Burlington Northern Santa Fe Retiree Medical Program Post 65 CIGNA Indemnity Medical plus Prescription Drug Program

Summary Plan Description

Effective January 1, 2006

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BNSF Retiree Post 65 CIGNA Indemnity Medical and Prescription Drug Program

The Santa Fe Pacific Retiree Medical Program for eligible Santa Fe Pacific Retirees age 65 and over (the "Post-65 Retiree Medical Program") offers you protection against the financial burden an illness or injury can create. The Post-65 Retiree Medical Program allows you to choose the Medical Program option and coverage level that best meet your coverage needs.

Depending on your location, Medical Program options from which you can choose include:

- The Post-65 CIGNA Indemnity Medical Only option for Santa Fe Pacific Retirees (Indemnity Medical Only); or

- The Post-65 CIGNA Indemnity Medical and Prescription Drug option for Santa Fe Pacific Retirees (Indemnity Medical plus Rx); or

- A (BNSF sponsored) Medicare Health Maintenance Organization (HMO), when available in the area where you live. "BNSF sponsored" means BNSF contributes toward the cost of coverage while you participate in the Post-65 Retiree Medical Program.

You may also elect to opt out of the Post-65 Retiree Medical Program, which is an election to waive Medical Program coverage for yourself and any dependents. If you opt out of the Post-65 Retiree Medical Program, you may not be able to re-enroll. Once you opt out of medical coverage, you cannot re-enroll at any time unless you meet the special circumstances for re-enrollment described under the HIPAA Special Enrollment Rules on page 6 of this summary booklet.

Of course, you may opt out of the BNSF Post-65 Retiree Medical Program because you are enrolled in a Medicare HMO (called Medicare Part C). You will be responsible for paying the full cost of Medicare Part C HMO coverage. BNSF will no longer contribute toward the cost of the Medicare HMO coverage under the BNSF Program.

Coverage level options in the Post-65 Retiree Medical Program from which you can choose include:

- Retiree only; and

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

Generally, you are required to enroll your spouse and dependent children in the same Post-65 Retiree Medical Program option in which you are enrolled. If you enroll in either the Indemnity Medical Only option or the Medical plus Rx option and elect coverage for dependents, your dependents ***under age 65*** will be enrolled in the CIGNA PPO option.

When making your Post-65 Retiree Medical Program coverage decisions, you should consider your health and the health of your dependents you want to enroll.

If you decide to enroll in the Post-65 Retiree Medical Program, the Company will share the cost of coverage. You will be responsible for paying your share of the cost of coverage on a monthly basis. Your monthly payments 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.

This Summary Plan Description (SPD) covers benefits available through the Post-65 Retiree CIGNA Indemnity Medical and Prescription Drug Program option only. Post-65 Retiree CIGNA Indemnity Medical Only Program benefit information is provided in a separate SPD. CIGNA PPO option benefit information for dependents under age 65 is provided in a separate SPD. Please refer to the SPD for the "Pre-65 Retiree Program" for benefit information on the CIGNA PPO. Medicare HMO coverage and benefit information is provided in separate HMO membership booklets.

If you elect either of the the Post-65 Retiree Indemnity options you have special rights under ERISA as described in the section of this SPD titled “Your Rights Under ERISA”. If you elect a BNSF sponsored Medicare HMO, you will have ERISA rights under the Post-65 Retiree Medical Program to the extent that there are questions regarding your eligibility for Post-65 Retiree Medical Program coverage, your contributions toward coverage, or any other rights under the Post-65 Retiree Medical Program that are not directly Medicare-benefit related. Medicare rules will apply to your participation in a Medicare HMO. The Medicare HMO will not coordinate benefits with the Post-65 Retiree Indemnity option.

Eligibility and Enrollment

Your Eligibility for Post-65 Retiree Coverage

You are eligible to enroll for Post 65 Retiree coverage if you meet the eligibility requirements for the Santa Fe Pacific Retiree Medical Program. You must have been a full-time regularly assigned active salaried employee of Santa Fe Pacific Corporation or its affiliates participating in the Program prior to September 22, 1995, and remained in a salaried position continuously up to your actual retirement date. If you retired prior to reaching age 65, you must have elected and maintained your coverage under the BNSF Pre-65 Retiree Medical Program until you reached age 65. In addition, you must meet all of the following requirements.

- Your retirement is from service with Santa Fe Pacific Corporation, its successor or its affiliates;
- If you retire after June 1, 1994 you have 10 or more years of service with the Company after reaching age 45;
- On your retirement 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 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 Post-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 Post-65 Retiree Medical Program include:

- Your legal spouse, unless you are legally separated or divorced.
- Your unmarried children under age 19 (or 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, your legally adopted children, children placed with you or your spouse 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 (for grandchildren, a parent-child relationship does not exist if the child's natural parent lives in the same home).

- A child on whose behalf you are subject to 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 Your Benefits Resources (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. 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 Post-65 Retiree Medical Program's maximum age. To be eligible for continued coverage, the child must legally reside with you, must be incapable of self-sustaining employment, must be unmarried, and must be primarily dependent on you for financial support. To continue coverage for a disabled child, you must provide the Claims Administrator 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. If your disabled dependent child is covered by Medicare, all of the Medicare rules that apply to Post-65 Retiree Medical Program coverage in this summary booklet will apply to your Medicare-covered disabled dependent child.

At the time of your death, your eligible dependents may elect to continue coverage by continuing to pay the applicable premium. Your dependents other than your spouse may elect to continue coverage until they become covered by another health care plan (other than Medicare) or otherwise become ineligible (e.g., no longer meet the age requirement for coverage). Your spouse may elect to continue coverage until he or she becomes covered by another health plan (other than Medicare).

Enrollment

You must enroll within 31 days after the date you first become eligible for coverage under the Post-65 Retiree Medical Program. Your enrollment elections will remain in place for the calendar year in which

you enroll. You are allowed to change enrollment elections during the year ***only*** if you have an eligible Family Status Event as described on page 5.

When you enroll in the Post-65 Retiree Medical Program, you will be advised of the cost of coverage. From time to time, BNSF reviews the cost of the various Retiree Medical Program options. You will be notified of any changes in the cost of coverage within a reasonable period of time prior to the date of the change.

Electing the Opt-Out Option

If you choose to opt out of Post-65 Retiree Medical Program coverage, you want to think about having other group medical coverage in place to cover your spouse or dependents who are not Medicare entitled at the time you opt out. Since you must be age 65 to be eligible for coverage under the Post-65 Retiree Medical Program, you will have enrolled in Medicare. However, your spouse and your dependents may need to seek other health insurance coverage if you opt out. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows a person 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 a person has a break in coverage that is greater than 62 days, he or she may not be able to carry over credit for any prior medical coverage to any new medical coverage.

Although the Post-65 Retiree Medical Program does not have a pre-existing condition exclusion period, you should still become familiar with HIPAA's coverage credit carryover rules for your spouse and your dependent children who are under age 65. At some future date, your spouse or child may want to purchase medical coverage that does have a pre-existing condition exclusion period.

Changing Your Election During the Year

If you are enrolled in the Post-65 Retiree Medical Program, you cannot change your coverage election during the calendar year unless one of the following eligible Family Status Events should occur:

- Your marriage, legal separation, divorce, or annulment;
- The birth, placement for adoption with you, or adoption by you of a child;
- The death of a dependent (including your spouse);
- Loss of spouse or dependent coverage under another group health plan for a reason other than failure to pay premium;
- Service of a Qualified Medical Child Support Order (QMCSO) issued under ERISA Section 609, as approved by the Program Administrator;
- A significant change in your spouse's group medical coverage, as determined by the Program Administrator;
- A dependent satisfies or ceases to satisfy eligibility requirements; or
- A change in residence, but only if your current option is not available in your new location.

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**. For example, your marriage allows you to enroll your new spouse but does not allow you to change from an HMO option to the Indemnity option.

HIPAA Special Enrollment Rules

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

- You waive Post-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 Post-65 Retiree medical coverage.

Giving Notice of a Family Status Event

If you have a Family Status Event, or if you want to enroll under the HIPAA rules, you can log on to YBR's web site at www.ybr.com/benefits. If you prefer to use the phone, you can use the YBR Resource Line by dialing 1-877-847-2436. Except as noted below (under "Effective Date of Revised Coverage"), if you do not request the change within 31 days of the event, you will not be allowed to make any changes until the next Annual Enrollment period 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.

Benefit Changes Due to Relocation

If you originally elected BNSF sponsored Medicare HMO coverage and later relocate outside the HMO service area, you can change your Post-65 Retiree Medical Program election to one of the Post-65 Retiree

Indemnity options within 31 days after the date of your relocation. You may not change your coverage level election until the next Annual Enrollment unless you have a Family Status Event as described above under "Changing Your Election During the Year."

You also may change your Post-65 Retiree Medical Program election if the Medicare HMO you chose closes its service office in your location or significantly reduces its coverage. You should know that a change in professional staffing within a Medicare HMO does not constitute a significant reduction in coverage, even though you might be required to change primary care physicians.

If you do not request a change within 31 days of one of these events, you will have to wait until Annual Enrollment to change your coverage under the Post-65 Retiree Medical Program.

Special Circumstances for Re-Enrollment In Post-65 Retiree Medical Program

If you find a Medicare HMO in your area that is not part of the Santa Fe Pacific Post-65 Retiree Medical Program, you can try it independently. However, BNSF will not contribute toward the cost of that coverage because it is not a BNSF sponsored Medicare HMO. If you do not like the new plan, you can switch back to the Santa Fe Pacific Post-65 Retiree Medical Program effective with the next Annual Enrollment. Before you make a change back to this Retiree Medical Program, be certain you have first enrolled in Medicare Parts A and B. Medicare has special rules for changing from Medicare HMO coverage (called Medicare Part C coverage) to Medicare Part A and B coverage. The Post-65 Retiree Indemnity Program always calculates its benefit assuming Medicare has paid first, even when you or a Medicare eligible dependent has failed to properly enroll in Medicare.

Post-65 Retiree CIGNA Indemnity Medical and Prescription Drug Program

The Post-65 Retiree CIGNA Indemnity Medical and Prescription Drug Program option requires that you pay a calendar year deductible and a percentage of expenses (coinsurance), but includes out-of-pocket limits. The Program has a $1,000,000 lifetime benefit limit for each covered person. This limit is cumulative from your active and Pre-65 Retiree Medical Program coverage. For example, if you received $100,000 in benefits while covered under the active Medical Program, and $25,000 while covered under the Pre-65 Retiree Program, you have a remaining lifetime limit of $875,000 under the Post-65 Retiree Indemnity Program option.

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. The Summary of Benefits appears below. Certain limits also apply to specific benefits.

Post-65 CIGNA Indemnity Medical and Prescription Drug Program Summary of Benefits	
	Summary of Benefits ($1,000,000 Lifetime Benefit Limit)
Calendar-year deductible Individual Family Maximum	 $250 per person $500 per family
Calendar-year out-of-pocket maximum (excludes deductible) Individual Family	 $1,250 per person $2,500 per family
Preventive care	Program pays 100%, no deductible (up to $250 per covered person)
Routine mammogram	Program pays 100%
Outpatient short-term rehabilitation* Chiropractic therapy Physical therapy Speech therapy Occupational therapy	Program pays 80% after deductible is met, then 100% after out-of-pocket maximum is met. Subject to treatment limits.*
All other covered charges	Program pays 80% after deductible is met, then 100% after out-of-pocket maximum is met

*There is a 60-calendar-day limit per condition for outpatient rehabilitation. Chiropractic therapy will be reviewed for medical necessity on the 35th visit.

Understanding Deductibles and Coinsurance

Certain rules apply to deductibles and coinsurance payments for the Medical and Rx Indemnity Program option. It is important that you understand how the rules apply. You and your covered dependent(s) must pay part of the expenses for services and supplies received. The Program includes a deductible, coinsurance and out-of-pocket limits.

Calendar-year deductibles are separate from coinsurance payments. The Medical and Rx Indemnity Program has both individual and maximum family deductibles. Before the Program will pay any benefits, you must meet its deductible. A *deductible* is money you must spend each calendar year for eligible expenses before the Program pays benefits. The deductibles are shown in the Summary of Benefits chart on page 8. The deductible does not include any deductible that must be paid under Medicare. You are responsible for paying Medicare deductibles, as well as the required Post-65 Indemnity Program deductible. However, the Medicare deductible will be counted toward the Indemnity Program deductible.

After you meet your deductible the Indemnity Medical plus Rx Program pays a portion of your expenses up to your calendar-year out-of-pocket expense maximums. *Out-of-pocket expenses* are covered expenses incurred for charges made by providers that the covered person must pay. Out-of-pocket expenses do not include any prescription copayments. You are responsible for the out-of-pocket expenses under the Indemnity Medical plus Rx Program, in addition to the Medicare coinsurance or copayment you are required to pay. However, Medicare coinsurance or copayment amounts will be counted toward the Program out-of-pocket expense maximums.

There are calendar-year **individual and aggregate family out-of-pocket maximums** under this Program. Once a covered person reaches the out-of-pocket maximum, Indemnity Medical plus Rx Program calculates eligible benefits at 100% after Medicare coordination rather than 80% for the remainder of the calendar year. When the individual expenses of two or more covered persons in the family meet the aggregate family limit, expenses for all covered family members will be calculated at 100% after Medicare coordination for Medicare entitled dependents during the rest of that calendar year. These individual and aggregate family out-of-pocket maximums do not include the Medicare deductible. See the Summary of Benefits chart on page 8 for details on the Indemnity Medical plus Rx Program individual and family out-of-pocket maximums.

Please note that under the Indemnity Medical Plus Rx Program, Medicare will provide your primary health coverage (and primary health coverage for your spouse beginning at age 65) with the this Program as the secondary plan. However, your covered dependent(s) under age 65 are covered under the CIGNA PPO option. The following charges are not covered under the Post-65 Retiree Indemnity Mecial Plus Rx Program and will **not** count toward the annual deductible or out-of-pocket maximums for the Indemnity Program.

- For you and your dependents eligible for Medicare, those charges in excess of Medicare's allowable charges that are determined to exceed reasonable and customary charges. Balance billing by Medicare physicians and agreements to pay a physician fee in excess of the Medicare approved fee are always excluded under the Program's reasonable and customary limitation.

- Charges for services and supplies not covered under the Post-65 Retiree Indemnity Program.

- Charges that exceed the Post-65 Retiree Indemnity Program's applicable lifetime or calendar year dollar maximums. (Keep in mind your "life-time limit balance" is transferred from your BNSF active and pre-65 Retiree coverage.)

- Any penalties paid because a covered person failed to comply with the Program's pre-certification requirements. Please refer to page 12 of the SPD for information on Pre-Admission Certification.

  You should know that you and your Medicare eligible spouse are required to obtain certification for any inpatient treatment not covered under Medicare, and for any additional days that exceed the Medicare approved inpatient treatment days, or that exceed your lifetime inpatient days under Medicare. If you fail to obtain certification for these days, those services and supplies may not be covered under the Post-65 Retiree Indemnity Program. Please refer to page 12 of the SPD for additional information on Pre-Admission Certification.

- Copayments for prescription drugs.

- Charges for non-Medicare covered services and supplies that are determined not to be medically necessary by the Claims Administrator.

- For you and your Medicare-eligible spouse, Medicare deductibles, copayments and coinsurance.

For additional information on benefits if you are Medicare eligible, please refer to page 41.

What You Should Know About Covered Services

The Indemnity Medical Plus Rx Program reimburses only those medical services and supplies that are medically necessary and not otherwise excluded or limited under Indemnity Program terms. If you are covered under the Post-65 Retiree Indemnity Program, you pay a deductible and coinsurance, up to the out-of-pocket maximum and only medically necessary covered charges that meet the Indemnity Program's definition of reasonable and customary will be paid or reimbursed.

Certain medical services may be subject to pre-admission certification. You and your Medicare eligible spouse are required to obtain certifications for any inpatient treatment not covered by Medicare, and for any inpatient days that exceed the Medicare approved inpatient days, or the Medicare lifetime maximum inpatient days. Failure to comply with the Program's pre-admission certification requirement could result in payment of a substantial penalty that will not be included as part of the calendar-year deductible or out-of-pocket maximum. You will also be responsible for paying the full cost for medical services that should have been, but were not, pre-authorized under the Program.

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 Post-65 Retiree Indemnity Program.

2. It must be commonly and customarily recognized with respect to the standards of good medical practice as appropriate and effective in the identification of 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 are 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 Post-65 Retiree Indemnity 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 Post-65 Retiree Indemnity Program will only reimburse services and supplies determined medically necessary by the Claims Administrator.

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 that one or more of the eight requirements listed above have not been met.

Reasonable and Customary Charges

For services and supplies that may be covered under the Post-65 Retiree Indemnity Program but not under Medicare, only reasonable and customary charges are paid under the Program. Program 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 Post-65 Retiree Indemnity 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.

The Post-65 Retiree Indemnity Program will coordinate with Medicare for paying covered charges incurred by you and your Medicare-eligible spouse as described in the section titled "Benefits for Medicare" beginning on page 41 of this summary booklet.

Pre-Admission Certification and Continued Stay Review

Pre-admission certification (PAC) and continued stay review (CSR) are required for inpatient treatments not covered under Medicare, or inpatient days in excess of the Medicare allowable days or the Medicare lifetime inpatient days. PAC and CSR refer to the process used to certify the medical necessity and length of hospital stays during a course of treatment. You, your dependents, or your treating physician should request PAC prior to an inpatient hospital admission. If PAC 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. Remember, you do not need to request PAC for Medicare approved inpatient days.

PAC is not a guarantee of Program benefits. Payment of benefits is subject to the general terms, limitations, and exclusion under the Program.

You and your dependents are responsible for obtaining PAC when it is necessary. For your dependents under age 65, please refer to the SPD for the "Pre-65 Retiree Program" for more detailed benefit information under the CIGNA PPO option.

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 PAC for a length of stay that does not exceed the federal requirements.

To obtain PAC for any inpatient hospital admission or to find out if PAC is required, call the toll-free number shown on your Program identification card. Remember, PAC is not required for Medicare covered inpatient days. However, it is required if a Medicare eligible person's inpatient days exceed the Medicare allowable days, or the Medicare lifetime inpatient days limit.

When a covered person receives PAC, the treating physician and the hospital will be advised of the length of stay certified by the PAC reviewer. Continued stay review (CSR) should be requested by the patient or the treating physician prior to the end of the certified length of stay if additional inpatient days may be needed. You can make requests on behalf of your dependents.

To obtain CSR for additional inpatient days, call the toll-free number shown on your Program identification card.

If the patient or the physician decides to extend an inpatient stay when the continued stay reviewer has indicated the Program will not pay for additional days, you will be responsible for paying for the added days. This same rule applies if you request PAC for inpatient days in excess of the Medicare allowable inpatient days, and the PAC reviewer determines the Post-65 Retiree Indemnity Program will not cover the additional days. You may not count your payment for the days that have not been certified toward the calendar-year deductible or out-of-pocket maximum. You may appeal the continued stay reviewer's denial of additional days under the Program's appeal provisions found on page 33. All medical decisions regarding treatment are between the patient and treating physician. The continued stay reviewer is responsible for determining only whether the Program will pay for extra inpatient days.

When to Request Pre-Admission Certification

Non-emergency admissions: If you or your covered dependent age 65 or over is planning inpatient surgery or treatment not covered by Medicare, you must call the PAC number on your Program Identification card for certification within the 14-day period before the inpatient admission.

Emergency admissions: If you or your covered 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 PAC toll-free number on your Program identification card* by the end of the first scheduled work day after the admission.

Pregnancy: You should *call the PAC toll-free number on your Program identification card* by the end of the third month of pregnancy.

Medicare beneficiaries: Medicare is the primary health plan for you and your enrolled spouse age 65 and older (and for Medicare-entitled disabled dependent children). Pre-admission certification is not required for inpatient hospital admission where the admission is covered by Medicare.

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 Program identification card*. Participation in the case management program is voluntary. There is no penalty if you do not want to participate in case management.

Transplant Program

Medicare is the primary plan for you and your spouse age 65 or over. If Medicare does not cover a proposed transplant, or certain transplant costs, you must call the toll-free number on your Post-65 Retiree Indemnity Program identification card for information on whether the Post-65 Retiree Indemnity Program covers the transplant cost before taking any action.

Medical Care Services

The following medically necessary services are covered under the Post-65 Retiree Indemnity Program subject to the deductibles and out-of-pocket maximums that apply. Reimbursement of medical expenses is subject to the Program's reasonable and customary limits for those services and supplies not covered by Medicare. Inpatient services are subject to the PAC and CSR requirements explained on pages 12 and 13. Medicare covered rules apply to you and your enrolled spouse age 65 or older.

Hospital Charges

- For hospitals, only semi-private room and board is paid. Private room and board charges are limited to the semi-private room rate. If the hospital has only private rooms, the private room charges will be covered up to the most common semi-private room rate charged by similar institutions in the geographical area, as determined by the Claims Administrator. Intensive care unit charges are limited to the ICU daily room rate.

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

- 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.

- Outpatient surgical facility services, including physician's fees, anesthesia and facility charges, that are furnished by a hospital on the day the procedure is performed and are ordered by the treating physician.

- Charges for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; and oxygen and other gases and their administration. Experimental and investigational treatments in any of these categories are not reimbursable under the Post-65 Retiree Indemnity Program.

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

- 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 caesarean section, or require that a provider obtain authorization for prescribing a length of stay not in excess of the above periods.

- Other services and supplies provided they are medically necessary and required for the care of the patient as determined by the Claims Administrator.

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 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.

- A free-standing surgical facility that meets all licensing, administrative, staffing, and operating requirements established by the Claims Administrator.

The term *hospital* does not include an institution that is primarily a place for rest, a place for the aged, or a nursing home.

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.

Multiple Surgical Reduction

In the event multiple surgeries are performed during one operation, the major or primary surgical procedure is paid as any other surgery, subject to the Program's reasonable and customary limits. There will be a 50% payment reduction for the secondary surgical procedure subject to the terms and conditions of the Post-65 Retiree Indemnity Program.

Home Health Care Charges

Charges made by a home health care agency for the following medical services and supplies are covered only if there is a home health care treatment plan on file for the patient:

- Part-time or intermittent nursing care by or under the supervision of a registered graduate nurse.

- Part-time or intermittent services of a home health care aide.

- Physical, occupational or speech therapy subject to applicable Post-65 Retiree Indemnity Program limitations.

- Medical supplies; durable medical equipment used in the course of rendering home health care services; drugs and medicines lawfully dispensed only on the written prescription of a physician; and laboratory services, but only to the extent that such charges would otherwise be covered under the Post-65 Retiree Indemnity Program had the person been confined in a hospital or skilled nursing facility as a registered bed patient.

Home health care charges do **not** include any of the following:

- Charges that exceed the home health care maximum or the maximums applicable to private duty nursing care or physical, occupational or speech therapy under the Post-65 Retiree Indemnity Program. No charges may exceed the applicable Indemnity Program's lifetime maximum benefits.

- Care or treatment that is not stated in the home health care treatment plan.

- The services of a person who is a member of your family or your dependent's family or who normally lives in your home or your dependent's home.

- A period when a person is not under the continuing care of a physician.

A *home health care agency* must primarily provide skilled nursing and other therapeutic services and be licensed to provide these services, if licensing is required. It must maintain complete medical records on each of its patients. There must be a full-time administrator who follows rules and policies established by a professional group that includes physicians. If there are no licensing requirements in the home health care agency's locale, the Claims Administrator must approve the agency.

A *home health care aide* must be trained in providing care of a medical or therapeutic nature and must report to and be under the direct supervision of the home health care agency.

A *home health care treatment plan* is a written plan for the care and treatment in the patient's home. To qualify, the plan must be approved in writing by a physician who certifies that the patient would require confinement in a hospital or skilled nursing facility without the home health care plan.

Home health care visits are limited to 40 visits per Program Year. Each visit by an employee of a home health care agency will be considered one visit, and each four hours or less of home health care aide services will be considered one home health care visit.

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, meets any state or local licensing requirements, and is approved by the Claims Administrator.

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 hospice facility's most common daily rate for a semi-private room, subject to the Program's reasonable and customary limits. Other covered charges include:

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

- Services of a physician, psychologist, social worker, family counselor or ordained minister for individual and family counseling. Bereavement counseling is available under the Indemnity Program. The hospice benefit includes a total of three bereavement-counseling sessions.

- Charges for pain relief treatment, including drugs, medicines, and medical supplies.

- Services of a 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.

- 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 dependents in daily living.

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.

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 Post-65 Retiree Indemnity Program pays charges for a skilled nursing facility. Reimbursement is limited to semi-private room charges up to 60 days per calendar year. No prior hospitalization is required. Charges for room and board are paid at the facility's most common daily rate for a semi-private room, subject to the Post-65 Retiree Indemnity Program's reasonable and customary limits.

Infertility Treatment Charges

Charges for office visits, including tests and counseling, are paid according to the terms of the Program option you have elected. Procedures for correction of infertility are covered. **In vitro fertilization, artificial insemination, GIFT and ZIFT embryo transplantation, or related procedures are not covered under the Post-65 Retiree Indemnity Program. Call the toll-free number to confirm that any infertility treatment you may be considering is covered under the Post-65 Indemnity Program.**

Other Covered Charges

- Emergency licensed ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided.

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

- Outpatient private duty nursing subject to approval under the PAC requirement on page 13 and limited to 40 visits per calendar year. There must be a written order from the physician and nursing notes indicating the care is non-custodial.

- Outpatient short-term rehabilitation up to a maximum of 60 calendar days per condition. The following therapies are included under this limitation: physical therapy, speech therapy, occupational therapy, and chiropractic therapy. Chiropractic therapy includes all treatments administered by chiropractors. Chiropractic therapy will be reviewed for medical necessity on the 35th visit.

- Family planning office visits including tests, counseling, and surgical sterilization procedures for vasectomy and tubal ligation. Reversals of surgical sterilizations 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 Indemnity Program prescription drug benefit and require a copayment.

- Temporomandibular Joint (TMJ) Treatment subject to pre-approval by the Claims Administrator. This benefit does not cover appliances and orthodontic treatment.

- Dental care limited to accidental injury of sound, natural teeth sustained while covered under the Program.

- Non-elective, therapeutic abortion for the covered retiree, covered spouse, or any dependent.

- Routine mammogram—a single baseline mammogram for women age 35 to 39, a mammogram every one to two years for women age 40 to 49 and/or annual mammogram for women age 50 and older.

- Elective second surgical opinion.

- Outpatient pre-admission testing.

- Maternity, including initial visit to determine pregnancy, subsequent prenatal visits, postnatal visits, and delivery in a hospital or birthing center. The Post-65 Retiree Indemnity Program does not restrict benefits for any hospital length of 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. Nor does the Post-65 Retiree Indemnity Program require that a provider obtain authorization for prescribing a length of stay not in excess of the above periods.

- Treatment from a specially trained and licensed acupuncturist for chronic pain.

- 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 screw nails, sutures, and wire mesh—excluding 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 complication on all stages of mastectomy, including lymphedema;

- Charges for initial purchase and fitting of external prosthetic devices that are used as a replacement or substitute for a missing body part and are necessary to alleviate or correct an illness, injury, or congenital defect, including only artificial arms and legs and terminal devices such as a hand or hook. Replacement of such prostheses is covered only if needed due to normal body growth.

- Routine preventive care for children (including immunizations) under and over age two, and well-woman care (including Pap test). There is an annual limit of $250 for each of these preventive care categories under the Post-65 Retiree Indemnity Program.

- Allergy testing, treatment and immunizations.

- Foot orthotics only when determined to be medically necessary by the Claims Administrator.

Substance Abuse and Mental Health

The Post-65 Retiree Indemnity Medical plus Rx Program does not provide mental health or substance abuse benefits for covered persons age 65 and over. Therefore, once you attain age 65, you become ineligible for the mental health/substance abuse care administered by CIGNA Behavioral Health; and once your eligible dependents attain age 65, they become ineligible for the mental health/substance abuse care administered by CIGNA Behavioral Health.

Mental health/substance abuse benefits are available for your eligible dependents if they are under age 65. For detailed benefit information for dependents under age 65, refer to "Substance Abuse and Mental Health" section under the CIGNA PPO option within the Pre-65 Retiree Program SPD. You must call CIGNA Behavioral Health for pre-certification at this toll free number: 1-800-291-6012.

Outpatient Prescription Drug Benefit

Effective January 1, 2003, 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, for a specified percentage of the discounted price. Your prescription drug coinsurance amounts do not apply toward your Post-65CIGNA Indemnity Medical plus Rx 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 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 You Pay
Generic	25%* (Minimum $10; Maximum $100)
Formulary	25%* (Minimum $25; Maximum $100)
Non-Formulary	25%* (Minimum $40; Maximum $100)

**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 1-800-378-7559.

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 You Pay
Generic	25%* (Minimum $20; Maximum $200)
Formulary	25%* (Minimum $50; Maximum $200)
Non-Formulary	25%* (Minimum $80; Maximum $200)

**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 obtained from a non-participating mail order pharmacy;
- 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 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 Post-65 CIGNA Indemnity Medical Plus Prescription Drug Program Does Not Cover

In addition to the limitations and exclusions described under the specific benefits listed in this benefit summary, the Indemnity Medical Plus Rx Program will **not** reimburse charges for the following:

- Services that are not medically necessary as determined by the Claims Administrator.

- 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 Post-65 Retiree Indemnity Program or to repair a congenital birth defect.

- 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 a Retiree at a Veterans Administration facility.

- Procedures, services, treatments or supplies (including drugs) that the Claims Administrator 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. The Claims Administrator 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. The Claims Administrator 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.

The Claims Administrator 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 the Post-65 Retiree Indemnity Program.

- Any injury resulting from, or in the course of, any employment for wage or profit.
- Any injury or sickness covered under any Workers' Compensation or similar law.
- 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 the Claims Administrator.
- Reversal of voluntary sterilization procedures and certain infertility services not specifically listed as covered under the Post-65 Indemnity Program.
- Transsexual surgery and related medical or psychological services.
- Surgical treatment for correction of refractive errors, including radial keratotomy.
- Routine foot care.
- 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.
- Replacement of external prostheses due to wear and tear, loss, theft or destruction, or any biomechanical external prosthetic devices.
- Over-the-counter disposable or consumable supplies, including orthotic devices, unless the latter are determined to be medically necessary by the Claims Administrator.
- 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 if:

  — It is used to improve speech skills that have not been fully developed;

  — It can be considered custodial or educational; or

— It is intended to maintain speech communication. Speech therapy that is not restorative in nature will not be covered.

- Charges in excess of reasonable and customary as determined by the Claims Administrator.
- Routine eye exams, eyeglasses or lenses with the exception of the first pair of eyeglasses or contacts after cataract surgery.
- Routine hearing exams or hearing aids.
- Treatment of teeth/periodontium except for emergency dental work to stabilize teeth due to injury to sound natural teeth.
- 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 Post-65 Retiree Indemnity 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, except a government plan for its own employees or Medicaid.
- 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 a 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 44 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 for or in connection with an elective abortion unless the physician certifies in writing that the pregnancy would endanger the life of the mother or the expenses are incurred to treat medical complications due to an abortion.

- Charges made by an assistant surgeon in excess of 20% of the surgeon's allowable charge or charges made by a cosurgeon in excess of the surgeon's allowable charge plus 20% (for purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts).

- Charges to the extent of the exclusions imposed by any certification requirement under the Post-65 Retiree Indemnity Program.

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

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 31 -34 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 the BNSF Post-65 Retire Medical Program terms and to make both initial claim determinations and final claim review decisions on ERISA appeals to CIGNA Healthcare ("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 Post-65 Retiree 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 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

A completed claim form must be submitted before benefits can be paid. You may obtain a claim form from CIGNA or call the Benefits Help Line at 1-800-234-1283 to request a claim form.

Complete and sign the form and submit your claim to the Claims Administrator. You and your covered spouse age 65 and older must submit the Medicare EOB with the CIGNA claim form.

All claims submitted to the Claims Administrator must provide the following information:

- Retiree's name and Social Security Number;
- 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.

Certain services require prior authorization in order to be covered. You or your Authorized Representative (typically, your health care provider) must request the medical necessity determination.

Timeframe for Deciding Initial Benefit Claims (Including Medical Necessity Determinations)

Pre-Service Claims--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 Post-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).

If your claim is denied by Medicare, you must appeal to Medicare. This Post-65 Retiree Indemnity Program does not process Medicare claims, answer Medicare questions, or review Medicare claims on appeal. For all non-Medicare claims and for claims submitted after Medicare pays first, the Company has delegated to the Claims Administrator the discretionary authority to interpret the Post-65 Retiree Indemnity Program terms and to make both initial claim determinations and final claim review decisions on ERISA appeals. 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 Post-65 Retiree Indemnity Program terms.

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.

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:

CIGNA Healthcare
Claims Office
P.O. Box 2546
Sherman, Texas 75091-2546

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 on page 47 of this SPD.

When Coverage Ends

Coverage for you and your covered dependents will end of the *first* to occur of the following:

- The date the Post-65 Retiree Indemnity Program is terminated or, if you worked for a BNSF affiliate, the date the BNSF affiliate terminates its participation in the Post-65 Retiree Indemnity Program;

- The date you are no longer eligible for coverage under the Post-65 Retiree Indemnity Program rules;

- The first day of the month for which you fail to make the required contributions for Post-65 Retiree Indemnity Program coverage; or

- The date benefits paid to you equal the lifetime maximum benefit payable under the Post-65 Retiree Indemnity Program. (Coverage for enrolled dependents who have not reached their lifetime maximum benefit will not be affected if you continue to be an eligible retiree.) 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 maximums under this Program.

Dependents will lose their coverage on the *first* to occur of the following:

- The date you are no longer eligible for Post-65 Retiree Indemnity Program coverage for any reason other than death; or

- The date the dependent no longer meets the Post-65 Retiree Indemnity Program's eligibility rules for dependent coverage. (Dependent eligibility is described on page 3 of the SPD.)

- A surviving spouse of a covered retiree will lose coverage on the date the spouse becomes covered under another plan (excluding Medicare).

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 Post-65 Retiree Indemnity 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 coverage 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 Post-65 Retiree Indemnity Program coverage:

- If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Post-65 Indemnity Program because you and your spouse are legally separated or divorced resulting in loss of coverage under the Post-65 Indemnity Program.

- Your dependent children will become qualified beneficiaries if they lose coverage under the Post-65 Indemnity Program because your dependent child either marries or reaches the maximum age under the Post-65 Indemnity Program and no longer qualifies for coverage under the Pre 65 Retiree Medical Program.

Notification

The Post-65 CIGNA Indemnity Medical plus Rx 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. You or your covered dependent must notify YBR's Customer Care Service by phone that a qualifying event has occurred. YBR will send you an election form. To continue Post-65 CIGNA Indemnity Medical plus Rx 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 “Electing the Opt-Out Option” 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 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 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 Post-65 CIGNA Indemnity Medical plus Rx Program and does not maintain any other group health program for eligible employees or retirees.

If You Have Questions

Questions concerning the Post-65 Retiree Indemnity 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 Post-65 CIGNA Indemnity Medical plus Rx 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 Post-65 CIGNA Indemnity Medical plus Rx Program provides for coordination of benefits when medical expenses incurred by you or your covered dependents are covered by 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 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 semi-private 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 Post-65 CIGNA Indemnity Medical plus Rx Program, when combined with benefits already paid by coordinating plans, will not be more than what this Post-65 CIGNA Indemnity Medical plus Rx Program would have paid had it been the only plan responsible for coverage. In other words, the total benefits normally payable under this Post-65 CIGNA Indemnity Medical plus Rx 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 Post-65 CIGNA Indemnity Medical plus Rx 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.

A plan without a coordinating provision is always the primary plan. If all plans have a coordinating provision:

1. The plan covering the patient directly, rather than as a dependent, is the primary and the others secondary.

2. If a child is covered under both parents' plans, the plan for the parent whose birthday occurs earlier in 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. The benefits of a plan that covers a child as the dependent of a stepparent will be determined after a plan that covers the child as a dependent of the parent with custody.

3. If neither 1 nor 2 applies, the plan covering the patient the longest is primary. When this Indemnity Program is the secondary plan, its payment is reduced to coordinate with the primary plan's benefits.

Benefits for Medicare—Eligible Covered Persons

You are enrolled automatically in Medicare Part A when you apply for Railroad Retirement benefits or Social Security benefits on or after reaching age 65. Anyone entitled to Medicare Part A benefits is automatically enrolled in Medicare Part B unless the person waives Medicare Part B. You should make certain you and your spouse (and any dependents entitled to Medicare due to disability or renal disease) are covered under Medicare Parts A and B. The Post-65 CIGNA Indemnity Medical plus Rx Program calculates benefits as if you and your Medicare entitled spouse (or dependents) are actually enrolled in Medicare Parts A and B even if you fail to apply for Social Security or Railroad Retirement benefits.

The Post-65 CIGNA Indemnity Medical plus Rx Program will coordinate with Medicare with respect to your claims and the claims for your Medicare entitled dependents. When a claim is submitted, you must submit the Medicare EOB. The benefits the Post-65 CIGNA Indemnity Medical plus Rx Program would pay in the absence of Medicare and the amount Medicare will pay (or would pay if you were enrolled) are calculated separately. If the Post-65 CIGNA Indemnity Medical plus Rx Program amount is greater, the Post-65 CIGNA Indemnity Medical plus Rx Program will pay that amount minus the Medicare amount. If the Medicare amount is equal to or greater than the Post-65 CIGNA Indemnity Medical plus Rx Program amount, the Program will not pay any benefit. Additional detail is provided in the section regarding "Clarification of Non-Duplication of Benefits."

Coordination with Medicare can be complicated because the Post-65 CIGNA Indemnity Medical plus Rx Program and Medicare may consider different services and supplies to be eligible benefits and will apply their own definitions, such as medical necessity and reasonable and customary charges. If you have any questions about the benefits for a specific claim you should contact the Claims Administrator.

Medicare Part A

Providers of services covered under Medicare Part A (hospitals, skilled nursing facilities, hospices) currently accept Medicare as payment in full under Medicare Part A, *if the provider accepts assignment from Medicare*. Certain home health care services also are covered under Medicare Part A. An Explanation of Benefits (EOB) under Medicare Part A must be submitted to the Claims Administrator for the Post-65 CIGNA Indemnity Medical plus Rx Program to process your claim. *If you do not choose to use a Medicare provider who accepts assignment, you may be responsible for paying any amount that would otherwise have been paid by Medicare Part A.* You should ask the medical provider if it accepts assignment from Medicare prior to incurring costs.

Medicare Part B

Medicare also has approved amounts it will pay for covered medical services and supplies under Part B. The Post-65 CIGNA Indemnity Medical plus Rx Program treats the Medicare-approved Part B amount as full payment for a claim. The Post-65 CIGNA Indemnity Medical plus Rx Program will not take into account any charges exceeding the Medicare-approved Part B amount. Therefore, you should make certain the medical provider you choose accepts Medicare assignment. If the provider does not accept

Medicare assignment, you may be required to pay part or all of the cost. This Post-65 CIGNA Indemnity Medical plus Rx Program will always base any reimbursement on what Medicare Part B pays, even when your medical provider does not accept Medicare Part B payments.

If there are expenses in addition to the Medicare Part B-approved charges, the medical care provider may "balance bill"—that is, bill the patient directly for the additional charges. You will be responsible for those additional charges, and this Post-65 CIGNA Indemnity Medical plus Rx Program will not reimburse you for these amounts under its Medicare coordination rules, nor will this amount be applied towards your deductible or out-of-pocket maximum. You should always ask a physician or other medical care provider whether they "balance bill" before you choose to receive services that are covered under Medicare Part B.

Deductibles and Out-of-Pocket Limits for Medicare Eligible Persons

The Post-65 CIGNA Indemnity Medical plus Rx Program includes annual deductibles and out-of-pocket limits as shown in the Summary of Benefits on page 8. The Post-65 CIGNA Indemnity Medical plus Rx Program calculates deductibles and out-of-pocket limits separately from Medicare. You are responsible for Medicare premiums, and these premiums do not apply to the Post-65 CIGNA Indemnity Medical plus Rx Program deductible and out-of-pocket limit requirements.

Clarification of Non-Duplication of Benefits Clause

The Post-65 CIGNA Indemnity Medical plus Rx Program pays benefits on a non-duplication of benefits method. Under this method, the Claims Administrator will determine what the Post-65 CIGNA Indemnity Medical plus Rx Program would pay in the absence of Medicare. Then, if the Post-65 CIGNA Indemnity Medical plus Rx Program amount is greater, the Program will pay that amount minus the Medicare amount. If the Medicare amount is equal to or greater than the Post-65 CIGNA Indemnity Medical plus Rx Program amount, the Program will not pay any benefit.

As an example, assume your deductibles with Medicare and the Post-65 CIGNA Indemnity Medical plus Rx Program are satisfied and you submit a $1,000 bill to both plans. Medicare pays $800 (80%) as the "primary" carrier. In the absence of Medicare coverage, the Post-65 CIGNA Indemnity Medical plus Rx Program would pay $800 (80%). However, the Post-65 CIGNA Indemnity Medical plus Rx Program, as a secondary carrier with a non-duplication of benefits clause, will only pay the difference between what is covered by Medicare and what would have been paid by the Program. Often that amount, as shown in the example, will be $0.

As a result, the Post-65 CIGNA Indemnity Medical plus Rx Program coverage does not generally provide benefit reimbursement unless the participant has reached the Post-65 CIGNA Indemnity Medical plus Rx Program out-of-pocket expense limit of $1,500 per individual or $3,000 per family. However, the Post-65 CIGNA Indemnity Medical plus Rx Program does cover prescription drugs for a small copayment, whereas Medicare does not currently cover prescription drugs. Additionally, the Post-65 CIGNA Indemnity Medical plus Rx Program could be beneficial during a catastrophic illness period.

Please note: The Post-65 CIGNA Indemnity Medical plus Rx Program is not considered to be a Medicare supplement or a Medigap policy. So, if you enroll in a Medicare supplement or a Medigap policy, you can keep your coverage under the Post-65 CIGNA Indemnity Medical plus Rx Program.

Creditable Coverage Under Medicare Part D

The Post-65 CIGNA Indemnity Medical Plus Rx Program provides creditable coverage under the Medicare Prescription Drug, Improvement, and Modernization Act. Therefore each year that you are

enrolled in the CIGNA Indemnity Medicare Plus Rx Program you will receive a notice of creditable coverage. This creditable coverage notice is important. If you choose to sign up for Medicare Part D with a PDP in the future and can provide a creditable coverage notice, you will not pay a penalty.

If you enroll in a PDP-sponsored Medicare Part D plan for 2006, you will automatically be defaulted into the CIGNA Medical Only Plan and you will not be eligible for the CIGNA Medical Plus Rx Plan until next annual enrollment.

General Information Affecting your Right to Program Benefits

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 Program Administrator has the right to recover the amount of the overpayment. In addition, if the overpayment is not returned, the Program Administrator reserves the right to deduct the overpayment from future Post-65 CIGNA Indemnity Medical plus Rx 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 Post-65 CIGNA Indemnity Medical plus Rx 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 Claims 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 Post-65 CIGNA Indemnity Medical plus Rx 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 Post-65 CIGNA Indemnity Medical plus Rx 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 Benefits

Participation in the Post-65 CIGNA Indemnity Medical plus Rx Program does not guarantee your right to any specific benefit under the Program. No supervisor, manager, or other Employee of BNSF or any BNSF-related Employer has the authority to enter into any spoken or written agreement regarding the terms of the Program.

Amendment or Termination of Program

The Post-65 CIGNA Indemnity Medical plus Rx Program has been established for the exclusive benefit of eligible Retirees and their eligible dependents. BNSF reserves the right to amend, modify, or terminate the Post-65 CIGNA Indemnity Medical plus Rx Program, including any benefits provided under the Program or the amount of any required contributions at any time and for any reason. If any change in the Post-65 CIGNA Indemnity Medical plus Rx Program should occur, you will be notified within a reasonable amount of time.

No Vested Rights

Your Post-65 CIGNA Indemnity Medical plus Rx Program benefits are not vested. Your right to benefits is limited to claims incurred before the first of the following events to occur:

- Amendment of the Program.
- Termination of the Program.
- Expiration of the period that claims can be accepted by the Claims Administrator.
- Termination of your eligibility to participate.
- Your failure to pay any required contributions.
- 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 limits. (Separate lifetime limits continue to apply to spousal and dependent coverage where not yet exhausted.)
- Any other event listed under the section of the SPD entitled "When Coverage Ends".

Right of Reimbursement

This Post-65 CIGNA Indemnity Medical plus Rx Program has a right to recovery for the following health care expenses:

- Expenses for which another party may be responsible as a result of a 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 first priority lien on the proceeds of any recovery by you or your dependents from such party to the extent of any benefits provided to you or your dependents by the Program. In addition, any amounts paid, whether to you directly, or through any third party, must be held in constructive trust up to the amount advanced by the Program. You or your dependents or their representative shall execute such documents as may be required to secure the Program's rights. The Program will be reimbursed 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 to protect the privacy and security of your confidential health information. As an employee welfare benefit plan under ERISA, the Medical Program is subject to the HIPAA privacy rules. Pursuant to the HIPAA privacy rules, the Medical 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 Medical 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 at P.O. Box 961055, Fort Worth, Texas 76161; Phone: 1-800-234-1283.

Administrative Information

Program Costs

Post-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 Post-65 Retiree contributions are deposited into the VEBA. Benefits for all Post-65 Retiree Medical Program options, except the Medicare HMO option, are self-insured by BNSF. Benefits under the Medicare HMO option are insured by the relevant HMO. Please review your HMO materials for additional details.

Program Name and Program Number

The Post-65 Retiree Medical Program is made available under the Burlington Northern Santa Fe Corporation Group Medical Program and 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 Post-65 Retiree Medical Program.

Company Name and Identification Number

The Post-65 CIGNA Medical plus Rx Program is sponsored by Burlington Northern Santa Fe Corporation, Employer Identification Number 41-1804964.

Program Administrator and Agent for Service of Legal Process

The Post-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
1-800-234-1283

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 is the Program Administrator. The Program Administrator has delegated the discretionary authority to interpret Program provisions relating to the payment of benefits to the Claims Administrator for both initial claims processing and for ERISA appeals requested in writing by Program beneficiaries. BNSF Employee Benefits 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 of any error or supplying information to correct any omission.

Claims Administrator

CIGNA Health Care
P. O. Box 2546
Sherman, Texas 75091-2546
Phone: 1-800-244-6224

Claims Administrator for the Outpatient Prescription Drug Benefit

Caremark, Inc.
2211 Sanders Road
Northbrook, IL 60062

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 Post-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 Medical Program participants will be entitled to:

Receive Information About Your Over 65 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 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 Medical Program Coverage

- Continue health care coverage for your spouse or dependents if there is a loss of coverage under the Retiree Medical Program as a result of a COBRA qualifying event subject to COBRA's Medicare entitlement rules. Your spouse or dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Retiree Medical Program on 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 or your dependent should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when a dependent becomes entitled to elect COBRA continuation coverage, when 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 or a dependent 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 Retiree Medical Program. The people who operate the BNSF 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 Pages 30 - 34) 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 Timing 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 AdministrationU.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
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 the Post-65 Retiree benefits, call Your Benefits Resources (YBR) at 1- 877-847-2436.

For questions regarding the services under the Post-65 CIGNA Indemnity Medical plus Rx Program, call CIGNA Member Services at 1-800-244-6224.

If you are eligible for an HMO and have questions about that option, call the HMO directly. Phone numbers are listed in your HMO materials.

This SPD is only a summary of the Program. It does not constitute a contract. The 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.