or your dependents are eligible to enroll for coverage and/or to continue coverage under Program terms.

Definitions

Claim--A claim is any request for a program benefit made in accordance with these claims procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures.

Claimant--As an individual covered by a Medical Benefit Program, you become a claimant when you make a request for a program benefit or benefits in accordance with these claims procedures.

Incorrectly Filed Claim--Any request for benefits that is not made in accordance with these claims procedures is considered an incorrectly filed claim.

Authorized Representative--Means an individual who has been identified in writing as the representative of an individual covered by a Medical Benefit Program and signed by the Claimant; however, in the case of a claim involving urgent care, a health care professional with knowledge of the Claimant's medical condition will be permitted to act as the Authorized Representative of the individual covered by the Medical Benefit Program. An Authorized Representative may act on behalf of a Claimant with respect to a benefit claim or appeal under these procedures. An assignment for purposes of payment does not constitute appointment of an Authorized Representative under these claims procedures. Unless the Claimant indicates otherwise in the authorization, all information and notifications regarding the claim will be sent to the Authorized Representative and not to the Claimant.

No individual may receive "protected health information" without the Program having received an "authorization" from the Claimant to the extent required by the Health Insurance Portability and Accountability Act of 1996, and its applicable regulations ("HIPAA").

Pre-Service Claim (pre-certification/ pre-authorization)--A claim is a pre-service claim if benefits under the Program are conditional on receiving approval in advance of obtaining the medical care.

Urgent Care Claim--A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods that otherwise apply (1) could seriously jeopardize the claimant's life or health or ability to regain maximum function or (2) would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. On receipt of a claim, the Claims Administrator will make a determination of whether it involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim will be treated as an urgent care claim. If the requested medical care has already been provided, the claim will be considered a post-service claim.

Concurrent Care Claims--A concurrent care decision occurs when the Benefit Program approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (1) where reconsideration of the approval results in a reduction or termination of the initially-approved period of time or number of treatments; and (2) where an extension is requested beyond the initially-approved period of time or number of treatments.

Post-Service Claim--A post-service claim is any claim for a benefit under this Benefit Program that is not a pre-service claim or an urgent care claim. Post-service claims are claims that involve only the payment or reimbursement of the cost for medical care that has already been provided.

How to File a Claim

*N*o claim forms are necessary when you or a dependent uses an Aetna network provider. However, at the start of each calendar year, the Claims Administrator may ask you to complete a claim form to update personal data.

If you or a dependent uses an out-of-network provider, you must submit a completed claim form before benefits can be paid. You may obtain a claim form from Aetna or from the Forms and Enrollment folder on the Benefits Intranet site at: http:// www.bnsfweb.bnsf.com/departments/hr/benefits/index.html.

Complete and sign the form and submit your claim to the Claims Administrator. When you submit your claim, include with it a copy of your medical bill showing the following:

• Employee's name and subscriber identification number with alpha prefix as shown on your identification card;

• Patient's full name;

• Nature of the sickness or injury;

• Type of service or supply furnished;

• Date or dates the service was rendered or the purchase was made;

• Itemized charges for each service or supply; and

• Provider of service with address and tax ID number.

You must submit separate claims for yourself and each of your covered dependents who have incurred medical expenses. Incomplete claim forms will not be processed.

All network and out-of-network claims must be filed no later than two (2) years after the date a service is received. Claims not filed within two (2) years from the date a service is received will not be eligible for payment under Program terms.

Timeframe for Deciding Initial Benefit Claims

Pre-Service Claims--Your benefit Program requires that you pre-certify for inpatient care, skilled nursing, coordinated home care and private duty nursing. The Claims Administrator will notify you or your representative of the determination within 15 days after receipt of the claim. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Administrator will notify you or your representative within 15 days after receiving the claim. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed and you or your representative must provide the specified information within 45 days after receiving the notice. The timeframe for deciding the claim will be suspended from the date the extension notice is sent until the date the missing necessary information is provided to the Claims Administrator.

Urgent Care Claim--The Claims Administrator will decide an initial urgent care claim within 72 hours after receiving the claim. However, if necessary information is missing from the request, you or your representative will be notified within 24 hours after receiving the claim to specify what information is needed. The specified information must be provided to the Claims Administrator within 48 hours after receiving the notice. The Claims Administrator will decide the claim within 48 hours after the receipt of the specified information.

Concurrent Care Claims--When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request the extension at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, the Claims Administrator will notify you or your representative of the determination within 24 hours after receiving the claim.

Post-Service Claim--The Claims Administrator will notify you or your representative of the determination within 30 days after receiving the claim. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Administrator will notify you or your representative within 30 days after receiving the claim. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed and you or your representative must provide the specified information within 45 days after receiving the notice. The timeframe for deciding the claim will be suspended from the date the extension notice is sent until the date the missing necessary information is provided to the Claims Administrator.

Notification of Initial Benefit Determination

Each time a claim is submitted, you or your representative will receive a written Explanation of Benefits form that will explain how much was paid towards the claim or whether the claim was denied, in whole or in part. If a claim is denied, in whole or in part, the Claims Administrator will give you or your representative a written notice of the denial and the reason for the denial. The Claim Denial Notice will include the following:

- explain the specific reason(s) for the denial;
- provide the specific reference to pertinent Medical Benefit Program provisions on which the denial was based;
- provide a description of any additional information necessary to reverse the denial, or in the case of an incomplete claim to perfect the claim;

- provide an explanation of the Medical Benefit Program's claim review procedures and applicable time limits; and
- if the Claims Administrator used or relied on internal guidelines, protocols, or other criteria, the letter will specify the criterion; and a copy of such rule, guideline, protocol or other criteria, and reasonable access to relevant documents, records and other information relevant to the Claim will be provided free of charge on request.

If Your Claim is Denied

The Medical Benefit Program is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA has special rules that must be followed when you or your representative chooses to appeal an adverse benefit decision (denied claim).

You have a right to appeal any claim denial, including any denial at the pre-service (pre-certification/ pre-authorization) level. It does not make any difference whether the denial is a complete denial or a partial denial. You or your representative should file a written request for appeal as soon as you receive a denial of benefits that you believe should be covered under the Medical Benefit Program but no later than **180** days from the date you receive notice that your claim has been denied. Failure to comply with this important deadline may cause you to forfeit any right to appeal the denial. If the claim is an Urgent Care Claim, you may appeal the decision and receive an expedited decision, please see below.

A person who did not make the initial decision shall decide your appeal. The review on appeal will not give any deference to the initial decision and will take into account all information submitted by you, regardless of whether it was submitted or considered in the initial decision.

Along with your written request for a review, you may submit any additional documents and written issues and comments you believe should be considered during the review. You should also include any clinical documentation from your physician that would substantiate coverage of the denied claim.

Upon request, you or your representative will be provided reasonable access to and copies of all documents, records and other information relevant to your claim, free of charge, including:

- information relied upon in making the benefit determination;
- information submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon in making the benefit determination;
- descriptions of the administrative processes and safeguards used in making the benefit determination;
- records of any independent reviews conducted by the Claims Administrator;
- if the claim was based on a medical judgment, including determinations about whether a particular service is experimental, investigational or not medically necessary or appropriate, an explanation of the scientific or clinical judgment for the decision applying the term of the Program, or an explanation for the denial; and
- expert advice and consultation obtained by the Claims Administrator in connection with your denied claim, whether or not the advice was relied upon in making the benefit determination.

Your request for an appeal should be addressed to:

Aetna Inc.
P.O. Box 14586
Lexington, KY 40512-4586

Timeframes for Deciding Benefits Appeals

Pre-Service Claims--The Claims Administrator will provide a written decision on the appeal of a pre-service claim within 30 days after receipt of the appeal.

Urgent Care Claims--The Claims Administrator will decide the appeal of an urgent care claim within 72 hours after receipt of the appeal.

Post-Service Claims--The Claims Administrator will decide the appeal of a post-service claim within 60 days after receipt of the appeal.

Concurrent Care Claims--The Claims Administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. Appeal of a denied request to extend a concurrent care decision will be decided in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

Notification of Decision on Appeal

The Claims Administrator will notify you, in writing, of its final decision and will include the following:

- the specific reasons for the appeal decision;
- a reference to the specific Medical Benefit Program provision(s) on which the decision was based;
- a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to or copies of all documents, records, and other information relevant to the determination (see prior page for a list of such documents); and
- a statement indicating entitlement to receive, upon request and without charge, a copy of any internal rule, guideline, protocol or similar criterion relied on in making the adverse decision regarding your appeal, and/or an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

The Claims Administrator's decision on appeal is final and binding. Benefits under this Program will be paid only if the Claims Administrator decides, in its sole discretion, that you are entitled to them. If you continue to disagree with the decision, you may exercise "Your Rights under ERISA" as explained on page 154 of this SPD.

Appeal for External Review

Aetna's external review process gives members the opportunity to have certain coverage denials reviewed by independent physician reviewers. An appeal will be eligible for external review if the following are satisfied:

- the standard levels of appeal have been exhausted,
- the appeal is made by the member or the member's authorized representative,
- the coverage denial is based on Aetna's determination that the proposed or rendered service or supply is not medically necessary or is experimental or investigational, and
- the cost of the service or supply at issue for which the member is financially responsible exceeds $ 500.

If upon the final standard level of appeal Aetna upholds the coverage denial and it is determined that the member is eligible for external review, the member will be informed in writing of the steps necessary to request an external review.

An independent review organization (IRO) refers the case for review by a neutral, independent physician with appropriate expertise in the area in question. Once all necessary information is submitted, the external review requests will generally be decided within 30 days of the request. Expedited reviews are available when a member's physician certifies that a delay in service would jeopardize the member's health. The decision of the independent external expert reviewer is binding on Aetna, the Company and the Health Plan. Members will not be charged a professional fee for the review.

Your Health Reimbursement Account (HRA)

(BCBS and Aetna Only)

The BN Retiree Medical Program includes a Health Reimbursement Account or HRA if you choose the BCBS Base or BYO or Aetna EPO or BYO. Features include:

- The HRA is financed solely with contributions from BNSF. You don't contribute to your HRA; BNSF funds the entire amount. The amounts contributed to your HRA by BNSF are not taxable to you as income, nor are any distributions taxable to you provided you use them for qualified medical expenses.

- On the first day of the calendar year, BNSF will contribute $500 to your individual HRA for you or $1000 if you cover any family members on your medical coverage election. You will receive a new contribution each year.

- You can use your HRA to reimburse eligible medical expenses incurred by you, your spouse, or your tax dependents (i.e. claimed as a dependent on your federal income tax return during the relevant period). Eligible expenses include:

  —Expenses that were applied to your annual deductible;
  —Copays for office visits or prescription drugs;
  —Coinsurance amounts;
  —Qualified over-the-counter medications that treat an illness or injury (i.e., not for general health); or
  —Transportation services necessary to receive medical care.

- If you do not spend your entire HRA account during the year unused amounts in your HRA are carried over from year-to-year.

- The HRA is administered by *Your Spending Account* (YSA) which means you may pay for eligible HRA expenses with the YSA debit card.

Qualified Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, as described on page 2, the HRA account will be adjusted as follows:

Mid-Year Change in Coverage Category

- If you move from the single coverage category to any other coverage category, your HRA amount will be increased by the incremental difference between the single HRA amount ($350) and the family HRA amount ($700). The balance going forward will be the original $350, less reimbursements, plus the additional $350.
- If you move from family coverage to single coverage, your HRA amount will be reduced to $350 and the balance will be $350 less previous reimbursements.

  Example: A participant exhausted the $700 family HRA amount prior to a qualified status change. As a result of the change, the coverage category changed to "You Only". The participant had already

used their $350 allotment for the year, so the balance will be adjusted to $0.00. (Note: BNSF will not attempt to recoup the difference of $350.)

Example: A participant had family coverage and had received reimbursements of $250 from the HRA. As a result of a qualified status change, their coverage category changed to "You Only". The HRA allotment will be reduced to $350 and the balance in the HRA will be $100. ($350 allotment - $250 already reimbursed)

Example: A participant had "You Only" coverage and had received reimbursements of $250 from the HRA. As a result of a qualified status change, their coverage category changed to "You + Family". The HRA allotment will be increased to $700. The balance in the HRA will be $450. ($700 allotment - $250 already reimbursed)

Divorce or Legal Separation

In the case of divorce or legal separation, your HRA balance will stay with your account. Your ex-spouse will have a COBRA enrollment opportunity, and if your ex-spouse enrolls in COBRA coverage in either the CIGNA Network or a BCBS PPO option, he or she will receive an HRA allotment at the time of enrollment.

Example: A participant has family coverage ($700 HRA). The participant gets divorced on July 1. At that time, the participant had used $250 of the HRA. Due to the divorce, the participant now has single coverage.

The participant's HRA allotment will be adjusted from $700 to $350 due to the coverage change. The remaining HRA balance is $100. If the ex-spouse enrolls in COBRA coverage, the ex-spouse will receive their own HRA balance. The amount will be $350 or $700 depending upon the coverage category.

Example: A participant has family coverage ($700 HRA). The participant gets divorced on July 1. At that time, the participant had used $500 of the HRA. Due to the divorce, the participant now has single coverage.

The participant's HRA allotment will be adjusted from $700 to $350 due to the coverage change. The remaining HRA balance is $0. If the ex-spouse enrolls in COBRA coverage, the ex-spouse will receive their own HRA balance. The amount will be $350 or $700 depending upon the coverage category.

Medicare Age Attainment

Medicare-eligible retirees are not eligible for the HRA, so when you or your spouse turns 65, your HRA is affected. When you turn 65 your HRA balance is forfeited; however, if your dependent(s) continue coverage, they will be provided a new HRA allotment, depending upon the coverage category ($350 for single coverage or $700 if any dependents are covered).

Example: A participant had family coverage and had received reimbursements of $450 from the HRA when he reached age 65. The HRA balance of $250 will be forfeited; however, if the spouse continues coverage, he or she will have an HRA allotment of $350 beginning with the date of that individual coverage.

Death

If you die while covered under the BN Retiree Medical Program, your balance will be forfeited. However, if your dependents continue coverage, your dependents will be given a new HRA allotment upon enrollment.

Example: You had family coverage and had received reimbursements of $500 from the HRA at the time of death. The HRA balance of $200 will be forfeited; however, if your spouse continues coverage, she will have an HRA allotment of $350 beginning with the date of her individual coverage.

Eligible Expenses

You may use your HRA for reimbursement of health care expenses that are not paid by your medical or dental coverage or that are not eligible for reimbursement through some other source. Expenses eligible for reimbursement from your HRA can include the following (for a more complete list see the YSA Web site at www.ybr.com/benefits):

• Medical, dental, or vision deductibles.

• Medical, dental, or vision copayments.

• Medical, dental, and vision expenses not reimbursed through coordination of benefits with a secondary payer.

• Vision care, including examinations, eyeglasses and contact lenses.

• Hearing care, including examinations and hearing aids.

• Dental care, including orthodontia expenses and dentures, but excluding cosmetic dental procedures.

• Emergency room visits.

• Expenses for operations or treatments, including obstetrical expenses, legal abortion, legal vasectomy, therapy, or x-ray treatment.

• Expenses that exceed Medical or Dental Program maximums.

• Routine checkups or visits to a doctor or clinic not covered by your medical or dental coverage.

• Out-of-pocket costs for prescription drugs, insulin and Laetrile, but only if Laetrile is prescribed by a doctor and purchased and used in a location where its sale and use are legal.

• Non-prescription drugs used for medical care.

• Outpatient mental health care.

• Charges for psychologists, chiropractors and physical therapy for medical care.

• Expenses for care in an institution other than a hospital, including the cost of meals and lodging, when confinement is medically necessary.

• Tuition fees for a special school for physically or mentally handicapped children, if the main reason for using the school is that it has resources for relieving the handicap.

• Tuition fees for a special school, such as one that teaches Braille or lip reading, that helps your dependent compensate for or overcome a physical handicap and prepares him or her for attendance at a regular school or for daily life.

• Tutoring fees for handicapped children provided the teacher is qualified to work with children who have severe learning disabilities.

• Charges for medical care included in the tuition fee of a college or private school.

• Educational devices for the blind.

• Charges for Braille reading material to the extent it is more expensive than non-Braille literature.

• Guide dogs for the blind or deaf, including training charges.

• Installation and repairs of special telephone and television equipment for the deaf.

• Installation and operating costs of special equipment in a car used by a physically handicapped person.

• Smoking cessation or weight loss programs prescribed by a physician.

• Treatment of obesity.

• Durable medical equipment, including wheelchairs, crutches and inclinators.

• Artificial limbs.

• Portable air conditioners purchased only for the use of a sick person.

• Fluoride treatment of your home's water if treatment is recommended by a dentist.

• Transportation costs directly related to and primarily for receiving medical care, including parking and mileage. Mileage is reimbursed at the current IRS mileage rate for medical expenses.

• Lasik Surgery.

• Other expenses that are considered allowable expenses for medical care under Internal Revenue Code Section 213(d), or as published by the Internal Revenue Service.

Excluded Expenses

The following expenses are not eligible for reimbursement from your HRA:

• Your contributions for medical and dental coverage under the BNSF Cafeteria Plan.

• Premium contributions for other health care plans, Life and Accidental Death and Dismemberment Insurance, and automobile insurance whether BNSF plans or the plans of another employer.

• Non-prescription drugs used for general health purposes.

• Marriage or family counseling.

• Household help prescribed by a physician.

• The salary of a licensed practical nurse (L.P.N.) who cares for a normal, healthy newborn child.

• Dancing, swimming and other types of lessons prescribed by a physician for the general improvement of health.

• Membership fees and other costs for smoking cessation or weight loss programs when the programs are for purposes of general health and well-being.

• Health club programs, including resort hotels, health clubs, gyms or steam baths.

• Custodial care while confined.

• Remedial reading classes for non-handicapped children.

• Meals and lodging while you are away from home for medical treatment that is not provided at a medical facility or for the relief of a specific condition, even if the trip is made on the advice of a doctor.

• Cosmetic surgery or procedures (including cosmetic dental procedures) as defined under Internal Revenue Code Section 213(d).

• Illegal operations, treatments or drugs.

• Funeral or burial expenses.

• Toiletries and cosmetics.

• Vitamins for general health purposes.

• Bottled water.

• Maternity clothes and uniforms.

• Expenses for permanent property improvements even if they are directly related to medical care (such as central air conditioning or a swimming pool).

• Expenses incurred prior to the date of your enrollment in the Health Reimbursement Account.

In addition, you will not be reimbursed for any expenses that are covered for you or your eligible Dependents under the provisions of any health care plan or insurance policy or that are reimbursed through any other source.

Claims Procedures

There are two ways to access funds in your Health Reimbursement Account. One is by using the YSA Debit Card and the other is to pay for eligible expenses through other means and file a claim for reimbursement.

- **YSA Debit Card**
  If you are eligible for the HRA, you will be issued a YSA MasterCard that you can use to pay for eligible expenses rather than paying out-of-pocket and submitting a claim for reimbursement. You will be sent one debit card, but you can request additional cards for your spouse and eligible dependents by calling YSA.

  You can use the YSA card at providers such as doctor offices, pharmacies, hospitals, and dentist offices as long as the provider is set up to process debit transactions. The YSA card allows the provider to be paid for services immediately. YSA card transactions are validated electronically at the time of the service or via paper documentation afterward. ***You should retain receipts for all transactions in case they are required for "substantiation" (documentation of the claim).*** If

receipts are required, you will receive an email containing instructions and a link to YSA for printing of a cover sheet to include with the documentation. It is important that you follow the instructions so that your receipts can be matched to your claim. If YSA does not have your email address, you will receive a letter containing instructions.

If the Claims Administrator determines that you have used the YSA card for an ineligible expense, or you do not provide the required documentation when requested, your account will be considered in "overpayment" status and your YSA card will be suspended until the overpayment is recovered or appropriate documentation is received.

Further details about the YSA card can found online at www.ybr.com/benefits by clicking on Your Spending Account on the left hand side.

- **Non Debit Card Claims Reimbursement**
  If you choose not to use the YSA card to pay for eligible expenses, you can file a manual claim for reimbursement. You can be reimbursed for eligible expenses as they are incurred, up to the maximum amount in your HRA. To file a reimbursement claim, you can access the web site for Your Spending Account, complete an online claim form, print the form, then fax or mail to YSA along with your receipts. Alternatively, you can download a claim form from the Forms and Enrollment Folder on the Benefits page of the BNSF web site and fax or mail to YSA.

If Your Claim is Denied

An appeal for a denied HRA claim should be addressed to:

Your Spending Account
Benefit Determination Review Team
P.O. Box 1444
Lincolnshire, IL 60069

Aetna High Deductible Health Plan with Health Savings Account

Your Health Benefits

This Program will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

Your Primary Care Physician

Although you are not required to select a Primary Care Physician, you are encouraged to do so. Consult your Primary Care Physician whenever you have questions about your health. He or she provides basic and routine care, and can refer you to specialists and facilities in the network, when medically necessary.

Primary and Preventive Care

Your selected Primary Care Physician can provide preventive care and treat you for illnesses and injuries. Coverage for out-of-network primary and preventive care is limited. Refer to the “Schedule of Benefits” for details.

Schedule of Benefits – Aetna High Deductible Health Program

LIFETIME MEDICAL PROGRAM LIFETIME MAXIMUM	In Network: Unlimited Out-of-Network: Unlimited			
BENEFITS	**Employee Only**		**Employee plus Family**	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Deductible (per calendar year)*	$2,500	$2,500	$5,000	$5,000
Program Coinsurance	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Coinsurance limit (Out-of-pocket Maximum)*	$2,000	$4,000	$4,000	$8,000
Inpatient Hospital Services (pre-certification required; $500 penalty if pre-certification not received)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Surgery & Diagnostic Tests (pre-certification required on certain procedures and treatments; $200 penalty if pre-certification not received)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Emergency (Hospital & Physician - - Initial treatment of accidental injuries or sudden and unexpected medical conditions with severe life threatening symptoms. Non-emergency use of emergency room is not covered.)	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Physician Office Visit	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Well Child & Adult Routine Care	100% (no deductible and no coinsurance)	60% after deductible	100% (no deductible and no coinsurance)	60% after deductible
Chiropractor (limited to 60 visits per calendar year)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment (DME)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Occupational / Physical / Speech Therapy (limited to 60 visits per therapy per calendar year)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Other Covered Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Prescription Drugs (Retail)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Prescription Drugs (Mail Order)	80% after deductible	Not Covered	80% after deductible	Not Covered
Inpatient Mental Health Services	80% after deductible (limited to 60 days per calendar year)	60% after deductible (limited to 10 days per calendar year)	80% after deductible (limited to 60 days per calendar year)	60% after deductible (limited to 10 days per calendar year)
Outpatient Mental Health Services	80% after deductible	60% after deductible (limited to 25 visits per calendar year)	80% after deductible	60% after deductible (limited to 25 visits per calendar year)
Inpatient Chemical Dependency	80% after deductible (limited to 60 days per calendar year)	60% after deductible (limited to 10 days per calendar year)	80% after deductible (limited to 60 days per calendar year)	60% after deductible (limited to 10 days per calendar year)
Outpatient Chemical Dependency	80% after deductible	60% after deductible (limited to 25 visits per calendar year)	80% after deductible	60% after deductible (limited to 25 visits per calendar year)
Medical Management /Aetna Healthline: • **Notification required before all elective inpatient admissions. Emergency and Obstetric admission notification required within 48 hours of admittance. penalty applied if pre-certification not received.** • **Notification required before certain outpatient procedures and treatments as outlinedbelow. $200 penalty applied if pre-certification not received.**				

*Penalties for not requesting pre-authorization and charges in excess of reasonable and customary for out-of-network providers are not credited toward the deductible or out-of-pocket maximum.

Special Comprehensive Medical Coverage

Although a specific service may be listed as a covered expense, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of an illness or condition. The Schedule of Benefits outlines the Payment Percentages that apply to the Covered Medical Expenses described below. There are exclusions, deductibles and stated maximum benefit amounts. Covered Medical Expenses include expenses for certain **hospital** and other medical services and supplies and must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses.

Hospital Expenses

Inpatient Hospital Expenses
Charges made by a **hospital** for giving **board and room** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.
For **Preferred Care**:

- If a private room is used, the daily **board and room** charge will be covered if:
  the person's **Preferred Care Provider** requests the private room; and
  the request is approved by Aetna.
- If the above procedures are not met, any part of the daily **board and room** charge which is more than the **semiprivate rate** is not covered.

For **Non-Preferred Care**:
Not included is any charge for daily **board and room** in a private room over the **semiprivate rate**.

Outpatient Hospital Expenses
Charges made by a **hospital** for **hospital** services and supplies which are given to a person who is not confined as a full-time inpatient.

Outpatient Surgical Expenses

Covered Medical Expenses include charges for outpatient surgical expenses to the extent shown below.
Covered Medical Expenses include charges made:

- in its own behalf by:
  a **surgery center**;
  the outpatient department of a **hospital**; or
  an office based surgical facility of a **physician** or a **dentist**.
- by a **physician**;
- on behalf of a salaried staff **physician** by the outpatient department of a **hospital**.
- for Outpatient Services and Supplies furnished in connection with a surgical procedure performed in the center or in a hospital. The procedure must meet these tests:
- It is not expected to:
  result in extensive blood loss;
  require major or prolonged invasion of a body cavity; or
  involve any major blood vessels.
- It can safely and adequately be performed only in a **surgical center** or in a **hospital** o r
  in an office based surgical facility of a **physician** or a **dentist**.
- It is not normally performed in the office of a **physician** or a **dentist**.

Outpatient Services and Supplies
These are:

- Services and supplies furnished by the **surgery center** or by a **hospital** on the day of the procedure.
- Services of the operating **physician** for performing the procedure and for:
  related pre and postoperative care; and
  the administering of an anesthetic.

- Services of any other **physician** for related postoperative care and for the administering of an anesthetic. This does not include a local anesthetic.

Limitations:
No benefit is paid for charges incurred:
- For the services of a **physician** who renders technical assistance to the operating **physician**.
- While the person is confined as a full-time inpatient in a **hospital**.

Convalescent Facility Expenses

Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury.

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a private room over the **semiprivate rate**.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a **convalescent facility**. This does not include private or special nursing, or **physician's** services.
- Medical Supplies.

Benefits will be paid for no more than 60 days, the Convalescent Days Maximum, during any one calendar year.

Limitations to Convalescent Facility Expenses
This section does not cover charges made for treatment of:
- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

Home Health Care Expenses

Home health care expenses are covered if:
- the charge is made by a **home health care agency**; and
- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:
- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Program if the person had been confined in a **hospital** or **convalescent facility**:
  medical supplies;
  drugs and medicines prescribed by a **physician**; and
  lab services provided by or for a **home health care agency**.

There is a maximum of 40 visits covered in a plan year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Limitations To Home Health Care Expenses
This section does not cover charges made for:
- Services or supplies that are not a part of the **home health care plan**.
- Services of a person who usually lives with you or who is a member of your or your wife's or husband's family.
- Services of a social worker.
- Transportation.

Routine Physical Exam Expenses

The charges for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included are:
- X-rays, laboratory and other tests including a Pap Smear given in connection with the exam; and
- materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For a dependent child:
- To qualify as a covered physical exam, the **physician's** exam must include at least:
- a review and written record of the patient's complete medical history;
- a check of all body systems; and
- a review and discussion of the exam results with the patient or with the parent or guardian.

For all exams given to your child under age 7, Covered Medical Expenses will not include charges for:
- More than 7 exams in the first year of the child's life.
- More than 2 exams in the second year of the child's life; or
- More than one exam per year during the next 5 years of the child's life.

For all exams given to your child age 7 up to age 18, Covered Medical Expenses will not include charges for more than one exam every 12 months in a row.

For all exams given to your child age 18 and over, Covered Medical Expenses will not include charges for more than one exam in 24 months in a row.

For you and your spouse:

For all exams given to you or your spouse, Covered Medical Expenses will not include charges for more than:

one exam in 24 months in a row for a person under age 65; and
one exam in 12 months in a row for a person age 65 and over;

Also included as Covered Medical Expenses are charges made by a physician for one annual routine gynecological exam. Included as part of the exam is a routine Pap smear.

Not covered are charges for:
- services which are covered to any extent under any other part of this Program or any other group plan sponsored by BNSF;
- services which are for diagnosis or treatment of a suspected or identified injury or disease;
- exams given while the person is confined in a **hospital** or other place for medical care;
- services not given by a **physician** or under his or her direction;
- medicines, drugs, appliances, equipment or supplies;
- psychiatric, psychological, personality or emotional testing or exams;
- exams in any way related to employment;
- premarital exams;
- vision, hearing or dental exams;
- a **physician's** office visit in connection with immunization or testing for tuberculosis.

Skilled Nursing Care Expenses

The charges made by a **R.N.** or **L.P.N.** or a nursing agency for "skilled nursing services" are included as Covered Medical Expenses. No other charges made by a **R.N.** or **L.P.N.** or a nursing agency are covered. As used here, "skilled nursing services" means these services:

- Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by a **R. N.** or **L.P.N.** if the person's condition requires skilled nursing care and visiting nursing care is not adequate.

Benefits will not be paid during a plan year for private duty nursing for any shifts in excess of the60 day Private Duty Nursing Care Maximum Shifts or a maximum of $10,000. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Not included as "skilled nursing services" is:

- that part or all of any nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs and companionship activities; or
- any private duty nursing care, given while the person is an inpatient in a **hospital** or other health care facility; or
- care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
- care provided solely for skilled observation except as follows:
  for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:
  change in patient medication;

  need for treatment of an **emergency condition** by a **physician**, or the onset of symptoms indicating the likely need for such services;

  surgery; or

  release from inpatient confinement; or

- any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a **R.N.** or **L.P.N.**

Hospice Care Expenses

Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

Facility Expenses

The charges made in its own behalf by a:

- **hospice facility**;
- **hospital**; or
- **convalescent facility**;

which are for:

Inpatient Care

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:
  pain control; and
  other acute and chronic symptom management.

- Not included is any charge for daily board and room in a private room over the Private Room Limit. Also not included is the charge for any day of confinement in excess of the Maximum Number of Days for all confinements for **Hospice Care**.

Outpatient Care

- Services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses For Outpatient Care

Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours in any one day.
- Medical social services under the direction of a **physician**. These include:
  assessment of the person's:
  social, emotional, and medical needs; and
  the home and family situation;
  identification of the community resources which are available to the person; and
  assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a **physician**.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a **physician**.

Charges made by the providers below for Outpatient Care, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant or case management services.
- A physical or occupational therapist.
- A **Home Health Care Agency** for:
  physical and occupational therapy;

  part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;

  medical supplies;

  drugs and medicines prescribed by a **physician**; and

  psychological and dietary counseling.

Not included are charges made:

- For bereavement counseling.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Contraception Expenses

Covered Medical Expenses include:

- charges incurred for contraceptive drugs that by law need a physician’s prescription; and that have been approved by the FDA.

- related outpatient contraceptive services such as:
  consultations;
  exams;
  procedures; and
  other medical services and supplies.

Not covered are:
- charges for services which are covered to any extent under any other part of this Program or any other group plan sponsored by your Employer; and
- charges incurred for contraceptive services while confined as an inpatient.

Infertility Services Expenses

The following infertility services expenses are not Covered Medical Expenses and are not payable by the Program:

- Ovulation induction with ovulatory stimulant drugs;
- Artificial insemination.
- Purchase of donor sperm or storage of sperm.
- Care of donor egg retrievals or transfers.
- Cryopreservation or storage of cryopreserved embryos.
- Gestational carrier programs.
- Home ovulation prediction kits.
- In vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and intracytoplasmic sperm injection.
- Frozen embryo transfers, including thawing.
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Care associated with a donor IVF program, including fertilization and culture.
- Injectable infertility medications.

Even though not incurred for treatment of a disease or injury, Covered Medical Expenses will include expenses incurred by a covered female for the diagnosis and treatment of the underlying medical condition for infertility. Contact member services for additional information on covered expenses.

Outpatient Short-Term Rehabilitation Expense Coverage

The charges made by:
- a **physician**; or
- a licensed or certified physical, occupational or speech therapist;

for the following services for treatment of acute conditions are Covered Medical Expenses.

Short-term rehabilitation is therapy which is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to:
- an injury;
- a disease; or
- congenital defect.

Short-term rehabilitation services consist of:
- physical therapy;
- occupational therapy,
- speech therapy; or
- spinal manipulation,

furnished to a person who is not confined as an inpatient in a **hospital** or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

Not covered are charges for:

- Services which are covered to any extent under any other part of this Program.
- Any services which are covered expenses in whole or in part under any other group plan sponsored by BNSF.
- Services received while the person is confined in a **hospital** or other facility for medical care.
- Services not performed by a **physician** or under his or her direct supervision.
- Services rendered by a physical, occupational, or speech therapist who resides in the person's home or who is a part of the family of either the person or the person's spouse.
- Services rendered for the treatment of delays in speech development, unless resulting from:
  - disease;
  - injury; or
  - congenital defect.
- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired to function without that ability.
- Treatment for which a benefit is or would be provided under the Spinal Manipulation Expenses section, whether or not benefits for the maximum number of visits under that section have been paid.

Also, not covered are any services unless they are provided in accordance with a specific treatment plan which:

- details the treatment to be rendered and the frequency and duration of the treatment.
- provides for ongoing reviews and is renewed only if therapy is still necessary.

Spinal Manipulation Expenses

Covered Medical Expenses include charges for treatment of spinal subluxation or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the Spinal Manipulation maximum visits will be payable in any one calendar year.

The maximum does not apply to expenses incurred:

- while the person is a full-time inpatient in a **hospital**;
- for treatment of scoliosis;
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating physician.

Durable Medical And Surgical Equipment Expenses

Covered Expenses

Covered Medical Expenses are the following:

- The rental of **durable medical and surgical equipment**.
- The initial purchase of **durable medical and surgical equipment** and accessories needed to operate it only if Aetna is shown that:
  - long term use is planned; and
  - the equipment cannot be rented; or
  - it is likely to cost less to buy it than to rent it.
- The repair or replacement of purchased **durable medical and surgical equipment** and accessories. Replacement will be covered only if Aetna is shown that:
  - it is needed due to a change in the person's physical condition; or
  - it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.
- Charges for oxygen

Limitations

Covered Medical Expenses do not include:

- more than one item of equipment for the same or similar purpose;
- equipment that is:
  - normally of use to persons who do not have a disease or injury;
  - for use in altering air quality or temperature; or
  - for exercise or training.

Complex Imaging Services

Covered Medical Expenses include charges for Complex Imaging Services received by a covered person on an outpatient basis when performed in:

- a physician's office
- a Hospital outpatient department or emergency room; or
- a licensed radiological facility

Complex Imaging Services include:

- C.A.T. Scans;
- Magnetic Resonance Imaging (MRIs);
- Positron Emmision Tomography (PET Scans); and
- any other outpatient diagnostic imaging service costing over $ 500.

Deductibles, copayments, coinsurance and other cost sharing features; maximum benefit amounts; and exclusions apply.

Other Medical Expenses

These include:

- Charges made by a **physician**.
- Charges for the following:
  - Drugs and medicines which by law need a **physician's** prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.
  - Diagnostic lab work and X-rays.
  - X-rays, radium, and radioactive isotope therapy.
  - Anesthetics and oxygen.
  - Rental of **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

    The initial purchase of such equipment if Aetna is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.

    Repair of purchased equipment.

    Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.
- Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given.
- Charges for orthopedic shoes, foot orthotics, or other devices to support the feet.
- Artificial limbs and eyes. Not included are charges for:

  eyeglasses;
  vision aids;
  hearing aids;
  communication aids; and
  orthopedic shoes, foot orthotics, or other devices to support the feet, unless **necessary** to prevent complications of diabetes.

National Medical Excellence Program ® (NME)

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Program will pay a benefit for Travel and Lodging Expenses, but only to the extent described below. The maximum Lodging expense is $50.00 per person per night and the Travel and Lodging Maximum is $10,000 per type of procedure.

Travel Expenses
These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

Lodging Expenses
These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:
- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

Travel and Lodging Benefit Maximum
For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:
- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:
  one year after the day the procedure is performed; and
  the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Benefits paid for Travel Expenses and Lodging Expenses do not count against any person's Maximum Benefit.

Limitations
Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Program.

Travel Expenses do not include expenses incurred by more than one **Companion** who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one **Companion** per night.

Family Planning
The charges made by:
- a **physician**; or
- a **hospital**;

for the following even though they are not incurred in connection with the diagnosis or treatment of a disease or injury, are Covered Medical Expenses.

Benefits will be payable for:
- a vasectomy for voluntary sterilization; and
- a tubal ligation for voluntary sterilization.

Not covered are charges for the reversal of a sterilization procedure.

Emergency Room Treatment

Emergency Care

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is **emergency care**;

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Payment Percentage.

Non-Emergency Care

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is not **emergency care**;

no benefits will be payable.

Treatment by an Urgent Care Provider

*You should not seek medical care or treatment from an **Urgent Care Provider** if your illness; injury; or condition; is an **emergency condition**. Please go directly to the emergency room of a **hospital** or call 911 (or the local equivalent) for ambulance and medical assistance.*

Urgent Care

This Program pays for the charges made by an **Urgent Care Provider** to evaluate and treat an urgent condition.

When travel to an Urgent Care Provider for treatment of an urgent condition is not feasible, such treatment may be paid at the Preferred level of benefits. If a claim for treatment of an urgent condition is paid at the Non-Preferred level and you believe that it should have been paid at the Preferred level, please contact Members Services at the toll free number on your I.D. card.

Non-Urgent Care

No coverage is provided for covered medical expenses for charges made by an Urgent Care Provider to treat a non-urgent condition.

Non-urgent care includes, but is not limited to, the following:

- routine or preventive care (this includes immunizations);
- follow-up care;
- physical therapy;
- elective surgical procedures; and
- any lab and radiologic exams which are not related to the treatment of the urgent condition.

Certification For Hospital Admissions

This certification section applies to Out-of-network admissions other than those for the treatment of alcoholism, drug abuse, or **mental disorders**. A separate section below applies to such admissions.

If:

- a person becomes confined in a **hospital** as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by:
  - your **Primary Care Physician**; or
  - a **Preferred Care Provider**;

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

- As to Hospital Expenses incurred during the confinement:
  If certification has been requested and denied:

  No benefits will be paid for Hospital Expenses incurred for board and room.
  Benefits for all other Hospital Expenses will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:
  No benefits will be paid for Hospital Expenses incurred for board and room.

  As to all other Hospital Expenses:
  Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.
  Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:
  Hospital Expenses incurred for board and room, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.
  Benefits for all other Hospital Expenses will be payable at the Payment Percentage.
- As to other Covered Medical Expenses:

  Benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Program; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not **necessary** will not be applied.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency admission** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card.
This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission**; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. (In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.)

If, in the opinion of the person's **physician**, it is necessary for the person to be confined for a longer time than already certified, you, the **physician** or the **hospital** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital**. A copy will be sent to you and to the **physician**.

Certification for Convalescent Facility Admissions, Home Health Care, Hospice Care, and Skilled Nursing Care (This applies to Out-of-Network only)

If a person incurs Covered Medical Expenses:

- while confined in a **convalescent facility** or a **hospice facility**; or

- for a service or a supply for home health care or **hospice care** while not confined as an inpatient or skilled nursing care; and

it has not been certified that:

- such confinement or any day of it is **necessary**; or
- such other services or supplies (either specifically or as a part of a planned program of care) are **necessary**, and
- the confinement or service or supply has not been ordered or prescribed by:
  your **Primary Care Physician**; or
  a **Preferred Care Provider**;

such Covered Medical expenses will be paid only as follows:

- As to Convalescent Facility Expenses and Hospice Care Facility Expenses incurred while confined in a **convalescent facility** or a **hospice facility**:

  If certification has been requested and denied:
  No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.
  Benefits for all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:
  No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

  As to all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement:
  Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for all other such expenses will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:
  Convalescent Facility Expenses or Hospice Care Facility Expenses, incurred during the confinement, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for all other such expenses, incurred during the confinement, will be paid at the Payment Percentage.

  As to all other Covered Medical Expenses incurred during the confinement, benefits will be paid at the Payment Percentage.

- As to Covered Medical Expenses incurred for services or supplies either as stated or as a part of a planned program of care for home health care, **hospice care** while not confined as an inpatient, or skilled nursing care:

  If certification for a service or supply has been requested and denied or if certification has not been requested and the service or supply is not **necessary**, no benefits will be paid for the denied or unnecessary service or supply.

  If certification has not been requested for a service or supply and the service or supply is **necessary**, benefits for the **necessary** service or supply will be paid as follows:

  Expenses incurred for the service or supply, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for all other Covered Medical Expenses incurred for the service or supply will be paid at the Payment Percentage.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Program; except that:

- To the extent that a day of confinement has been certified, the exclusion of services and supplies because they are not **necessary** will not apply to:
  Convalescent Facility Expenses for room and board; or

  Hospice Care Facility Expenses for room and board.

- To the extent that such service or supply has been certified for home health care, **hospice care**, or skilled nursing care, the exclusion of services or supplies because they are not **necessary** will not apply to such service or supply.

To get certification you must call the number shown on your ID card. Such certification must be obtained before an expense is incurred.

If a person's **physician** believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you must call to certify more days of confinement or services or supplies. Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.

If:
- services and supplies for **hospice care** provided to a person have been certified; and
- the person later requires confinement in a **hospital** for pain control or acute symptom management;

any other certification requirement in this Program will be waived for any such day of confinement in a **hospital.**

Certification For Certain Procedures and Treatments

Certification of the necessity of certain Out-of-Network procedures and treatments is required:
before the procedure is performed; or
before the treatment starts; unless

such procedure or treatment has been ordered and prescribed by:

- your **Primary Care Physician**; or
- a **Preferred Care Provider**.

When any of the procedures or treatments shown below are to be performed on an inpatient or outpatient basis, Covered Medical Expenses incurred in connection with the performance of the procedure or treatment will be payable as follows:

- If the procedure or treatment is not **necessary**:
  No benefits will be payable whether or not certification has been requested.
- If certification has been requested and the procedure or treatment is **necessary**:
  Benefits will be payable at the Payment Percentage.
- If certification has not been requested and the procedure or treatment is **necessary**:
  Expenses incurred in connection with its performance, up to the Excluded Amount, will not be considered to be Covered Medical Expenses.

  Benefits for Covered Medical Expenses in excess of the Excluded Amount will be payable at the Payment Percentage.

List of Procedures and Treatments
The following procedures or treatments require certification before the procedure or treatment is performed. Even though the procedures or treatments are most often done on an outpatient basis, certification is required whether the procedure or treatment will be performed:

- on an inpatient basis; or
- on an outpatient basis.

Allergy Immunotherapy
Bunionectomy
Carpal Tunnel Surgery
Colonoscopy
Computerized Axial Tomography
(CAT Scan)-Spine
Coronary Angiography
Dilation/Curettage
Hemorrhoidectomy
Knee Arthroscopy
Laparoscopy (pelvic)
Magnetic Resonance Imaging (MRI)-Knee
Magnetic Resonance Imaging (MRI)-Spine
Septorhinoplasty
Tympanostomy Tube
Upper GI Endoscopy

You or the provider performing the procedure or treatment, must call the number shown on your ID card to request certification.

If the procedure or treatment is performed due to an **emergency condition**, the call must be made:

- before the procedure or treatment is performed; or
- not later than 48 hours after the procedure or treatment is performed; unless the call cannot be made within that time. In that case, the call must be made as soon as it is reasonably possible. In the event the procedure or treatment is performed on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.

If the procedure or treatment is performed for any condition other than an **emergency condition**, the call must be made at least 14 days before the date the procedure is to be performed or the treatment is to start. If it is not possible to make the call during the specified time, it must be made as soon as reasonably possible before the date the procedure or treatment is to be performed.

Written notice of the certification decision will be sent promptly to you and the provider performing the procedure or treatment. This decision will be valid for 60 days from the date you receive the notice. If the procedure or treatment is to be performed after this 60 day period, certification must again be requested, as described above.

Certification For Hospital and Treatment Facility Admissions for Alcoholism, Drug Abuse, or Mental Disorders

If, in connection with the treatment of alcoholism, drug abuse, or a **mental disorder**, a person incurs Covered Medical Expenses while confined in a **hospital** or **treatment facility**; and it has not been certified that such confinement (or any day of such confinement) is **necessary**; and

- the confinement has not been ordered and prescribed by:
  the BHCC; or

  a **Preferred Care Provider** upon referral by the BHCC:

Covered Medical Expenses incurred on any day not certified during the confinement will be paid only as follows:

With respect to expenses for **hospital** and **treatment facility** board and room:

If certification has been requested and denied, or if certification has not been requested and the confinement (or any day of it) is not **necessary**, no benefits will be paid.

If certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

With respect to all other **hospital** and **treatment facility** expenses:

If certification has been requested and denied, or if certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

If certification has not been requested and the confinement is not **necessary**, no benefits will be paid.

Whether or not a day of confinement is certified, no benefits will be payable for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Program; except that, if certification has been given for any day of confinement, the exclusions of services and supplies because they are not **necessary** will not be applied to **hospital** and **treatment facility** board and room.

To get the days certified, you must call the number shown on your ID card. Such certification must be obtained before confinement as a full-time inpatient, or in the case of an **emergency admission**, within 48 hours after the start of a confinement as a fulltime inpatient or as soon as reasonably possible.

If the person's **physician** believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified. This must be done no later than on the last day that has already been certified.

Treatment of Alcoholism, Drug Abuse, or Mental Disorders

Certain expenses for the treatment shown below are Covered Medical Expenses.

Inpatient Treatment

If a person is a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Hospital

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- **Effective treatment of alcoholism or drug abuse**.
- Treatment of **mental disorders**.

Treatment Facility

Certain expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered. The expenses covered are those for:

- Board and room. Not covered is any **charge** for daily **board and room** in a private room over the **semiprivate rate**.
- Other **necessary** services and supplies.

Calendar Year Maximum Benefit
A Special Inpatient Calendar Year Maximum Days applies to the **hospital** and **treatment facility** expenses described above.

Outpatient Treatment
If a person is not a full-time inpatient either:
- in a **hospital**; or
- in a **treatment facility**;
-

then the coverage is as shown below.

Expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered.

For such treatment given by a **hospital**, **treatment facility** or **physician**, benefits will not be payable for more than the Special Outpatient Calendar Year Maximum Visits in any one plan year.

Explanation of Some Important Program Provisions

Calendar Year Deductible
This is the amount of Covered Medical Expenses you pay each plan year before benefits are paid

Lifetime Maximum Benefit
Unlimited.

Routine Mammogram
Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred by a female age 40 or over for one mammogram each calendar year.

Routine Screening for Cancer
Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred for:
- a digital rectal exam and a prostate specific antigen (PSA) test for a male age 40 or over; and
- colorectal cancer screening for persons age 50 or over, for routine screening for cancer.

Mouth, Jaws and Teeth
Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:
- services rendered; and
- supplies needed;

for the following treatment of or related to conditions of the:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, "**physician**" includes a **dentist**.

Surgery needed to:
- Treat a fracture, dislocation, or wound.
- Cut out:
  teeth partly or completely impacted in the bone of the jaw;
  teeth that will not erupt through the gum;
  other teeth that cannot be removed without cutting into bone;

the roots of a tooth without removing the entire tooth;
cysts, tumors, or other diseased tissues.

- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, replace, restore or reposition:

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut

due to injury.

Any such teeth must have been:

- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the plan year of the accident or the next one.

If:

- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical Expenses include only charges for:

- the first denture or fixed bridgework to replace lost teeth;
- the first crown needed to repair each damaged tooth; and
- an in-mouth appliance used in the first course of **orthodontic treatment** after the injury.

Except as provided for injury, not included are charges:

- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- for root canal therapy;
- for routine tooth removal (not needing cutting of bone).

Not included are charges:

- to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures or bridgework;
- for non-surgical periodontal treatment;
- for dental cleaning, in-mouth scaling, planing or scraping;
- for myofunctional therapy; this is:
  muscle training therapy; or
  training to correct or control harmful habits.

General Exclusions

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.

- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.

- Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

  there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

  if required by the FDA, approval has not been granted for marketing; or

  a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

  the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

  However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

  the disease can be expected to cause death within one year, in the absence of effective treatment; and

  the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

  Also, this exclusion will not apply with respect to drugs that:

  have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

  are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

  if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.
- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for **custodial care**.

- Those for services and supplies:
  Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

  Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically listed as covered.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.
- Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically listed as covered.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Program.
- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
- Those for weight control services including: surgical procedures; medical treatments; weight control/loss programs; dietary regimens and supplements; appetite suppressants and other medications; food or food supplements; exercise programs; exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **morbid obesity**, or for the purpose of weight reduction**,** regardless of the existence of comorbid conditions. Certain surgical procedures may be covered subject to meeting the Aetnas selection criteria.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:
  Improve the function of a part of the body that:
  is not a tooth or structure that supports the teeth; and
  is malformed:
  as a result of a severe birth defect; including cleft lip, webbed fingers, or toes; or

  as a direct result of:
  disease; or
  surgery performed to treat a disease or injury.

  Repair an injury. Surgery must be performed:
  in the calendar year of the accident which causes the injury; or
  in the next calendar year.
- Those to the extent they are not **reasonable charges**, as determined by Aetna.
- Those for the reversal of a sterilization procedure.
- Those for a service or supply furnished by a **Preferred Care Provider** in excess of such provider's **Negotiated Charge** for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Effect of Benefits Under Other Plans

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   c. If there is not such a court decree:

      If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

      If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the

stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:
   The benefits of a plan which covers the person on whose expenses claim is based as a:

   - laid-off or retired employee; or
   - the dependent of such person;

   shall be determined after the benefits of any other plan which covers such person as:

   - an employee who is not laid-off or retired; or
   - a dependent of such person.

   If the other plan does not have a provision:

   - regarding laid-off or retired employees; and
   - as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

   The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

   If the other plan does not have a provision:

   - regarding right of continuation pursuant to federal or state law; and
   - as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses incurred in a calendar year will be reduced by all "other plan" benefits payable for those expenses. When the coordination of benefits rules of this Plan and an "other plan" both agree that this Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Effect On Benefits Of This Program

When this Program is secondary, the maximum benefits payable under this Program, when combined with benefits already paid by coordinating plans, will not be more than what this Program would have paid had it been the only plan responsible for coverage. In other words, the total benefits normally payable under this Program will be reduced by the amount of benefits paid by all other plans for the same services and supplies. Benefits payable under other plans include benefits that would have been payable had proper claim been made for them.

Right To Receive And Release Needed Information.
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this Program and other plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility Of Payment.
Any payment made under another Plan may include an amount which should have been paid under This Program. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under This Program. Aetna will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery.
If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Effect of Medicare

Health Expense Coverage under this Plan will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

  having refused it;

  having dropped it;

  having failed to make proper request for it.

These are the changes:

- The amount of "regular benefits" under a;; Health Expense Benefits will be figured. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount Medicare provides for the expenses involved, this Plan will pay the difference. Otherwise, this Plan will pay no benefits. This will be done for each claim.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

Subrogation and Right of Recovery Provision

Definitions

As used throughout this provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness, or condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a "Covered Person" includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation

Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness, or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury**,** illness, or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitutes such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury, or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that this plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for

the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The plan reserves the right to notify responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Exclusion

This plan does not cover services and supplies, in the opinion of the Claims Administrator or its authorized representative, that are associated with injuries, illness, or conditions suffered due to the acts or omissions of a third party.

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Program has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this Program may have with respect to such overpayment.

Reporting of Claims

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. Your Employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received.

All benefits are payable to Preferred Care Providers or to you. However, this Program has the right to pay any health benefits to the service provider.

This Program may pay up to $ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

Names of **physicians**, **dentists** and others who furnish services.
Dates expenses are incurred.
Copies of all bills and receipts.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Board and Room Charges

Charges made by an institution for board and room and other **necessary** services and supplies. They must be regularly made at a daily or weekly rate.

Body Mass Index:

This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand Name Drug

A **prescription drug** which is protected by trademark registration.

Companion

This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Custodial Care

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Directory

This is a listing of **Preferred Care Providers** in the **Service Area** covered under this Program. A current list of participating providers is available through Aetna's online provider directory, DocFind, at www.aetna.com.

Durable Medical and Surgical Equipment
This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:
- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

Effective Treatment of Alcoholism Or Drug Abuse
This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:
- has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:
- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

Emergency Admission
One where the **physician** admits the person to the **hospital** or **treatment facility** right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:
- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by Aetna,
  reasonably be expected to result in:
  placing the person's health in serious jeopardy; or
  serious impairment to bodily function; or
  serious dysfunction of a body part or organ; or
  in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Care
This means the treatment given in a **hospital's** emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Condition
This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Generic Drug
A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Home Health Care Agency
This is an agency that:
- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one **physician** and one **R.N.**; and
- has full-time supervision by a **physician** or a **R.N**.; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

Home Health Care Plan
This is a plan that provides for care and treatment of a disease or injury.
The care and treatment must be:
- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital** or **convalescent facility**.

Hospice Care
This is care given to a **terminally ill** person by or under arrangements with a **Hospice Care Agency**. The care must be part of a **Hospice Care Program**.

Hospice Care Agency
This is an agency or organization which:
- Has **Hospice Care** available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:
  skilled nursing services; and
  medical social services; and
  psychological and dietary counseling.
- Provides or arranges for other services which will include:
  services of a **physician**; and
  physical and occupational therapy; and
  part-time home health aide services which mainly consist of caring for **terminally ill** persons; and
  inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:
  one **physician**; and
  one **R.N.**; and
  one licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of **Hospice Care**.
- Assesses the patient's medical and social needs.
- Develops a **Hospice Care Program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program
This is a written plan of **Hospice Care**, which:
- Is established by and reviewed from time to time by:
  a **physician** attending the person; and

appropriate personnel of a **Hospice Care Agency**.

- Is designed to provide:
  palliative and supportive care to **terminally ill** persons; and
  supportive care to their families.
- Includes:
  an assessment of the person's medical and social needs; and
  a description of the care to be given to meet those needs.

Hospice Facility

This is a facility, or distinct part of one, which:

- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**; at least one such **physician** must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a **R.N.**
- Has a full-time administrator.

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

L.P.N.

This means a licensed practical nurse.

Mail Order Pharmacy

An establishment where **prescription drugs** are legally dispensed by mail.

Mental Disorder

This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

For the purposes of benefits under this Program, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

Morbid Obesity:

This means a **Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

NME Patient
This is a person who:
- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

Necessary
A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:
- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:
- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:
- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge
This is the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Program.

Non-Occupational Disease
A non-occupational disease is a disease that does not:
- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:
- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not:
- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

Non-Preferred Care
This is a health care service or supply furnished by a health care provider that is not **Preferred Care**.

Non-Preferred Care Provider
A health care provider that has not contracted to furnish services or supplies at a **Negotiated Charge**.

Non-Preferred Pharmacy
A **pharmacy** which is not party to a contract with Aetna, or a **pharmacy** which is party to such a contract but does not dispense **prescription drugs** in accordance with its terms.

Non-Specialist
A **physician** who is not a **specialist**.

Non-urgent Admission
One which is not an **emergency admission** or an **urgent admission**.

Orthodontic Treatment
This is any:
- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:
- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:
- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Pharmacy
An establishment where **prescription drugs** are legally dispensed.

Physician
This means a legally qualified physician.

Preferred Care
This is a health care service or supply furnished by:
- A person's **Primary Care Physician** or any other **Preferred Care Provider**.
- A **Non-Preferred Care Provider** on the referral of the person's **Primary Care Physician** and if approved by Aetna.
- Any health care provider for an **emergency condition** when travel to a **Preferred Care Provider** or referral by a person's **Primary Care Physician** prior to treatment is not feasible and
- A Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible.

Preferred Care is also care which is recommended and approved by the BHCC.

Preferred Care Provider
This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:
- the service or supply involved; and
- the class of employees of which you are member.

Preferred Pharmacy
A **pharmacy,** including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Program, but only:
- while the contract remains in effect; and
- while such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with Aetna.

Prescriber
Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order of a **prescriber** for a **prescription drug**. If it is an oral order, it must promptly be put in writing by the **pharmacy**.

Prescription Drugs
Any of the following:
- A drug, biological, compounded **prescription** or contraceptive device which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable contraceptive drug prescribed to be administered by a paid healthcare professional.
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.
- Disposable diabetic supplies.

Primary Care Physician
This is the **Preferred Care Provider** who is:
- selected by a person from the list of Primary Care Physicians in the **Directory**;
- responsible for the person's on-going health care; and
- shown on Aetna's records as the person's Primary Care Physician.

Psychiatric Physician
This is a **physician** who:
- specializes in psychiatry; or
- has the training or experience to do the required evaluation and treatment of mental illness.

R.N.
This means a registered nurse.

Reasonable Charge
Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:
- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:
- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:
- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the prevailing charge in other areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the reasonable charge is the rate established in such agreement.

Semiprivate Rate
This is the **charge** for **board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Service Area
This is the geographic area, as determined by Aetna in which **Preferred Care Providers** for this Program are located.

Specialist
A **physician** who:
practices in any generally accepted medical or surgical sub-specialty; and
is providing other than routine medical care.

A **physician** who:
practices in such a sub-specialty; and
is providing routine medical care (such as could be given by a **primary care physician**),
will not be considered a Specialist for purposes of applying this Program's provisions.

Surgery Center
This is a freestanding ambulatory surgical facility that:
- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  physicians who practice surgery in an area hospital; and
  dentists who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a **R.N.**
- Is equipped and has trained staff to handle medical emergencies.

- It must have:
  a **physician** trained in cardiopulmonary resuscitation; and
  a defibrillator; and
  a tracheotomy set; and
  a blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

Terminally Ill
This is a medical prognosis of 6 months or less to live.

Treatment Facility (Alcoholism Or Drug Abuse)
This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and **effective treatment of alcoholism or drug abuse**.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a **physician**.
- Provides, on the premises, 24 hours a day:
  Detoxification services needed with its effective treatment program.

  Infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical services that may be required.

  Supervision by a staff of **physicians**.

  Skilled nursing care by licensed nurses who are directed by a full-time **R.N.**

Treatment Facility (Mental Disorder)
This is an institution that:
- Mainly provides a program for the diagnosis, evaluation, and effective treatment of **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing care by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

Urgent Admission
One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider

This is:

- A freestanding medical facility which:
  Provides unscheduled medical services to treat an urgent condition if the person's **physician** is not reasonably available.

  Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.

  Makes charges.

  Is licensed and certified as required by any state or federal law or regulation.

  Keeps a medical record on each patient.

  Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.

  Is run by a staff of **physicians**. At least one **physician** must be on call at all times.

  Has a full-time administrator who is a licensed **physician**.

- A **physician's** office, but only one that:
  has contracted with Aetna to provide urgent care; and is, with Aetna's consent, included in the **Directory** as a Preferred Urgent Care Provider.

It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition

This means a sudden illness; injury; or condition; that:

- is severe enough to require prompt medical attention to avoid serious deterioration of the covered person's health;
- includes a condition which would subject the covered person to severe pain that could not be adequately managed without urgent care or treatment;
- does not require the level of care provided in the emergency room of a **hospital**; and
- requires immediate outpatient medical care that cannot be postponed until the covered person's **physician** becomes reasonably available.

Prescription Drug Expense Coverage

A prescription drug may not be covered unless it is medically necessary for the prevention or treatment of an illness or condition. The Schedule of Benefits outlines the Payment Percentages that apply to the Covered Prescription Drug Expenses described below.

This Program pays the benefits shown below for certain **prescription drug** expenses incurred for the treatment of a disease or injury. These benefits apply separately to each covered person.

If a **prescription drug** is dispensed by a **pharmacy** to a person for treatment of a disease or injury, a benefit will be paid, subject to the deductible and coinsurance shown in the Schedule of Benefits.

Benefit Amount

The benefit amount for each covered **prescription drug** or refill dispensed by a **preferred pharmacy** will be an amount equal to the Payment Percentage of the total charges. The total charge is determined by:

- the **preferred pharmacy**; and
- Aetna.

Any amount so determined will be paid to the **preferred pharmacy** on your behalf. The Benefit Amount for each covered **prescription drug** or refill dispensed by a **nonpreferred pharmacy** will be an amount equal to the Payment Percentage of the **nonpreferred pharmacy's** charge for the drug

Limitations

No benefits are paid under this section:

- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For more than a 34 day supply per prescription or refill. However, this limitation does not apply to a supply of up to 90 day per prescription or refill for drugs which are provided by a mail order pharmacy.
- For the administration or injection of any drug.
- For the following injectable drugs:
  - Fertility drugs
  - Allergy sera or extracts; and
  - Imitrex, if it is more than the 48th such kit or 96th such vial dispensed to the person in any year.

- For any refill of a drug that is more than the number of refills specified by the **prescriber**. Before recognizing charges, Aetna may require a new **prescription** or evidence as to need:
  - if the **prescriber** has not specified the number of refills; or
  - if the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.
- For any refill of a drug dispensed more than one year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Program or under any other medical or **prescription drug** expense benefit plan carried or sponsored by BNSF.
- For any drugs which do not, by federal or state law, require a prescription order (i.e. an over-the-counter (OTC) drug), even if a prescription is written.
- Any **Prescription Drug** for which there is an over-the-counter (OTC) product which has the same active ingredient and strength.
- For immunization agents.
- For biological sera and blood products.
- For nutritional supplements.
- For any fertility drugs, except oral fertility drugs up to a maximum of $2,500 per calendar year.
- For any smoking cessation aids or drugs.
- For **a prescription drug** dispensed by a mail **order pharmacy** that is not a **preferred pharmacy**

- For appetite suppressants.
- For more than 8 pills per month of performance enhancing/lifestyle drugs. Retail pharmacy only, no mail order.
    - This limitation applies to oral prescription drugs. For injectable, or topical (including, but not limited to, gels, creams, ointments and patches) forms normal plan limits apply.
- For Accutane, Retin-A and Renova if over age 26.

Claims Procedures

In general, health services and benefits must be medically necessary to be covered under the Medical Benefit Program. Medical necessity determinations are made on either a pre-service, concurrent, or post-service basis, as described below. Under Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Medical Benefit Program. The procedures described on pages 136-140 are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

The Company has delegated the discretionary authority to interpret BNSF Medical Program terms and to make both initial claim determinations and final claim review decisions on ERISA appeals to Aetna (Claims Administrator)**.** The BNSF Employee Benefits Committee retains the discretionary authority to determine whether you and/or your dependents are eligible to enroll for coverage and/or to continue coverage under Program terms.

Definitions

Claim--A claim is any request for a program benefit made in accordance with these claims procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures.

Claimant--As an individual covered by a Medical Benefit Program, you become a claimant when you make a request for a program benefit or benefits in accordance with these claims procedures.

Incorrectly Filed Claim--Any request for benefits that is not made in accordance with these claims procedures is considered an incorrectly filed claim.

Authorized Representative--Means an individual who has been identified in writing as the representative of an individual covered by a Medical Benefit Program and signed by the Claimant; however, in the case of a claim involving urgent care, a health care professional with knowledge of the Claimant's medical condition will be permitted to act as the Authorized Representative of the individual covered by the Medical Benefit Program. An Authorized Representative may act on behalf of a Claimant with respect to a benefit claim or appeal under these procedures. An assignment for purposes of payment does not constitute appointment of an Authorized Representative under these claims procedures. Unless the Claimant indicates otherwise in the authorization, all information and notifications regarding the claim will be sent to the Authorized Representative and not to the Claimant.

No individual may receive "protected health information" without the Program having received an "authorization" from the Claimant to the extent required by the Health Insurance Portability and Accountability Act of 1996, and its applicable regulations ("HIPAA").

Pre-Service Claim (pre-certification/ pre-authorization)--A claim is a pre-service claim if benefits under the Program are conditional on receiving approval in advance of obtaining the medical care.

Urgent Care Claim--A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods that otherwise apply (1) could seriously jeopardize the claimant's life or health or ability to regain maximum function or (2) would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. On receipt of a claim, the Claims Administrator will make a determination of whether it involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim will be treated as an urgent care claim. If the requested medical care has already been provided, the claim will be considered a post-service claim.

Concurrent Care Claims--A concurrent care decision occurs when the Benefit Program approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (1) where reconsideration of the approval results in a reduction or termination of the initially-approved period of time or number of treatments; and (2) where an extension is requested beyond the initially-approved period of time or number of treatments.

Post-Service Claim--A post-service claim is any claim for a benefit under this Benefit Program that is not a pre-service claim or an urgent care claim. Post-service claims are claims that involve only the payment or reimbursement of the cost for medical care that has already been provided.

How to File a Claim

*N*o claim forms are necessary when you or a dependent uses an Aetna network provider. However, at the start of each calendar year, the Claims Administrator may ask you to complete a claim form to update personal data.

If you or a dependent uses an out-of-network provider, you must submit a completed claim form before benefits can be paid. You may obtain a claim form from Aetna or from the Forms and Enrollment folder on the Benefits Intranet site at: http:// www.bnsfweb.bnsf.com/departments/hr/benefits/index.html.

Complete and sign the form and submit your claim to the Claims Administrator. When you submit your claim, include with it a copy of your medical bill showing the following:

• Employee's name and subscriber identification number with alpha prefix as shown on your identification card;

• Patient's full name;

• Nature of the sickness or injury;

• Type of service or supply furnished;

• Date or dates the service was rendered or the purchase was made;

• Itemized charges for each service or supply; and

• Provider of service with address and tax ID number.

You must submit separate claims for yourself and each of your covered dependents who have incurred medical expenses. Incomplete claim forms will not be processed.

All network and out-of-network claims must be filed no later than two (2) years after the date a service is received. Claims not filed within two (2) years from the date a service is received will not be eligible for payment under Program terms.

Timeframe for Deciding Initial Benefit Claims

Pre-Service Claims--Your benefit Program requires that you pre-certify for inpatient care, skilled nursing, coordinated home care and private duty nursing. The Claims Administrator will notify you or your representative of the determination within 15 days after receipt of the claim. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Administrator will notify you or your representative within 15 days after receiving the claim. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed and you or your representative must provide the specified information within 45 days after receiving the notice. The timeframe for deciding the claim will be suspended from the date the extension notice is sent until the date the missing necessary information is provided to the Claims Administrator.

Urgent Care Claim--The Claims Administrator will decide an initial urgent care claim within 72 hours after receiving the claim. However, if necessary information is missing from the request, you or your representative will be notified within 24 hours after receiving the claim to specify what information is needed. The specified information must be provided to the Claims Administrator within 48 hours after receiving the notice. The Claims Administrator will decide the claim within 48 hours after the receipt of the specified information.

Concurrent Care Claims--When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request the extension at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, the Claims Administrator will notify you or your representative of the determination within 24 hours after receiving the claim.

Post-Service Claim--The Claims Administrator will notify you or your representative of the determination within 30 days after receiving the claim. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Administrator will notify you or your representative within 30 days after receiving the claim. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed and you or your representative must provide the specified information within 45 days after receiving the notice. The timeframe for deciding the claim will be suspended from the date the extension notice is sent until the date the missing necessary information is provided to the Claims Administrator.

Notification of Initial Benefit Determination

Each time a claim is submitted, you or your representative will receive a written Explanation of Benefits form that will explain how much was paid towards the claim or whether the claim was denied, in whole or in part. If a claim is denied, in whole or in part, the Claims Administrator will give you or your representative a written notice of the denial and the reason for the denial. The Claim Denial Notice will include the following:

- explain the specific reason(s) for the denial;
- provide the specific reference to pertinent Medical Benefit Program provisions on which the denial was based;
- provide a description of any additional information necessary to reverse the denial, or in the case of an incomplete claim to perfect the claim;
- provide an explanation of the Medical Benefit Program's claim review procedures and applicable time limits; and
- if the Claims Administrator used or relied on internal guidelines, protocols, or other criteria, the letter will specify the criterion; and a copy of such rule, guideline, protocol or other criteria, and reasonable access to relevant documents, records and other information relevant to the Claim will be provided free of charge on request.

If Your Claim is Denied

The Medical Benefit Program is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA has special rules that must be followed when you or your representative chooses to appeal an adverse benefit decision (denied claim).

You have a right to appeal any claim denial, including any denial at the pre-service (pre-certification/ pre-authorization) level. It does not make any difference whether the denial is a complete denial or a partial denial. You or your representative should file a written request for appeal as soon as you receive a denial of benefits that you believe should be covered under the Medical Benefit Program but no later than **180** days from the date you receive notice that your claim has been denied. Failure to comply with this important deadline may cause you to forfeit any right to appeal the denial. If the claim is an Urgent Care Claim, you may appeal the decision and receive an expedited decision, please see below.

A person who did not make the initial decision shall decide your appeal. The review on appeal will not give any deference to the initial decision and will take into account all information submitted by you, regardless of whether it was submitted or considered in the initial decision.

Along with your written request for a review, you may submit any additional documents and written issues and comments you believe should be considered during the review. You should also include any clinical documentation from your physician that would substantiate coverage of the denied claim.

Upon request, you or your representative will be provided reasonable access to and copies of all documents, records and other information relevant to your claim, free of charge, including:

- information relied upon in making the benefit determination;
- information submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon in making the benefit determination;
- descriptions of the administrative processes and safeguards used in making the benefit determination;
- records of any independent reviews conducted by the Claims Administrator;
- if the claim was based on a medical judgment, including determinations about whether a particular service is experimental, investigational or not medically necessary or appropriate, an explanation of the scientific or clinical judgment for the decision applying the term of the Program, or an explanation for the denial; and
- expert advice and consultation obtained by the Claims Administrator in connection with your denied claim, whether or not the advice was relied upon in making the benefit determination.

Your request for an appeal should be addressed to:

Aetna Inc.
P.O. Box 14586
Lexington, KY 40512-4586

Timeframes for Deciding Benefits Appeals

Pre-Service Claims--The Claims Administrator will provide a written decision on the appeal of a pre-service claim within 30 days after receipt of the appeal.

Urgent Care Claims--The Claims Administrator will decide the appeal of an urgent care claim within 72 hours after receipt of the appeal.

Post-Service Claims--The Claims Administrator will decide the appeal of a post-service claim within 60 days after receipt of the appeal.

Concurrent Care Claims--The Claims Administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. Appeal of a denied request to extend a concurrent care decision will be decided in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

Notification of Decision on Appeal

The Claims Administrator will notify you, in writing, of its final decision and will include the following:

- the specific reasons for the appeal decision;
- a reference to the specific Medical Benefit Program provision(s) on which the decision was based;
- a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to or copies of all documents, records, and other information relevant to the determination (see prior page for a list of such documents); and
- a statement indicating entitlement to receive, upon request and without charge, a copy of any internal rule, guideline, protocol or similar criterion relied on in making the adverse decision regarding your appeal, and/or an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

The Claims Administrator's decision on appeal is final and binding. Benefits under this Program will be paid only if the Claims Administrator decides, in its sole discretion, that you are entitled to them. If you continue to disagree with the decision, you may exercise "Your Rights under ERISA" as explained on page 154 of this SPD.

Appeal for External Review

Aetna's external review process gives members the opportunity to have certain coverage denials reviewed by independent physician reviewers. An appeal will be eligible for external review if the following are satisfied:

- the standard levels of appeal have been exhausted,
- the appeal is made by the member or the member's authorized representative,
- the coverage denial is based on Aetna's determination that the proposed or rendered service or supply is not medically necessary or is experimental or investigational, and
- the cost of the service or supply at issue for which the member is financially responsible exceeds $ 500.

If upon the final standard level of appeal Aetna upholds the coverage denial and it is determined that the member is eligible for external review, the member will be informed in writing of the steps necessary to request an external review.

An independent review organization (IRO) refers the case for review by a neutral, independent physician with appropriate expertise in the area in question. Once all necessary information is submitted, the external review requests will generally be decided within 30 days of the request. Expedited reviews are available when a member's physician certifies that a delay in service would jeopardize the member's health. The decision of the independent external expert reviewer is binding on Aetna, the Company and the Health Plan. Members will not be charged a professional fee for the review.

When Coverage Ends

Coverage for you and your covered dependents will end on the *first to occur* of the following:

- The date you fail to pay the required contribution.

- The date the Pre-65 Retiree Medical Program is terminated by BNSF or by the BNSF affiliate that offers early Retiree medical coverage for all eligible early Retiree classes, or for the early Retiree class to which you belong.

- The date benefits paid to you equal the lifetime maximum benefit payable under the BNSF Pre-65 Retiree Medical Program. (Coverage for enrolled dependents who have not reached their lifetime maximum benefit will not be affected if your dependents continue to meet the Program's eligibility requirements.) Benefits paid on behalf of you, your spouse, or dependent child under the BNSF Medical Program for active salaried employees will count toward the lifetime maximum under this Program.

- The beginning of the month in which you reach age 65. When you reach age 65, your spouse and dependents under age 65 will continue to be covered under this Pre-65 Medical Program until the *first to occur* of the following:

    - For a spouse, the beginning of the month in which the spouse reaches age 65.

    - For a dependent child, the date the child no longer meets the Program's eligibility for dependent coverage. (Dependent eligibility is described on page 2 of the SPD.)

Continuation of Coverage Under COBRA

(Consolidated Omnibus Budget Reconciliation Act of 1985 as Amended)

This section contains important information about your covered dependent's right to COBRA continuation coverage, which is a temporary extension of coverage under the Pre-65 Retiree Medical Program. The information that follows generally explains COBRA continuation coverage, when it may become available to your family, and what you need to do to protect the right to receive it. The right to COBRA continuation was created by a federal law, the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA").

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of BNSF Medical Program coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Your eligible dependents could become qualified beneficiaries if coverage under the BNSF Medical Program is lost because of a qualifying event.

Eligibility

Your covered dependents will become eligible for COBRA continuation coverage after any of the following qualifying events result in the loss of Pre-65 Retiree Medical Program coverage:

- If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Pre-65 Retiree Medical Program because you and your spouse are legally separated or divorced resulting in your spouse losing coverage under the Pre-65 Retiree Medical Program; or

- Your dependent children will become qualified beneficiaries if they lose coverage under the Pre 65 Retiree Medical Program because your dependent child either marries or reaches the maximum age under the Pre-65 Retiree Medical Program and no longer qualifies for coverage under the Pre-65 Retiree Medical Program.

  For example: If your dependent child is a full-time student at an accredited college and the child reaches age 23 two years after your early retirement date, and you waived COBRA and elected coverage under the Pre-65 Retiree Medical Program, the child may elect 36 months of COBRA continuation from the date the child turns age 23.

Notification

The Pre-65 Retiree Medical Program will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator, Your Benefits Resources (YBR), has been notified that a qualifying event has occurred. If a qualifying event other than divorce, legal separation, loss of dependent status or entitlement to Medicare occurs, your employer will notify YBR of the qualifying event. YBR will send you an election form. To continue Pre-65 Retiree Medical Program coverage, you must return the election form within 60 days from the later of:

- The date you receive the form; or

- The date your coverage ends due to a qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse, a dependent child's losing eligibility for coverage as a dependent child, or entitlement to Medicare), you or your covered dependent must notify YBR's Customer Care Service by phone that a qualifying event has occurred. This notification must be received by YBR within 60 days after the later of:

- The date of such event; or
- The date your eligible dependent would lose coverage on account of such event.

YBR will send you an election form. To continue Pre-65 Retiree Medical Program coverage, you must return the election form within 60 days from the later of:

- The date you receive the form; or
- The date your coverage ends due to a qualifying event.

Failure to promptly notify YBR of these events will result in loss of the right to continue coverage for your dependents. After receiving this notice, YBR will send you an election form within 14 days. If your dependents wish to elect continuation coverage, the election form must be returned to YBR within 60 days from the later of:

- The date the form is received by the qualified beneficiary, or
- The date the qualified beneficiary's coverage ends due to the qualifying event.

Once YBR receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your spouse, and parents may elect COBRA continuation coverage on behalf of their children.

If you are eligible for trade adjustment assistance (TAA) pursuant to the Trade Act of 1974 and you did not elect continuation coverage within the initial 60-day election period, you may elect continuation coverage within 60 days of the first day of the month in which you become eligible for TAA, but no later than 6 months from the date health coverage is lost. If you elect continuation coverage during this second election period, your coverage will begin on the first day of the second election period, rather than the date health coverage is lost. The period between the loss of coverage and the beginning of the second election period does not count as a break in coverage for purposes of the coverage rules under HIPAA (as described in the section titled "Opting Out of Early Retiree Coverage" on page 4).

Cost

If your spouse or dependent elects to continue coverage, they must pay the entire cost of coverage (BNSF's contribution and the pre-65 retiree portion of the contribution), plus a 2% administrative fee for the duration of COBRA continuation.

For COBRA coverage to remain in effect, payment must be received by YBR by the first day of the month for which the payment is due, subject to a 30-day grace period. The first payment is due no later than 45 days after the election to continue coverage, and it must cover the period of time back to the first day of COBRA continuation coverage.

Duration

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is your death, your entitlement to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. If more than one qualifying event occurs, no more than 36 months of total COBRA continuation coverage will be available.

COBRA continuation coverage will be terminated even if the full COBRA continuation period has not ended on the first to occur of the following:

- The COBRA beneficiary fails to make the required contributions when due.
- The COBRA beneficiary first becomes entitled to Medicare benefits after the initial COBRA qualifying event; or
- BNSF terminates the Pre-65 Retiree Medical Program and does not maintain any other group health program for eligible employees or retirees.

If You Have Questions

Questions concerning the Pre-65 Retiree Medical Program or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Pre-65 Retiree Medical Program Informed of Address Changes

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator. You can contact the COBRA Administrator at the below address:

Your Benefits Resources
2300 Discovery Lane
Orlando, Florida 32826
Phone: 1-877-847-2436

Coordination of Benefits

The following Program rules on coordination of benefits with group health plans other than Medicare will apply to non-Medicare entitled early Retires, their spouses and dependent children covered under the Pre-65 Retiree Medical Program.

The Pre-65 Retiree Medical Program provides for coordination of benefits when medical expenses incurred by you or your covered dependents are covered by a governmental program other than Medicare or Medicaid; automobile no-fault coverage; group, blanket or franchise insurance coverage, including student coverage; the California Unemployment Insurance Code; service plan contracts; group or individual practice or other pre-payment plans; or coverage under a labor-management trusteed plan, union welfare plan or any type of employer-sponsored plan.

Coverage under an individual policy or contract is not included. Each plan or part of a plan that has the right to coordinate benefits is treated as a separate plan. This coordination of benefits provision ensures that the total benefits available to you will not exceed 100% of the allowable expenses. An "allowable expense" is any medically necessary, reasonable and customary medical expense for which you or your dependents are covered under at least one medical plan. When benefits from a plan are in the form of services, not cash payments, the reasonable cash value of the service will be used to coordinate benefits. An allowable expense does not include the difference between the cost of a private and semiprivate room, except while the person's stay in a private room is medically necessary.

If benefits are payable under more than one group plan, the maximum benefits payable under this Program, when combined with benefits already paid by coordinating plans, will not be more than what this Program would have paid had it been the only plan responsible for coverage. In other words, the total benefits normally payable under this Program will be reduced by the amount of benefits paid by all other plans for the same services and supplies. Benefits payable under other plans include benefits that would have been payable had proper claim been made for them.

When you are covered under more than one group plan, the plan that pays your benefits first, without regard to any other plan, is called the primary plan. If this Program is the primary plan for you or your covered dependents, your medical expenses will be covered under this Program first. If this Program is the secondary plan for you or your covered dependents, this Program will cover eligible expenses that are not covered under your primary plan. In no event will this Program, if it is your secondary plan, exceed the amount of benefits that would be payable to you if this were your primary plan.

For purposes of this coordination in benefits provision, an "allowable expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan covering a person provides benefits in the form of services (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans covering the person is not an allowable expense.

A plan without a coordinating provision is always the primary plan. If all plans have a coordinating provision:

- The plan covering the eligible person directly, rather than as a dependent, is primary and the others secondary.

- If a child is covered under both parents' plans, the plan of the parent whose birthday occurs earlier during the calendar year is primary. If both parents have the same birthday, the plan covering the

parent longer is primary. When the parents are separated or divorced, their plans pay in the following order:

– The plan of the parent with custody of the child.

– The plan of the spouse of the parent with custody of the child.

– The plan of the parent not having custody of the child.

However, if the terms of a court decree have established financial responsibility for the child's health care expenses, the benefits of that plan are determined first.

If none of the above applies, the plan covering the patient longest is primary. When this Pre-65 Retiree Medical Program is the secondary plan, its payment is reduced to coordinate with the primary plan's benefits.

The plan that covers the person as an active employee, or as a dependent of an active employee, pays before the plan that covers an individual as a laid-off or retired employee or such employee's dependent. If the other plan does not have this same rule, then this rule will not apply if the result is that each plan determines its benefits after the other.

Special Rules for Medicare Entitled Dependents

If your spouse or dependent is entitled to Medicare due to disability, when you take early retirement, the Pre-65 Medical Program will coordinate with Medicare for their coverage.

The Pre-65 Retiree Program will pay benefits after Medicare makes its payment. Your spouse or dependent must submit a Medicare Explanation of Benefits (EOB) with a claim for benefits under the Pre-65 Retiree Program. Then the Pre-65 Retiree Program will calculate the Program benefits. The Medicare EOB amount will be offset against what the Pre-65 Retiree Program would pay if there were no payments from Medicare. This is called coordination of benefits with Medicare. This coordination will occur even if your spouse or dependent does not apply for Medicare when eligible. If there is no Medicare EOB to submit because your spouse or dependent has not applied for Medicare when eligible, the Pre-65 Retiree Medical Program will make a determination as to what Medicare would pay if your spouse or dependent were covered under Medicare. It is important for your spouse or dependent to apply for Medicare if Social Security disabled and Medicare entitled when first eligible.

Cost of Pre-65 Retiree Coverage

BNSF shares in the cost of your coverage. The actual cost of coverage may change from year to year depending on the overall experience of the Pre-65 Retiree Medical Program. BNSF reserves the right to change the percentages you are required to contribute for Pre-65 Medical Program coverage. There is no guarantee the percentage of your contribution or the actual cost of your coverage will remain the same from year to year. You will be notified of any changes prior to their effective date.

General Information Affecting Your Right to BNSF Pre-65 Retiree Medical Program Benefits

Your Provider Relationships

The choice of a health care provider, whether in-network or out-of-network, is solely your choice and BCBS will not interfere with your relationship with any health care provider.

BCBS does not furnish health care services. It provides access to discounted or rate negotiated network health care services and it makes payments to health care providers for covered services under the Program which you receive. BCBS is not liable for any act or omission of any network provider or the agent or employee of any network provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a health care provider are not provided by BCBS. Any contractual relationship between BCBS and a health care provider in the network is not a contract for providing services. It is a contract for discounted or negotiated rates intended to reduce the overall cost of services for those persons electing to use a network health care provider.

Recovery of Overpayments

If you or a Program beneficiary should receive a benefit payment from this Program in excess of the payment that should have been received, the Claims Administrator has the right to recover the amount of the overpayment. In addition, if the overpayment is not returned, the Claims Administrator reserves the right to deduct the overpayment from future Pre-65 Retiree Medical Program benefits payable to you if the overpayment was made to you. If the overpayment was made to any other beneficiary under the Program, the excess payment may be deducted from future Pre-65 Retiree Medical Program benefits payable to that beneficiary.

No Assignment of Benefits

The Program will not prevent a medical care provider from receiving payment for eligible charges for covered services if there is a valid assignment of benefits. The Program Administrator has the discretionary authority to determine whether an assignment of benefits to a medical provider is valid. You may not commit benefits payable to you to pay your personal debts or other obligations that are not otherwise covered under a valid assignment of Program benefits. You may not sell any right or interest you or a covered dependent may have in any benefit under this Program.

Right to Information

You must provide the Program Administrator and the Claims Administrator with any information they consider necessary to administer the Program. If the information you give on an enrollment form or claim application is wrong, or if you omit important information, your Program coverage may be canceled or your claim may be denied. If your address should change, or if a spouse's or dependent child's address should change, you must notify the Company and YBR immediately.

No Guarantee of Benefit

Participation in this Program does not guarantee your right to any benefit under the Program.

Amendment or Termination of Program

The Pre-65 Retiree Medical Program, including all or some of the Program options available for Pre-65 Retiree election, may be amended or terminated by BNSF at any time and for any reason. BNSF reserves the right to amend, modify or terminate the Program, including any benefits offered under one or more of the available Program options. BNSF does not guarantee that Pre-65 retirees will always have access to a particular Program option, even though the Program option may be available to active employees of BNSF. BNSF also reserves the right to amend eligibility rules, and the method of determining Pre-65 retiree contributions. There are no vested rights under the Pre-65 Retiree Medical Program and any right to benefits is limited to claims incurred before the first to occur of the following events:

- Amendment of the Pre-65 Retiree Medical Program.
- Termination of the Pre-65 Retiree Medical Program.
- Expiration of the period that claims can be accepted by the Claims Administrator.
- Failure to pay the cost of coverage under the Program.
- Any dependent covered under the Program, no longer meeting the eligibility requirements under the Program.
- Any Retiree, spouse or dependent covered under the Program, meeting the Program's lifetime maximum.
- Any other event listed under the section of the SPD entitled "When Coverage Ends".

Right of Reimbursement

This Program has a right to recovery for the following health care expenses:

• Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your covered dependent(s).

• Expenses to the extent they are covered under the terms of any automobile medical; automobile no-fault; uninsured or underinsured motorist; Workers' Compensation; government insurance (other than Medicaid); or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your covered dependent(s).

If you or a covered dependent incurs health care expenses as described above, the Claims Administrator will automatically have a lien on the proceeds of any recovery by you or your dependent(s) from such party to the extent of any benefits provided to you or your dependent(s) by the Program. You or your dependent(s) or their representative shall execute such documents as may be required to secure the right of the Program to reimbursement. The Program must be reimbursed for the lesser of the following amounts:

• The amount actually paid by the Program; or

• The amount actually received from the third party at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or otherwise.

Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 and its applicable regulations (HIPAA) is a federal law that, in part, requires group health plans, like the Burlington Northern Santa Fe Group

Medical Program for Burlington Northern Pre-65 Retirees to protect the privacy and security of your confidential health information. As an employee welfare benefit plan under ERISA, the Program is subject to the HIPAA privacy rules. Pursuant to the HIPAA privacy rules, the Program will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, program administration or as required or permitted by law. A description of the Program's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the Notice of Privacy Practices, which will be furnished to you and can also be accessed on the BNSF intranet site at http://bnsfweb.bnsf.com/departments/hr/index.html. You can also receive a copy of the Notice of Privacy Practices by contacting the BNSF Privacy Official, P.O. Box 961055, Fort Worth, Texas 76161, (Phone) 800-234-1283.

Administrative Information

Program Costs

Pre-65 Retiree Medical Program benefits and administrative costs are paid from a tax-qualified Internal Revenue Code Section 501(c)(9) trust, commonly referred to as a VEBA. Employer contributions and pre-65 Retiree contributions are deposited in the VEBA. Benefits for the Burlington Northern Pre-65 Retiree Medical Program are self-insured by BNSF.

Program Name and Program Number

The Pre-65 Retiree Medical Program is made available under the Burlington Northern Santa Fe Corporation Group Medical Program. The Pre-65 Retiree Medical Program is a participating Program in the Burlington Northern Santa Fe Group Benefits Plan, a consolidated welfare benefits program under ERISA that files its annual returns under Plan Number 501.

Company and Employer

The terms "BNSF", "Company" and "Employer" as used in this SPD refer to Burlington Northern Santa Fe Corporation, or an affiliate of BNSF whose retirees are eligible to participate in the Pre-65 Retiree Medical Program.

Company Name and Identification Number

The Pre-65 Retiree Medical Program is sponsored by Burlington Northern Santa Fe Corporation, Employer Identification Number 41-1804964.

Program Administrator and Agent for Service of Legal Process

The Pre-65 Retiree Medical Program Administrator's name, address and telephone number are as follows:

Employee Benefits Committee
c/o BNSF Railway Company
2500 Lou Menk Drive
Fort Worth, Texas 76131
800-234-1283

The agent for service of legal process is:

Mr. Jeffrey R. Moreland
Executive Vice President Law & Government Affairs and Secretary
2500 Lou Menk Drive
Fort Worth, Texas 76131

The Burlington Northern Santa Fe Employee Benefits Committee (the "Committee") is the Program Administrator. The Program Administrator has delegated the discretionary authority to interpret Program provisions relating to the payment of benefits to BCBS or Aetna for both initial claims processing and for ERISA appeals requested in writing by Program participants and beneficiaries. The Committee retains the discretionary authority to determine whether a Retiree or dependent is eligible for initial or continued enrollment in the Program. The discretionary authority delegated to the Claims Administrator includes the authority to interpret the provisions of the Program for purposes of resolving any inconsistency or ambiguity, correcting any error, or supplying information to correct any omission.

Claims Administrator for the BNSF Pre-65 Retiree Medical Program

BCBS PPO Base and BYO Options (including out-of-network claims)

The Claims Administrator for the Pre-65 Retiree Medical Program is:

Blue Cross and Blue Shield of Illinois
Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690
Phone: 888-399-5945

Claim Appeal Coordinator for Mental Health and Substance Abuse is:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Health Care Service Corporation
Mental Health Unit
P.O. Box 2307
Chicago, Illinois 60690-2307
Phone: 1-800-851-7498

Aetna EPO and BYO Options

The Claims Administrator for the Pre-65 Retiree Medical Program is:

Aetna
P.O. Box 14586
Lexington, KY 40512-4586
Phone: 800-826-2386

Claims Administrator for the Outpatient Prescription Drug Benefit

Caremark, Inc.
2211 Sanders Road
Northbrook, IL 60062

Named Fiduciary

Blue Cross and Blue Shield is the Named Fiduciary under ERISA for all ERISA appeals regarding Program benefit matters. The BNSF Employee Benefits Committee retains the discretionary authority to determine eligibility and enrollment rights under the Pre-65 Retiree Medical Program.

COBRA Administrator

Your Benefits Resources
2300 Discovery Lane
Orlando, Florida 32826
Phone: 1-877-847-2436

Program Year

The Program Year is the calendar year.

Your Rights Under ERISA

As a participant in the BNSF Pre-65 Retiree Medical Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Pre-65 Retiree Medical Program participants will be entitled to:

Receive Information About Your Pre-65 Retiree Medical Program Benefits

- Examine, without charge, at the Program Administrator's office and other locations, such as worksites and union halls, all documents governing the Pre-65 Retiree Medical Program, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Program with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon, written request to the Program Administrator, copies of documents governing the operation of the Program, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) an updated summary plan description. The Program Administrator may make a reasonable charge for the copies.

- Receive a summary of the Program's annual financial report. The Program Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Pre-65 Retiree Medical Program Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Pre-65 Retiree Medical Program as a result of a COBRA qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Pre-65 Retiree Medical Program for the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods, if any, for coverage for preexisting conditions under your group health coverage, if you have creditable coverage from another health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment in some group health plans.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Program participants, ERISA imposes duties upon the people who are responsible for the operation of this Pre-65 Retiree Medical Program. The people who operate the Pre-65 Retiree Medical Program, called *fiduciaries* of the Program, have a duty to do so prudently and in the interest of you and other Program participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all

within certain time schedules. After completion of the appeal process (see page 136) you have the right to bring a civil action under ERISA Section 502(a).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Program Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Program Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Program Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the Program's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that Program fiduciaries misuse the Program's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — for example, if it finds your claim is frivolous.

You and the Program may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Assistance With Your Questions

If you have any questions about the Program, you should contact the Program Administrator.

If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Program Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The next page lists the EBSA area offices.

Offices of the Employee Benefits Security Administration
U.S. Department of Labor

Atlanta Regional Office
61 Forsyth Street, S.W.
Suite 7B54
Atlanta, GA 30303
Phone: 404/562-2156

Boston Regional Office
One Bowdoin Square
7th Floor
Boston, MA 02114
Phone: 617/424-4950

Chicago Regional Office
200 W. Adams Street
Suite 1600
Chicago, IL 60606
Phone: 312/353-0900

Cincinnati Regional Office
1885 Dixie Highway
Suite 210
Ft. Wright, KY 41011-2664
Phone: 606/578-4680

Dallas Regional Office
525 Griffin Street
Room 707
Dallas, TX 75202-5025
Phone: 214/767-6831

Detroit District Office
211 W. Fort Street
Suite 1310
Detroit, MI 48226-3211
Phone: 313/226-7450

Kansas City Regional Office
City Center Square
1100 Main
Suite 1200
Kansas City, MO 64105-2112
Phone: 816/426-5131

Los Angeles Regional Office
790 E. Colorado Boulevard
Suite 514
Pasadena, CA 91101
Phone: 818/583-7862

Miami District Office
111 N.W. 183rd Street
Suite 504
Miami, FL 33169
Phone: 305/651-6464

New York Regional Office
1633 Broadway, Room 226
New York, NY 10019
Phone: 212/399-5191

Philadelphia Regional Office
Gateway Building
3535 Market Street
Room M300
Philadelphia, PA 19104
Phone: 215/596-1134

St. Louis District Office
815 Olive Street
Room 338
St. Louis, MO 63101-1559
Phone: 314/539-2691

San Francisco Regional Office
71 Stevenson Street
Suite 915
P.O. Box 190250
San Francisco, CA 94119-0250
Phone: 415/975-4600

Seattle District Office
1111 Third Avenue
Suite 860
MIDCOM Tower
Seattle, WA 98101-3212
Phone: 206/553-4244

Washington, D.C. District Office
1730 K Street, N.W.
Suite 556
Washington, DC 20006
Phone: 202/254-7013

Who to Call About Your Benefits

For questions regarding the enrollment process or your Pre-65 Retiree benefits, call YBR Customer Care Representative at 1-877-847-2436.

For questions regarding the services under the BCBS option, call Member Services at 1-888-399-5945.

This SPD is only a summary of the BNSF BCBS PPO option under the Program. It does not constitute a contract. The Pre-65 Retiree Medical Program has been established under a plan document. If there are any differences between this SPD and the plan document, the plan document will control.