

**NATIONAL RAILWAY CARRIERS
AND
UNITED TRANSPORTATION UNION
(NRC/UTU)
HEALTH AND WELFARE PLAN**

JANUARY 1, 2007

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I

IMPORTANT NOTICE

This booklet describes the Health Care Benefits provided for U.S. residents under the National Railway Carriers and United Transportation Union Health and Welfare Plan ("Plan"). Other benefits provided by the Plan are described in a separate booklet entitled Life Insurance Benefits for U.S. Employees and Retirees and Accidental Death and Dismemberment Insurance Benefits for U.S. Employees.

The Plan is maintained pursuant to collective bargaining agreements between certain freight railroads and the United Transportation Union (the "UTU") that provide for the Plan benefits this booklet describes.

* * * *

Because certain employees sometimes work in train service and sometimes in engine service, the Plan has been designed to avoid movement back and forth during each calendar year - and the hardships they may cause to the employee and the employee's dependents - between eligibility under the Plan and eligibility under The Railroad Employees National Health and Welfare Plan. Thus, the Plan provides that the following employees of participating railroads who work under a collective bargaining agreement with either the UTU or the Brotherhood of Locomotive Engineers and Trainmen ("BLET") are eligible for Plan coverage during a given calendar year:

- employees as to whom UnitedHealthcare has been advised, before the last Friday in August of the prior calendar year, had earnings from train service in excess of 50% of their total train and engine service earnings during the twelve-month period ending June 30 of such prior calendar year;
- employees as to whom UnitedHealthcare has received no advice, before the last Friday in August of the prior calendar year, regarding the employees' earnings in train and engine service during the twelve-month period ending June 30 of such prior calendar year but who are listed in UnitedHealthcare's records as

working under a UTU collective bargaining agreement as of the last Friday of the prior calendar year;

- employees hired after the last Friday in August of the prior calendar year under a UTU agreement, provided they did not first work under a collective bargaining agreement with the BLET.
- employees who don't fall within any of the three groups mentioned above and who move after the last Friday in August of the prior calendar year, to a position covered by a UTU agreement, provided that as of the date of the move they had not last worked under a BLET agreement.

Employees not eligible for coverage under the Plan during a given calendar year because they do not come within any of the groups described above will not become eligible for coverage at any time during such given calendar year even if they work under a UTU agreement from time to time during that year. These employees may continue to be eligible for coverage under the national plan collectively bargained with the BLET.

* * * *

The Plan's Health Care Benefits described in this booklet are the Comprehensive Health Care Benefit ("**CHCB**"), the Managed Medical Care Program ("**MMCP**"), the Basic Health Care Benefit ("**BHCB**"), the Mental Health and Substance Abuse Care Benefit ("**MHSA**"), and the Managed Pharmacy Services Benefit ("**MPSB**"). These Benefits are not insured. They are payable directly by the Plan.

Highmark BlueCross BlueShield ("Highmark") and UnitedHealthcare ("UnitedHealthcare") administer separate programs under the **CHCB** and under the **BHCB**. You may choose which of these two programs covers you if you elect to participate in the **CHCB** or **BHCB**.

A Managed Medical Care Program Information Statement will be sent to you if either the **MMCP** administered by UnitedHealthcare or the **MMCP** administered by Aetna is available under the Plan in your area. In areas where the **MMCP** administered by UnitedHealthcare is available under the Plan, you may choose an **MMCP** administered either by UnitedHealthcare or by Highmark. In areas where the **MMCP** administered by Aetna is available under the Plan, you may

choose an **MMCP** administered either by Aetna or by Highmark.

ValueOptions, Inc. ("ValueOptions") administers the **MHSA**.

Medco Health Solutions, Inc. ("Medco") administers the **MPSB**.

Toll-free telephone service is available from all of these companies:

Highmark:	1-866-267-3320
UnitedHealthcare:	1-888-445-4379
Aetna:	1-888-332-8742
Medco:	1-800-842-0070
ValueOptions:	1-800-934-7245

You will notice that some of the terms used in your booklet are in bold print. These terms have a special meaning under the Plan that are set forth in the "Definitions" section of this booklet.

II

Highlights

Here is a brief outline of the Health Care Benefits for U.S. residents provided by the Plan. A more elaborate description of each Benefit, including limitations, exclusions and other details, appears in the body of this booklet.

Comprehensive Health Care Benefit (CHCB)

Maximum Benefit per Lifetime*	\$1,000,000
-------------------------------	-------------

Deductible per Calendar Year*

Individual	\$100
Family	\$300

Out-of-Pocket Maximum per Calendar Year*

Individual	\$1,500
Family	\$3,000

*Payments made toward satisfying the **CHCB's** Individual and Family Deductibles and Out-of-Pocket Maximums also count toward satisfying the Individual and Family Deductibles and Out-of-Pocket Maximums under the **BHCB**, the **Out-of-Network Services** portions of the **MHSA** and the **MMCP** and, for those enrolled in the **BHCB**, the **In-Network Services** portion of the **MHSA** as well. Benefits payable under the **CHCB** are added together with benefits payable for **Out-of-Network Services** under the **BHCB** and the **MMCP**, and for **Out-of-Network Services** for **Mental Health Care** under the **MHSA**, for purposes of applying the Maximum Benefit per Lifetime. In addition, the total amount that counts for purposes of applying your Maximum Benefit per Lifetime under The Railroad Employees National Health and Welfare Plan counts for purposes of applying the Maximum Benefit per Lifetime under this Plan.

Eligible Expenses Payable
After Deductible is Satisfied

75% in areas where **MMCP** coverage is offered
but not chosen

85% in areas where **MMCP** coverage is not
offered

Eligible Expenses Payable After
Out-of-Pocket Maximum is Reached 100%

*These Benefits may be reduced if applicable care
coordination/medical management procedures are not
followed. See pages 56 through 59.*

*See pages 103 through 104 for special rules applicable to
routine physical exams.*

Managed Medical Care Program (MMCP)

	In- Network Services	Out-of- Network Services
Maximum Benefit per Lifetime*	None	\$1,000,000
Deductible per Calendar Year*		
Individual	None	\$200
Family	None	\$600

Out-of-Pocket Maximum per Calendar Year*

Individual	None	\$1,500
Family	None	\$3,000

*Payments made toward satisfying the **MMCP's** Individual and Family Deductibles and Out-of-Pocket Maximums also count toward satisfying the Individual and Family Deductibles and Out-of-Pocket Maximums under the **CHCB**, the **BHCB**, the **Out-of-Network Services** portion of the **MHSA** and, for those enrolled in the **BHCB**, the **In-Network Services** portion of the **MHSA** as well. Benefits payable for **Out-of-Network Services** under the **MMCP** are added together with benefits payable under the **CHCB**, for **Out-of-Network Services** under the **BHCB**, and for **Out-of-Network Services** for **Mental Health Care** under the **MHSA**, for purposes of applying the Maximum Benefit per Lifetime. In addition, the total amount that counts for purposes of applying the Maximum Benefit per Lifetime under The Railroad Employees National Health and Welfare Plan counts for purposes of applying the Maximum Benefit per Lifetime under this Plan.

Office Visit Co-payment	\$15	N/A
Urgent Care Center Co-payment	\$15	N/A
Emergency Room Co-payment (See pages 62 through 63).	\$30	N/A
Eligible Expenses Payable after Co-payments/ Deductibles are Satisfied	100%	75%**

Eligible Expenses Payable
after Out-of-Pocket

Maximum is Reached N/A 100%**

***These Benefits may be reduced if applicable care coordination/medical management procedures are not followed. See page 68.*

Basic Health Care Benefit (BHCB)

Deductible per Calendar Year*

Individual	\$300
Family	\$900

Out-of-Pocket Maximum
Per Calendar Year*

Individual	\$2,500
Family	\$5,000

	In-Network Services	Out-of Network Services
Eligible Expenses Payable After Deductible is Satisfied	70%**	50%**
Maximum Benefit per Lifetime*	None	\$1,000,000

*Payments made toward satisfying the **BHCB's** Individual and Family Deductibles and Out-of-Pocket Maximums also count toward satisfying the Individual and Family Deductibles and Out-of-Pocket Maximums under the **CHCB**, the **MHSA**, and the **Out-of-Network Services** portion of the **MMCP**. Benefits payable for **Out-of-Network Services** under the **BHCB** are added together with benefits payable under the **CHCB**, for **Out-of-Network Services** under the **MMCP**, and for **Out-of-Network Services** for **Mental Health Care** under the **MHSA**, for purposes of applying the Maximum Benefit per Lifetime. In addition, the total amount that counts for purposes of applying your Maximum Benefit per Lifetime under The Railroad Employees National Health and Welfare Plan counts for purposes of applying the Maximum Benefit per Lifetime under this Plan.



***These Benefits may be reduced if applicable care coordination/medical management procedures are not followed. See page 76.*

The chart on the next two pages provides a shorthand comparison of the benefits under the **CHCB**, **MMCP** and **BHCB**. Those benefits are more fully described in the preceding "Highlights" section and on pages 49 through 75 of this booklet. You need to read those materials carefully to get a more complete picture of how the different benefit programs compare with each other.

	Basic Health Care Benefit	
	In-Network	Out-of-Network
Medical/MHSA		
Annual Deductible		
Individual	\$300	
Family	\$900	
Office Visits, Emergency Room, Urgent Care	70%	50%
Coinsurance	70%	50%
Annual Out-of-pocket Maximum		
Individual	\$2,500	
Family	\$5,000	
Prescription Drugs		
Retail		
Generic	70%*	50%
Brand on formulary	65%*	50%
Brand not on formulary	60%*	50%
Mail Order		
Generic	70%*	
Brand on formulary	65%*	
Brand not on formulary	60%*	

NOTE: Deductibles do not apply toward Annual Out-of-Pocket Maximum

* Prescription drug benefit for persons enrolled in **BHCB** has an in-network Annual Out-of-Pocket maximum of \$2,000 per individual and \$4,000 per family.

Comprehensive Health Care Benefit		Managed Medical Care Program	
Where MMCP Is Not Available	Where MMCP Is Available	In-Network	Out-of-Network
\$100		N/A	\$200
\$300		N/A	\$600
85%	75%	\$15/Office Visit	75%
85%	75%	100%	75%
\$1,500		N/A	\$1,500
\$3,000		N/A	\$3,000
CHCB and MMCP Drug Benefits			
In-Network		Out-of-Network	
100% after \$5 Copay		75%	
 100% after \$10 Copay		75%	
100% after \$10 Copay			
 100% after \$15 Copay			

Mental Health and Substance Abuse Care Benefit (MHSA) for Individuals Enrolled in the Comprehensive Health Care Benefit or the Managed Medical Care Program

In-Network Services

Inpatient Benefits

Maximum Benefit per Lifetime	None
Eligible Expenses Payable	100%

Outpatient Benefits

Maximum Benefit per Lifetime	None
Office Visit Co-payment	\$15
Eligible Expenses Payable After Co-payment	100%

Out-of-Network Services

Maximum Benefit for Mental Health Care per Lifetime*	\$1,000,000
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Maximum Benefit for Substance Abuse Care per Lifetime*	\$100,000
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Deductible per Calendar Year*

Individual	\$100
Family	\$300

Out-of-Pocket Maximum per Calendar Year*

Individual	\$1,500
Family	\$3,000

*Payments made toward satisfying the Individual and Family Deductibles and Out-of-Pocket Maximums listed above under the **Out-of-Network Services** portion of the **MHSA** also count toward satisfying the Individual and Family Deductibles and Out-of-Pocket Maximums under the **CHCB**, the **BHCB**, and the **Out-of-Network Services** portion of the **MMCP**. The benefits payable for **Out-of-Network Services for Mental Health Care** under the **MHSA** listed above are added together with benefits payable under the **CHCB**, and for

Out-of-Network Services under the **BHCB** and the **MMCP**, for purposes of applying the Maximum Benefit for **Mental Health Care** per Lifetime. In addition, the total amount that counts for purposes of applying your Maximum Benefit for **Mental Health Care** per Lifetime and your Maximum Benefit for **Substance Abuse Care** per Lifetime under The Railroad Employees National Health and Welfare Plan counts for purposes of applying the Maximum Benefit for **Mental Health Care** per Lifetime and the Maximum Benefit for **Substance Abuse Care** per Lifetime under this Plan.

Eligible Expenses Payable
After Deductible is Satisfied 75%**

Eligible Expenses Payable After
Out-of-Pocket Maximum is Reached 100%**

***These Benefits may be reduced if applicable ValueOptions Certification and/or Pretreatment Outpatient Assessment procedures are not followed. See pages 87 through 89.*

Mental Health and Substance Abuse Care Benefit (MHSA) for Individuals Enrolled in the Basic Health Care Benefit

Maximum Benefit for Substance Abuse Care per Lifetime	\$100,000
Deductible Per Calendar Year*	
Individual	\$300
Family	\$900
Out-of-Pocket Maximum Per Year*	
Individual	\$2,500
Family	\$5,000

	In- Network Services	Out-of- Network Services
Eligible Expenses Payable After Deductible is Satisfied	70%	50%
Eligible Expenses Payable After Out-of-Pocket Maximum is Reached	100%	100%
Maximum Benefit for Mental Health Care per Lifetime*	None	\$1,000,000

*Payments made toward satisfying the Individual and Family Deductibles and Out-of-Pocket Maximums listed above also count toward satisfying the Individual and Family Deductibles and Out-of-Pocket Maximums under the **BHCB**, the **CHCB**, and the **Out-of-Network Services** portion of the **MMCP**. The Benefits listed above to the extent they are payable for **Mental Health Care** are added together with benefits payable under the **CHCB**, and for **Out-of-Network Services** under the **BHCB** and the **MMCP**, for purposes of applying the Maximum Benefit for **Mental Health Care** per Lifetime. In addition, the total amount that counts for purposes of applying the Maximum Benefit for **Mental Health Care** per Lifetime and your Maximum Benefit for **Substance Abuse Care** per Lifetime under

The Railroad Employees National Health and Welfare Plan counts for purposes of applying the Maximum Benefit for **Mental Health Care** per Lifetime and the Maximum Benefit for **Substance Abuse Care** per Lifetime under this Plan.

*These Benefits may be reduced if applicable ValueOptions **Certification** and/or **Pretreatment Outpatient Assessment** procedures are not followed. See pages 87 through 89.*

**Managed Pharmacy Services Benefit (MPSB)
for Individuals Enrolled in the
Comprehensive Health Care Benefit or the
Managed Medical Care Program**

PRESCRIPTION DRUG CARD PROGRAM
(supply of 21 days or less)

In-Network Pharmacy

Co-payment per **Generic Drug** Prescription \$5

Co-payment per **Brand Name Drug** Prescription Ordered by your Physician to be "Dispensed As Written" or Where There is no Equivalent **Generic Drug** \$10

Co-payment per **Brand Name Drug** Prescription Where There is a Generic Equivalent and **Brand Name** Was Not Ordered by your Physician to be "Dispensed As Written" \$10 plus the difference in cost between the equivalent **Generic Drug** and the **Brand Name Drug** dispensed

Eligible Expenses Payable After Co-payment is Satisfied 100%

Out-of-Network Pharmacy

Eligible Expenses Payable 75%

NOTE: If you buy a supply of Prescription Drugs for a period in excess of 21 days at an In-Network or Out-of-Network Pharmacy, you will receive no Benefits under the Plan.

MAIL ORDER PRESCRIPTION DRUG PROGRAM

(supply of 22 to 90 days)

Co-payment per Prescription (Generic Drug)	\$10*
Co-payment per Prescription (Brand Name Drug)	\$15
Eligible Expenses Payable	
After Co-payment is Satisfied	100%

***Generic Drugs**, if available, will be dispensed unless the written prescription requires otherwise.

Managed Pharmacy Services Benefit (MPSB) for Individuals Enrolled in the Basic Health Care Benefit

PRESCRIPTION DRUG CARD PROGRAM (supply of 21 days or less)

	In-Network Pharmacy	Out-of Network Pharmacy
Eligible Expenses Payable for Generic Drugs	70%	50%
Eligible Expenses Payable for Brand Name Drugs that are Formulary Drugs	65%	50%
Eligible Expenses Payable for Brand Name Drugs that are Non-Formulary Drugs	60%	50%
Out-of-Pocket Maximum per Calendar Year*		
Individual	\$2,000	None
Family	\$4,000	None
Eligible Expenses Payable After Out-of-Pocket Maximum is reached		100%

NOTE: If you buy a supply of Prescription Drugs for a period in excess of 21 days at an In-Network or Out-of-Network Pharmacy, you will receive no Benefits under the Plan.

MAIL ORDER PRESCRIPTION DRUG PROGRAM

(supply of 22 to 90 days)

Eligible Expenses Payable for
Generic Drugs 70%

Eligible Expenses Payable for
Brand Name Drugs that are
Formulary Drugs 65%

Eligible Expenses Payable for
Brand Name Drugs that are
Non-Formulary Drugs 60%

Out-of-Pocket Maximum
per Calendar Year*

Individual \$2,000
Family \$4,000

Eligible Expenses Payable After
Out-of-Pocket Maximum is Reached 100%

*The Individual and Family Out-of-Pocket Maximums per calendar year under the **MPSB** for individuals enrolled in the **BHCB** apply separately from all other Out-of-Pocket Maximums. The only amounts that count towards the Individual and Family Out-of-Pocket Maximum amounts for the **MPSB** for individuals enrolled in the **BHCB** are amounts paid for prescription drugs obtained under the **MPSB**, either through the Prescription Drug Card Program or the Mail Order Prescription Drug Program, during the period of enrollment in the **BHCB**. No other charges or co-payments count toward these Out-of-Pocket Maximum amounts.

* * * *

Employee Contributions

Employees are required to make monthly contributions to the Plan, except for those who "opt out" as described under the heading, "Opting Out of Plan Coverage" on page 21 and on pages 128 through 131. Your contribution will be deducted from your wages by your employer. The amount deducted will not be counted as part of your wages for federal tax purposes. The amount of the contribution is determined by a formula set forth in collective bargaining agreements between your employer and the UTU.

Opting Out of Plan Coverage

If you certify that you have medical, mental health/ substance abuse and prescription drug coverage for yourself and your dependents under another group health plan or health insurance policy, you may "opt out" of the Plan's other than on-duty employee Health Care Benefits and its dependent Health Care Benefits. By opting out, you will be giving up this Plan coverage for yourself and your dependents.

If you opt out, the monthly employee contribution to the Plan described under the heading "Employee Contributions" on page 20 will not be deducted from your wages. In addition, and subject to some exceptions, you will receive a monthly bonus of \$100 in most months.

Even if you opt out, you will be covered under the Plan for employee Health Care Benefits for on-duty injuries and for life and accidental death and dismemberment insurance.

A more elaborate summary of the opt-out opportunity, including a description of the exceptions to receiving the monthly bonus, is set forth under the heading "Opting Out of Plan Coverage" at pages 128 through 131 of this booklet.

III

Eligibility and Coverage

WHO IS ELIGIBLE FOR COVERAGE

Eligible Employees

You are an **Eligible Employee** and therefore eligible for coverage if:

- You are a U.S. resident, you are employed by a participating employer, and you work under a collective bargaining agreement with either the UTU or the BLET; and
- If you were hired on or after March 1, 2004, at least three full calendar months have passed since the month in which you first rendered the **Requisite Amount of Compensated Service** for the participating employer by whom you are now employed. If in the interim you begin working for a different participating employer, you will not become an **Eligible Employee** until three full calendar months have passed since the month in which you first rendered the **Requisite Amount of Compensated Service** for your new participating employer; and
- UnitedHealthcare's records indicate that, as of the last Friday in August of the prior calendar year, you had last worked under a collective bargaining agreement with the UTU;

or

- you were hired after the last Friday in August of the prior calendar year under a UTU agreement and did not first work under a collective bargaining agreement with the BLET;

or

- after the last Friday in August of the prior calendar year, you moved to a position covered by a UTU agreement and as of the date of the move you had not last worked under a BLET agreement.

Eligible Employees of hospital association railroads, who must look to their hospital association for their health care benefits, have limited Employee Health Care Benefits under the Plan (see pages 40 through 47 for details).

A person who is a living donor of an organ or tissue to a **Covered Family Member** will be considered a **Covered Family Member** for purposes of the Plan's Health Care Benefits, but such Benefits will be paid to that person only for **Eligible Expenses** in connection with the donation of an organ or tissue to a **Covered Family Member** under the benefit program (**CHCB**, **MMCP**, or **BHCB**) in which the **Covered Family Member** receiving the organ or tissue is enrolled.

Eligible Dependents

Your **Eligible Dependents** are:

- Your wife or husband.
- Your unmarried children under 19.
- Your unmarried children between 19 and 25 who:
 - are registered students in regular full-time attendance at school, and
 - are dependent for care and support mainly upon you and wholly, in the aggregate, upon themselves, you, your spouse, and scholarships and the like, and
 - have their legal residence with you.
- Your unmarried children 19 or over who:
 - are dependent for care and support mainly upon you and wholly, in the aggregate, upon you, your spouse, and governmental disability benefits and the like, and
 - have a permanent physical or mental condition that began prior to age 19, and
 - are unable to engage in any regular employment, and
 - have their legal residence with you.
- Your children who are Alternate Recipients under a **Qualified Medical Child Support Order**.

Children include:

- natural children,
- stepchildren,
- adopted children (including children placed with you for adoption), and
- other children related to you by blood or marriage, provided the children have their legal residence with you and are dependent for care and support mainly upon you and wholly, in the aggregate, upon themselves, you, your spouse, scholarships and the like, and governmental disability benefits and the like.

WHEN COVERAGE STARTS

If you are an **Eligible Employee** hired on or after March 1, 2004, you become covered under this Plan on the first day of the later of the calendar month in which you first become an **Eligible Employee** or the calendar month after the month in which you most recently rendered the **Requisite Amount of Compensated Service** under a collective bargaining agreement with the UTU or the BLET. Your **Eligible Dependents** become covered on the same day you become covered. Remember, if you are hired on or after March 1, 2004, you become an **Eligible Employee** on the first day of the fourth calendar month beginning after the month in which you first rendered the **Requisite Amount of Compensated Service** for the participating employer for whom you are now working.

If you are an **Eligible Employee** hired prior to March 1, 2004, you become covered under this Plan on the first day of the calendar month following the month during which you first rendered the **Requisite Amount of Compensated Service** under a collective bargaining agreement with the UTU or the BLET.

You and your **Eligible Dependents** continue to be covered during the month following each month in which you render or receive, in the aggregate, the **Requisite Amount of Compensated Service** or the **Requisite Amount of Vacation Pay** under a collective bargaining agreement with the UTU or the BLET, except that you will not be covered for any Health Care Benefits, other than those provided for on-duty injuries, and your **Eligible Dependents** will not be covered at all, during any month with respect to which you have opted out of Plan coverage. (The opt-out opportunity, including a description of the special rules that may apply if your spouse is also a railroad employee, is described at pages 128 through 131 of this booklet.)

If you were an **Eligible Employee** but your employment relationship with a participating employer ends and you then return to work with the same participating employer, you will once again become an **Eligible Employee**, and you and your **Eligible Dependents** become covered under the Plan on the first day of the first calendar month after the month in which you first render the **Requisite Amount of Compensated**

Service under a collective bargaining agreement with the UTU or the BLET.

If you were an **Eligible Employee** hired before March 1, 2004, but your employment relationship with a participating employer ends and you then return to work with a different participating employer, you will once again become an **Eligible Employee**, and you and your **Eligible Dependents** become covered under the Plan on the first day of the first calendar month after the month in which you first render the **Requisite Amount of Compensated Service** under a collective bargaining agreement with the UTU or the BLET

If you were an **Eligible Employee** hired on or after March 1, 2004, but your employment relationship with a participating employer ends and you begin working for a different participating employer, you will again become an **Eligible Employee** only after you again satisfy the conditions set forth on pages 22 and 23 and you and your **Eligible Dependents** will again become covered under the Plan on the first day of the later of the calendar month in which you again become an **Eligible Employee** or the calendar month after the month in which you most recently rendered the **Requisite Amount of Compensated Service** for your new participating employer under a collective bargaining agreement with the UTU or the BLET.

WHEN COVERAGE STOPS

Coverage for all Health Care Benefits stops when:

- you first become covered under **Another Railroad Health and Welfare Plan**;
- your employer or the UTU stops participating in the Plan;
or
- the class of employees you belong to stops being included under the Plan.

In addition, except as provided in the section "Continuation of Coverage After You Last Rendered Compensated Service," beginning on page 28, coverage for all Health Care Benefits for you and your **Eligible Dependents** stops on the earlier of the following:

- the last day of the month following the month you last rendered or received, in the aggregate, the **Requisite Amount of Compensated Service** or the **Requisite Amount of Vacation Pay** under a collective bargaining agreement with either the UTU or the BLET;
- the date your employment relationship ends for reasons other than retirement, such as resignation.

Coverage for an individual dependent stops sooner upon the occurrence of one of the following events:

- a dependent child becomes covered as an **Eligible Employee** under this Plan; or
- a dependent stops being an **Eligible Dependent**.

CONTINUATION OF COVERAGE AFTER YOU LAST RENDERED COMPENSATED SERVICE

Furloughed Employees

If you are furloughed after you became an **Eligible Employee** AND you have rendered compensated service for three months, you will be covered for Employee and Dependents Health Care Benefits during your furlough until the end of the fourth month following the month in which you last rendered compensated service.

If you received **Vacation Pay** before the date on which you are furloughed, but in a month subsequent to the month in which you last rendered compensated service, the continued coverage described above will be measured from the month in which you received that **Vacation Pay**.

If you return to work as an **Eligible Employee** before your coverage ends, you will continue to be covered during the month in which you again render compensated service.

If you return to work as an **Eligible Employee** after your coverage ends, you will not be covered again until the month following the month in which you next render the **Requisite Amount of Compensated Service**.

If you become disabled before your coverage ends, you should refer to the section below for Disabled Employees on pages 29 through 30.

Suspended or Dismissed Employees

If you are suspended or dismissed after you became an **Eligible Employee**, and

- you have had an employment relationship with your employer for at least six months, and
- you have rendered compensated service for three months as an **Eligible Employee**,

you will be covered for Employee and Dependents Health Care Benefits during your suspension or after your dismissal until the end of the fourth month following the month in which you last rendered compensated service or, if you are a Suspended Employee, the month in which you last received **Vacation Pay**, if later.

If you received **Vacation Pay** before the date on which you are dismissed, but in a month subsequent to the month in which you last rendered compensated service, the continued coverage described above will be measured from the month in which you received that **Vacation Pay**.

If you return to work as an **Eligible Employee** before your coverage ends, you will continue to be covered during the month in which you again render compensated service.

If you return to work as an **Eligible Employee** after your coverage ends, you will not be covered again until the month following the month in which you next render the **Requisite Amount of Compensated Service**.

If you are awarded full back pay for all time lost as a result of your suspension or dismissal, your coverage will be provided as if you had not been suspended or dismissed in the first place.

If you become disabled before your coverage ends, you should refer to the section below for Disabled Employees.

Pregnant Employees

If you cease to render compensated service as a result of your pregnancy, you will be covered for Employee and Dependents Health Care Benefits until the end of the fifth month following the month in which you last rendered compensated service.

If you return to work as an **Eligible Employee** before your coverage ends, you will continue to be covered during the month in which you again render compensated service.

If you return to work as an **Eligible Employee** after your coverage ends, you will not be covered again until the month following the month in which you again render the **Requisite Amount of Compensated Service**.

Disabled Employees

If you cease to render compensated service solely as a result of disability, including disability due to your pregnancy, or if you become disabled by reason of pregnancy or otherwise before your coverage as a Furloughed, Suspended or Dismissed Employee ends, and provided in any case that you remain continuously disabled, you will be covered for

Employee Health Care Benefits until the end of the second calendar year next following the year in which you last rendered compensated service and for Dependents Health Care Benefits until the end of the calendar year next following the year in which you last rendered compensated service.

If you received **Vacation Pay** before the date on which you relinquished your employment rights for any reason, but in a year subsequent to the year in which you last rendered compensated service, the continued coverage described above will be measured from the year in which you received that **Vacation Pay**.

If your disability ends before the end of the second calendar year next following the year in which you last rendered compensated service, your coverage will end at the same time your disability ends, unless you then return to work and render compensated service, in which event your coverage by reason of disability will continue until the end of the month in which your disability ends.

You may be required to submit proof of your disability to Highmark or UnitedHealthcare (if you are covered under the **CHCB** or **BHCB**), or to the company that administers your **MMCP** (if you are covered under the **MMCP**). Failure to provide this proof of disability, when requested, will cause your coverage for Employee and Dependents Health Care Benefits to end. In that event, Highmark or UnitedHealthcare, as the case may be, with regard to the **CHCB** or **BHCB**, or the company that administers your **MMCP**, will determine the date that coverage terminated based on the most current disability information available.

Retired Employees

If you retire, you will be covered for Employee and Dependents Health Care Benefits during the month following the month in which you last rendered compensated service.

If you received **Vacation Pay** before the date on which you relinquished your employment rights to retire, but in a month subsequent to the month in which you last rendered compensated service, the continued coverage described above will be measured from the month in which you received that **Vacation Pay**.

Retired Employees may be eligible for benefits under The Railroad Employees National Early Retirement Major Medical Benefit Plan. See page 196.

Deceased Employees

If you die while covered for Dependents Health Care Benefits, they will continue until the end of the fourth month following your death.

Employees under Compensation Maintenance Agreements, etc.

All coverage will continue for as long as your employer is obligated to provide continued coverage of the kind provided under the Plan because of an agreement, statute, or order of a regulatory authority, but only if your employer makes a payment for you as if you had rendered the **Requisite Amount of Compensated Service** and you have not relinquished your employment rights.

Employees Opting Out of Plan Coverage

If you have opted out of Plan coverage with respect to any month in which coverage would otherwise be continued as described above because of furlough, suspension or dismissal, pregnancy, disability, retirement, death or compensation maintenance agreements, etc., such continued coverage will apply only to Employee on-duty Health Care Benefits and to life and accidental death and dismemberment insurance, and not to Employee other than on-duty Health Care Benefits or to any Dependent Health Care Benefits.

Returning Veterans

If you had been an **Eligible Employee** and if you return to work for the same employer after completion of service in the armed forces of the United States, your coverage will begin on the day you first render compensated service upon your return.

Employees Taking Family or Medical Leave Pursuant to the Family and Medical Leave Act of 1993

Solely for purposes of determining coverage for Employee and Dependents Health Care Benefits (and whether an

employee contribution is required), during the month immediately following any month in which you take a period of family or medical leave authorized and provided for under the federal Family and Medical Leave Act ("FMLA"), such period of authorized leave will be treated as if it were a period during which you rendered compensated service. FMLA leave will not be treated as compensated service (i) for purposes of measuring any continued coverage described under the heading "Continuation of Coverage After You Last Rendered Compensated Service," beginning on page 28 of this booklet, or (ii) for any purpose whatsoever if, immediately prior to the beginning of the FMLA leave, you are not covered for employee other than on-duty Health Care Benefits or your Dependents are not covered for any Health Care Benefits under the Plan.

If you do not return to compensated service at the end of any period of family or medical leave, you will ordinarily be responsible for reimbursing your employer for its cost of continuing, during the period of leave, any Health Care Benefits under the Plan that were in fact continued for you or your Dependents during your leave.

Contact your employer for more information about family or medical leave under the federal statute.

Please note that your coverage ends immediately upon termination of your employment relationship with a participating employer, unless that termination occurs by reason of retirement, dismissal, or death.

**SUMMARY OF CONTINUATION OF COVERAGE
IF YOU CEASE TO RENDER COMPENSATED SERVICE
(OTHER THAN CONTINUATION UNDER COBRA
OR THE FAMILY AND MEDICAL LEAVE ACT) AND HAVE
NOT OPTED OUT**

Reason for Ceasing to Render Compensated Service	The Date Coverage Terminates (See Note 1)
	Coverage for Employee and Dependents Health Care Benefits
Furlough, Suspension or Dismissal	End of fourth month following the month in which you last rendered compensated service or received Vacation Pay . (See Note 2)
Leave of Absence	End of month following the month in which you last rendered or received, in the aggregate, the Requisite Amount of Compensated Service or the Requisite Amount of Vacation Pay .
Employment Relationship Terminates other than for Retirement or by Dismissal	Date of termination of employment relationship. (See Note 3)
Employment Relationship Terminates for Retirement	End of month following the month in which you last rendered compensated service or received Vacation Pay . (See Note 4)
Disability - Inability to Perform Work in your Regular Occupation	Earlier of date your disability ends or end of second calendar year following the year in which you last rendered compensated service or received Vacation Pay for Employee Health Care Benefits (end of first calendar year for Dependents Health Care Benefits)
Pregnancy	End of fifth month following the month in which you last rendered compensated service.

See **Notes** on the next page.

Notes:

1. For complete information concerning termination of coverage, including modifications of the provisions outlined above, see the section of this booklet entitled "Eligibility and Coverage" beginning on page 22. Under certain circumstances and provided the Plan is continued, benefits may be payable after coverage terminates. Information in this regard is also contained in the "Eligibility for Benefits" section on pages 40 through 48.
2. For a Furloughed Employee, **Vacation Pay** must be received prior to furlough. For a Dismissed Employee, **Vacation Pay** must be received prior to severance of the employment relationship.
3. In the event an **Eligible Employee** dies while covered, coverage for Dependents Health Care Benefits continues to the end of the fourth month following the month in which the **Eligible Employee** died.
4. For a **Retired Employee**, **Vacation Pay** must be received prior to the relinquishment of employment rights.

See page 196 for information as to other coverage available upon termination of your coverage under this Plan.

OPTIONAL CONTINUATION COVERAGE UNDER COBRA

This part of your booklet contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **The material in this section generally explains COBRA continuation coverage, when it may become available to you and 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 Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your Plan coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their Plan coverage. What follows is only a summary of your COBRA continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact UnitedHealthcare toll free at 1-888-445-4379.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan 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.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after UnitedHealthcare has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify UnitedHealthcare of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify UnitedHealthcare within 60 days after the qualifying event occurs. The notice must be in writing and must be sent to:

UnitedHealthcare
Railroad Administration (COBRA)
P. O. Box 150453
Hartford, CT 06115-0453

How is COBRA Coverage Provided?

Once UnitedHealthcare 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. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of the coverage you lost as a result of the qualifying event. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of the employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for the employee's spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation

coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled, or has a total and permanent disability entitling him or her to an annuity under the Railroad Retirement Act, and you notify UnitedHealthcare of the determination within sixty (60) days from the date it was made, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to UnitedHealthcare. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions about your Plan 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 Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep UnitedHealthcare 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 UnitedHealthcare.

Other Continuation of Coverage Provisions

Under certain circumstances, your coverage may be continued, often without cost to you, for all or part of the 18, 29 or 36 month continuation period (see "Continuation of Coverage After You Last Rendered Compensated Service," beginning on page 28 of this booklet). Coverage can be continued under **COBRA** for the remainder of the 18, 29 or 36 month continuation period by making the required payments.

Contact Information

Information about the Plan and COBRA continuation coverage can be obtained on request by calling UnitedHealthcare toll free at 1-888-445-4379 or by writing UnitedHealthcare, Railroad Administration (COBRA), P.O. Box 150453, Hartford, CT 06115-0453.

ELIGIBILITY FOR BENEFITS

Employees of Non-Hospital Association Railroads

If you are an **Eligible Employee** employed in a position that does not call for your employee health care benefits to be provided by a hospital association, you are eligible for Employee and Dependents Health Care Benefits under the Plan.

Employees of Hospital Association Railroads

If you are an **Eligible Employee** employed in a position that calls for your Employee Health Care Benefits to be provided by a hospital association, you are eligible only for Dependents Health Care Benefits under the Plan, except as described below.

You are eligible for Employee Health Care Benefits if you are Suspended or Dismissed. Coverage for Suspended Employees begins on the first day of the second calendar month after the date you last rendered any compensated service. Coverage for Dismissed Employees begins on the date of dismissal. In both cases, coverage ends on the last day of the fourth calendar month following the month in which you last rendered any compensated service or received **Vacation Pay**. In the case of Dismissed Employees, payment for vacation must be received prior to dismissal to be considered as **Vacation Pay**.

Your other health care benefits, including pregnancy benefits, will be provided by your hospital association under its eligibility rules, and not by this Plan.

Employees Who Have Opted Out of Plan Coverage

If you have opted out of Plan coverage, you are eligible only for Employee on-duty Health Care Benefits.

Benefits While You are Covered by the Plan

You are eligible for Employee and Dependents Health Care Benefits for **Eligible Expenses** incurred while you are covered by the Plan.

Benefits After Coverage Ends

Employee Health Care Benefits

After your coverage ends, Employee Health Care Benefits (for employees who have opted out, only on-duty Employee Health Care Benefits) will continue to be payable, but only for injuries that occurred and sicknesses (or pregnancies) that commenced before or while you were covered, and then only until the earliest of the following:

- For Injury or Sickness:
 - three months from the date your coverage ends, unless at the end of that three-month period you are under treatment by a **Physician** for a disability that was caused by an injury that occurred, or a sickness that commenced, before or while you were covered, and the disability prevents you from performing work in your last regular occupation and any other comparable occupation. *Under no circumstance are benefits payable after the end of this three-month period for any injury or sickness that does not cause your continuous disability or for any injury occurring or sickness commencing after your coverage ends.*
 - until you stop being so disabled.
 - when you fail to render compensated service or receive **Vacation Pay** for two calendar years. Such **Vacation Pay**, however, must be received prior to your furlough or dismissal, or before you relinquish your employment rights in connection with your retirement. Moreover, such **Vacation Pay** must be received before
 - you become covered under **Another Railroad Health and Welfare Plan**,
 - your employer or the UTU stops participation in the Plan, or
 - the class of employees to which you belong stops being included under the Plan.
- For Pregnancy:
 - If you are pregnant on the date your coverage ends, benefits will continue to be payable for **Eligible Expenses** related to that pregnancy.

Dependents Health Care Benefits

If your **Eligible Dependent** is disabled on the date that dependent's coverage ends, Dependents Health Care Benefits will be payable while your **Eligible Dependent** continues to be disabled for **Eligible Expenses** incurred in the calendar year in which coverage stops and the next two succeeding calendar years, but only for the injury, sickness or pregnancy causing the continuous disability of your **Eligible Dependent** after coverage stops.

If you cease to render compensated service due to pregnancy and your child is born after your coverage ends, Dependents Health Care Benefits will apply to the **Eligible Expenses** of your newborn child only during the first fourteen days of age.

Dependents Health Care Benefits for a pregnancy of a dependent spouse will be payable for **Eligible Expenses** incurred, if conception occurs before or while you are covered.

None of the three immediately preceding paragraphs applies to you if you have opted out of Plan coverage.

Dependent Spouses Covered as Employees Under a Hospital Association Plan

Health Care Benefits under this Plan are limited with respect to spouses who are covered under this Plan as **Eligible Dependents** and who are also **Eligible Employees** under this Plan or The Railroad Employees National Health and Welfare Plan who must look to a hospital association for employee health care benefits, and who have not opted out of foreign-to-occupation health care coverage under this Plan and the hospital association plan. Dependents Health Care Benefits under this Plan will be payable for such a spouse only:

- for any covered injury or sickness if he or she is covered under this Plan as a Suspended or Dismissed Employee, and
- for any covered injury or sickness, if under this Plan the spouse's employee coverage is other than as a Suspended or Dismissed Employee, subject to the following conditions:

- benefits under this Plan are payable only to the extent that they exceed the benefits under the hospital association plan; and if the hospital association plan benefits are decreased or eliminated, this determination will be made as if no such decrease in or elimination of the hospital association plan benefits had been made;
- he or she is a member of the hospital association plan; and
- non-hospital association facilities or services are not used when it is possible to use hospital association facilities or services.

If a spouse who is an **Eligible Dependent** is also a retiree eligible for coverage under The Railroad Employees National Early Retirement Major Medical Benefit Plan, who must look to a hospital association for early retiree health care benefits, Dependents Health Care Benefits will be payable under this Plan only to the extent that the expenses for which such benefits are payable exceed the benefits under the hospital association plan.

The following conditions apply:

- the dependent spouse must be a member of the hospital association plan.
- non-hospital association facilities or services must not be used when it is possible to use hospital association facilities or services.
- if any hospital association plan benefits are decreased or eliminated, benefits under this Plan, if any, will be determined as if there had been no decrease in or elimination of benefits under the hospital association plan.

Dependents Covered under Another Railroad Health and Welfare Plan

If benefits are payable under **Another Railroad Health and Welfare Plan** for a person who is a dependent not only of an employee covered by that plan but also of an **Eligible Employee** covered by this Plan, and that dependent is covered under this Plan as an **Eligible Dependent**, Dependents Health Care Benefits will be payable under this Plan only:

- if the **Eligible Employee** covered under this Plan has a birthday earlier in the calendar year than the employee covered by the other Plan, and
- in all other cases, only to the extent that payments under both Plans do not exceed the benefits that would have been paid under this Plan alone.

Participation in the Managed Medical Care Program (MMCP)

If you reside in a network area, you and your **Eligible Dependents** – or if you are an **Eligible Employee** of a hospital association railroad, your **Eligible Dependents** – may participate in the **MMCP**. A network area is a geographical area in which the Plan offers (has approved) a managed medical care network.

If you live in an area where the Plan has selected UnitedHealthcare as a managed care vendor, you may choose the **MMCP** administered by UnitedHealthcare or the **MMCP** administered by Highmark. If you live in an area where the Plan has selected Aetna as a managed care vendor, you may choose the **MMCP** administered by Aetna or the **MMCP** administered by Highmark.

If you don't reside in a network area, you may nonetheless enroll in the **MMCP** in an area where the Plan makes it available. You must call UnitedHealthcare's customer service phone number, 1-888-445-4379, to begin the special enrollment process.

Please bear in mind that if you are enrolled in the **MMCP**, you may obtain the In-Network level of benefits only from **In-Network Providers**, unless you have an **Out-of-Network Authorization**. **Covered Health Services** you receive from any provider who is not an **In-Network Provider**, i.e., is not part of the managed care network offered by the Plan – even if the network is maintained by a vendor to the Plan, e.g., UnitedHealthcare, Highmark, Aetna – are covered at the **Out-of-Network Services** benefits level. This holds true whether you reside in a network area or not.

In-Network Providers for UnitedHealthcare can be found at www.myuhc.com (registered users) or if not registered, www.provider.uhc.com/railroad/ and for Aetna at www.aetna.com/docfind/custom/rr/. If you are enrolled in the

MMCP administered by Highmark, you can identify **In-Network Providers** by calling Highmark's member service at 1-866-267-3320, and either speaking with a member service representative, or entering the provider's zip code in response to an automated prompt. If you know a zip code is in a Railroad-approved geographic area, you can check for **In-Network Providers** in that zip code through www.bcbs.com.

For purposes of the following eligibility rules, your residence is determined by the latest information provided to the Plan by your employer. It is thus very important that you promptly notify your employer of any residence change.

Existing Employees

Each **Eligible Employee** living in a given network area who is eligible for coverage at the time a managed medical care network is established in that area will be enrolled in the network along with his/her **Eligible Dependents**, unless the **Eligible Employee** is then covered by the **BHCB** or provides timely written notice to UnitedHealthcare to remain covered under the **CHCB**.

Newly Hired Employees

Each newly hired employee who, at the time he/she first renders the **Requisite Amount of Compensated Service** after becoming an **Eligible Employee**, lives in an area where the Plan's **MMCP** is available through UnitedHealthcare, may choose to be enrolled, along with his/her **Eligible Dependents**, in the **MMCP** administered by UnitedHealthcare, the **MMCP** administered by Highmark, the **BHCB** administered by UnitedHealthcare or the **BHCB** administered by Highmark.

Starting with the first day of the month in which an employee becomes an **Eligible Employee** covered by the Plan and continuing until the next Open Enrollment, if he/she has failed to enroll in the **MMCP** administered by Highmark, the **BHCB** administered by UnitedHealthcare or the **BHCB** administered by Highmark, he/she and his/her **Eligible Dependents**, will be placed in the **MMCP** administered by UnitedHealthcare or, if you were hired before March 1, 2004, in the **MMCP** administered by Highmark. If such an **Eligible Employee** hired on or after March 1, 2004, lives in an area where the Plan's **MMCP** is not available through UnitedHealthcare, he/she will be enrolled, along with his/her **Eligible**

Dependents, in the Plan's **CHCB** administered by UnitedHealthcare.

Returning Employees

Eligible Employees who return to compensated service and become eligible for coverage within 24 months of loss of eligibility for coverage, and whose employment relationship has not terminated at any time prior to such return, will, along with their **Eligible Dependents**, be enrolled in the program of Plan benefits (with the same administrator) in which they were enrolled when their eligibility for Plan coverage was lost.

An **Eligible Employee** who does not return to service within 24 months of losing eligibility for coverage, or whose employment relationship terminates before returning to work even if he/she comes back within the 24-month period, will be considered a newly hired employee for purposes of determining in which Plan program he/she and his/her **Eligible Dependents** will be enrolled.

Transferring Employees

Eligible Employees who move, and their **Eligible Dependents**, will have the following options:

- If they were covered under the **CHCB** or **BHCB** administered by Highmark before the move, they will remain covered under the same program administered by Highmark. However, if they were covered under the **CHCB** and move to an area where the Plan's **MMCP** is available, they may request enrollment in the **MMCP** and choose the company (Highmark or Aetna in some areas; Highmark or UnitedHealthcare in others) they wish to administer the program.
- If they were covered under the **CHCB** or **BHCB** administered by UnitedHealthcare before the move, they will remain covered under the same program administered by UnitedHealthcare. However, if they were covered under the **CHCB** and move to an area where the Plan's **MMCP** is available, they may request enrollment in the **MMCP** and choose the company (Highmark or Aetna in some areas; Highmark or UnitedHealthcare in others) they wish to administer the program.
- If they were covered under the **MMCP** administered by Highmark before the move, they will remain covered

under the **MMCP** administered by Highmark, provided it is available under the Plan at their new location. If the **MMCP** is not available under the Plan at the new location, they will be covered under the **CHCB** administered by Highmark.

- If they were covered under the **MMCP** administered by either UnitedHealthcare or Aetna before the move:
 - If the **MMCP** administered by the same company is available in the new location, they will remain in the **MMCP** administered by that same company.
 - If the **MMCP** administered by the same company is not available in the new location, but the **MMCP** administered by the other company (either UnitedHealthcare or Aetna) is available in the new location, they may choose such other company or Highmark to administer their program. If they do not make a choice, they will be transferred to the **MMCP** administered by the other company, *i.e.*, not by Highmark. In this event, an interim **MMCP** will apply until enrollment in the **MMCP** in the new network area is completed, but not beyond the end of the first month following the month during which UnitedHealthcare receives notice that the **Eligible Employee** has moved to the new network area. The interim **MMCP** is identical to the **MMCP** except that the payments for **Out-of-Network Services**, as described on page 65, are 85% and 68% instead of 75% and 60%.
 - If the **MMCP** is not available under the Plan at the new location, they must choose UnitedHealthcare or Highmark to administer the **CHCB**.

Employees of Hospital Association Railroads

The description of the coverage – **MMCP**, **CHCB** or **BHCB** – applicable to Existing Employees, Newly Hired Employees, Returning Employees and Transferring Employees applies only to the **Eligible Dependents** of **Eligible Employees** of hospital association railroads and not to the **Eligible Employees** themselves. If an **Eligible Employee** of a hospital association railroad loses hospital association coverage and becomes covered for Employee Health Care Benefits under the Plan, he/she will have the same coverage – **MMCP**, **BHCB** or **CHCB** (in each case, administered by the

same company) – selected for his/her **Eligible Dependents**. If the **Eligible Employee** has no dependents, he/she will be covered just as if he/she was a newly hired employee.

Enrollment Changes

- **Open Enrollment.**

In October of each year, or during any other open enrollment period announced by the Plan, all **Eligible Employees** enrolled in the **MMCP** may elect to be enrolled, along with their **Eligible Dependents**, in the **CHCB** or **BHCB** administered by Highmark, or in the **CHCB** or **BHCB** administered by UnitedHealthcare. Also, the **Eligible Employee** may elect to move to the **MMCP** administered by Highmark from any other **MMCP** under the Plan or from the **MMCP** administered by Highmark to the **MMCP** administered by UnitedHealthcare or Aetna if either of them has been selected by the Plan to be a managed care vendor in the area where the **Eligible Employee** lives. In addition, **Eligible Employees** enrolled in the **BHCB** may choose to enroll instead, along with their **Eligible Dependents**, in the **CHCB** or **MMCP** (where available). Similarly, **Eligible Employees** enrolled in the **CHCB** may elect to be enrolled, along with their **Eligible Dependents**, in the **BHCB** or **MMCP** (where available). Similarly, **Eligible Employees** enrolled in the **CHCB** or **BHCB** may move from the **CHCB** or **BHCB** administered by UnitedHealthcare to the **CHCB** or **BHCB** administered by Highmark or from the **CHCB** or **BHCB** administered by Highmark to the **CHCB** or **BHCB** administered by UnitedHealthcare. Any **Eligible Employee's** election will be effective on the subsequent January 1, or on such other date as may be announced by the Plan.

- **Transfer to MMCP.** At any time, **Eligible Employees** enrolled in the **CHCB** may request any company administering the **MMCP** in the area where they live to enroll them, along with their **Eligible Dependents**, in the **MMCP** administered by that company. Enrollment in that **MMCP** will become effective on the first day of the month following the month in which the **MMCP** enrollment process is completed, and must then remain in effect until the next Open Enrollment as described in the preceding paragraph.

IV

Employee and Dependents Health Care Benefits

The Plan provides the Comprehensive Health Care Benefit (**CHCB**), the Managed Medical Care Program (**MMCP**), the Basic Health Care Benefit (**BHCB**), the Mental Health and Substance Abuse Care Benefit (**MHSA**), and the Managed Pharmacy Services Benefit (**MPSB**). The **CHCB**, **MMCP**, **BHCB**, and **MHSA** provide payment for **Eligible Expenses** for **Covered Health Services**. The **MPSB** provides payment for **Eligible Expenses** for **Prescription Drugs** obtained from a pharmacy or by mail order. The general rules that apply in determining whether or not an expense is an **Eligible Expense** for **Covered Health Services** are explained at pages 91 through 92.

Special Arrangements with Providers Applicable to the CHCB and the Out-of-Network Services Portion of the BHCB, MMCP and MHSA

The Plan enjoys arrangements with various health care providers pursuant to which those providers' charges for **Eligible Expenses** under the **CHCB** and the **Out-of-Network Services** portion of the **BHCB**, **MMCP** and **MHSA** are discounted. These discounts are made available to **Covered Family Members** as a result of direct and indirect arrangements with the providers through Highmark, UnitedHealthcare, Aetna and Coalition America, Inc.

Many of the providers that have such arrangements with Highmark that are applicable to the **CHCB** are called **BlueCross BlueShield Participating Providers** and, with UnitedHealthcare, **UnitedHealthcare Preferred Providers**.

If **BlueCross BlueShield Participating Providers** or **UnitedHealthcare Preferred Providers** are used for services under the **CHCB**, the amount of **Eligible Expenses** for which you are responsible will generally be less than if other

providers are used. The same is true with respect to additional providers who have direct or indirect discount arrangements that are made available to **Covered Family Members**. The percentage of **Eligible Expenses** payable remains the same. However, because the **Eligible Expenses** may be less when **BlueCross BlueShield Participating Providers** or **UnitedHealthcare Preferred Providers** are used, the portion that you owe will be less. Again, the same is true with respect to the additional providers whose direct or indirect discount arrangements are made available to **Covered Family Members**.

You will receive an Identification Card showing that you and your **Eligible Dependents** are entitled to these discounts where available from **BlueCross BlueShield Participating Providers** or **UnitedHealthcare Preferred Providers**. This Identification Card must be shown every time health care services are given. This is how the provider knows that you or your **Eligible Dependent** is covered under one of these programs. Otherwise, you could be billed for the provider's normal charge.

Call Highmark at 1-866-267-3320 for a directory of **BlueCross BlueShield Participating Providers** or visit their website at www.bcbs.com. Call UnitedHealthcare at 1-888-445-4379 for a directory of **UnitedHealthcare Preferred Providers**, or visit their website at www.myuhc.com.

BlueCross BlueShield Participating Providers and **UnitedHealthcare Preferred Providers** are generally responsible for filing your claims. In most cases, you do not need to submit claims for services or supplies you receive from them.

You must submit claims for services and supplies rendered by other providers, including providers who have direct or indirect discount arrangements that are made available to **Covered Family Members**, unless the provider undertakes to do so for you. See the section of this booklet entitled "Processing of Claims and Benefit Determinations" at page 166.

If a **BlueCross BlueShield Participating Provider** bills you for any part of the discount amount or for any amount beyond the applicable deductible and the percentage of **Eligible Expenses** you owe, call Highmark at 1-866-267-3320. If the bill is from a **UnitedHealthcare Preferred Provider**, call UnitedHealthcare at 1-888-445-4379.

COMPREHENSIVE HEALTH CARE BENEFIT

The **CHCB** pays a percentage of **Eligible Expenses** for **Covered Health Services** that consist of **Medical Care** in a calendar year that exceed the applicable deductible.

To receive the highest benefit level, you must comply with care coordination/medical management requirements (see pages 56 through 59).

Eligible Expenses for **Covered Health Services** that consist of **Mental Health Care** or **Substance Abuse Care**, or for **Prescription Drugs** obtained as part of outpatient **Medical Care** (except with respect to **Home Health Care Agency** services) are not covered under the **CHCB**. The Plan does cover these **Eligible Expenses**, however, to the extent provided under the **MHSA** (see pages 79 through 90) and the **MPSB** (see pages 108 through 115).

Deductibles

There are two types of deductibles, Individual and Family. The Individual Deductible is \$100. It applies separately to each **Covered Family Member** each calendar year.

The Family Deductible is \$300. This is the most you and your **Eligible Dependents** will have to pay for Individual Deductibles in any calendar year. This Family Deductible applies no matter how many **Covered Family Members** you have. Only **Eligible Expenses** which count toward a person's Individual Deductible count toward the Family Deductible.

Payments made toward satisfying any deductible under the **CHCB** will also count toward satisfying the applicable deductible under the **BHCB**, the **Out-of-Network Services** portions of the **MHSA** and the **MMCP** and, for those enrolled in the **BHCB**, the **In-Network Services** portion of the **MHSA**.

Percentage of Covered Eligible Expenses Payable

In those areas where the Plan does not offer the **MMCP**, the **CHCB** pays:

- 85% of **Eligible Expenses** incurred until the Out-of-Pocket Maximum is reached, but only

- 68% of **Eligible Expenses** (a 20% reduction in benefits) if a required notice to the company (Highmark or UnitedHealthcare) administering your **CHCB** is not given or if that company determines in performing its care coordination/medical management function that, although the service or supply is a **Covered Health Service**, it is not **Medically Appropriate**.

In those areas where the Plan does offer the **MMCP**, the **CHCB** pays:

- 75% of **Eligible Expenses** incurred until the Out-of-Pocket Maximum is reached, but only
- 60% of **Eligible Expenses** (a 20% reduction in benefits) if a required notice to the company (Highmark or UnitedHealthcare) administering your **CHCB** is not given or if that company determines in performing its care coordination/medical management function that, although the service or supply is a **Covered Health Service**, it is not **Medically Appropriate**.

When the annual Out-of-Pocket Maximum is met, the **CHCB** pays:

- 100% of **Eligible Expenses** for the remainder of the calendar year, but only
- 80% of **Eligible Expenses** (a 20% reduction in benefits) if a required notice to the company (Highmark or UnitedHealthcare) administering your **CHCB** is not given or if that company determines in performing its care coordination/medical management function that, although the service or supply is a **Covered Health Service**, it is not **Medically Appropriate**.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum limits the amount of **Eligible Expenses** you will have to pay in a calendar year.

There are two types of Out-of-Pocket Maximums, Individual and Family.

- The Individual Out-of-Pocket Maximum is \$1,500 each calendar year.

- The Family Out-of-Pocket Maximum is \$3,000 each calendar year. This Family Out-of-Pocket Maximum applies no matter how many **Covered Family Members** you have. Only **Eligible Expenses** which count toward a person's Individual Out-of-Pocket Maximum count toward the Family Out-of-Pocket Maximum.

Payments made toward satisfying the Out-of-Pocket Maximum under the **CHCB** also count toward satisfying the Out-of-Pocket Maximum under the **BHCB**, the **Out-of-Network** portions of the **MHSA** and **MMCP**, and, for those enrolled in the **BHCB**, the **In-Network Services** portion of the **MHSA** as well.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the **Reasonable Charge**.
- Charges you pay that are in excess of specific Plan limits or exclusions or for expenses not covered by the Plan.
- Co-payments you make for **In-Network Services** under the **MMCP** or, during periods when you are enrolled in either the **MMCP** or **CHCB**, for **In-Network Services**, under the **MHSA**.
- Co-payments you make and any other charges you pay under the **MPSB**.
- Charges you pay towards the Individual Deductible under the **CHCB**, the **BHCB**, the **Out-of-Network Services** portions of the **MMCP** and **MHSA** or, for those enrolled in the **BHCB**, the **In-Network Services** portion of the **MHSA**.
- Charges you pay as a result of the 20% reduction in benefits under the **Out-of-Network Services** portions of the **MMCP** and **BHCB** if a required notice under the applicable care coordination/medical management procedures of the company administering your **MMCP** or **BHCB** is not given or if that company determines that the service or supply, although a **Covered Health Service**, is not **Medically Appropriate**.
- Charges you pay as a result of the 50% reduction in benefits under the **Out-of-Network Services** portion of

the **MHSA** if required **Certification** from ValueOptions is not obtained.

Maximum Benefit

The lifetime maximum benefit payable for you or for any **Eligible Dependent** is \$1,000,000. Any part of it you have used, up to \$5,000, will be restored on each January 1.

This lifetime maximum benefit includes any amount paid under the **CHCB**, for **Out-of-Network Services** under the **MMCP** or **BHCB**, and for **Out-of-Network Services** for **Mental Health Care** under the **MHSA**.

There is no lifetime maximum benefit under the **MPSB**, under the **In-Network Services** portion of the **BHCB**, **MMCP** or, with respect to those in the **CHCB** or **MMCP**, under the **In-Network Services** portion of the **MHSA**.

There is a separate lifetime maximum benefit of \$100,000 for **Out-of-Network Services** for **Substance Abuse Care** under the **MHSA**.

The amounts counted under The Railroad Employees National Health and Welfare Plan against the lifetime maximum benefit of \$1,000,000 or the separate lifetime maximum of \$100,000 for **Substance Abuse Care** benefits shall also count against the similar lifetime maximum benefits provided under this Plan.

Care Coordination/Medical Management

The care coordination/medical management used by the Plan is designed to encourage an efficient system of care for **Covered Family Members** by identifying possible unmet covered health care needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. The care coordination/medical management activities are not a substitute for the medical judgment of your **Physician**, however, and the ultimate decision as to what medical care you actually receive must be made by you and your **Physician**.

Care coordination/medical management is triggered when the company administering your program receives notification of an upcoming treatment or service. The notification process serves as a gateway to care coordination/medical management activities.

When to Notify Care Coordination/Medical Management

Care coordination/medical management at the company administering your program must be notified as soon as possible after you know that you require any of the services or supplies shown below:

- Inpatient admissions to a **Hospital, Birth Center** or **Skilled Nursing Facility**.
- Home health care.
- **Hospice** care.
- Durable medical equipment (over \$1,000).
- Reconstructive procedures.
- Dental services rendered as a result of an accident.

With regard to organ/tissue transplants, care coordination/medical management must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation of a transplant.
- The donor search.

- The organ procurement/tissue harvest.
- The transplant procedure.

For an in-patient confinement which is the result of an **Emergency**, you (or your representative or **Physician**) must call care coordination/medical management within one day (excluding weekends and holidays) from the date the confinement begins.

You should notify care coordination/medical management promptly after you become aware that you are pregnant. You are required to give this notice, however, only if and when inpatient care for the mother or child is expected to continue beyond:

- 48 hours following a normal delivery, or
- 96 hours following a Caesarean section.

The notice you give must be given in sufficient time to allow the company to which it must be given to complete a review of the matter before the services are rendered. In the absence of sufficient advance notice, the company involved may not be able to complete its review and determine, before you incur expenses, if the service is a **Covered Health Service** and, if so, whether it is **Medically Appropriate**.

Remember: This notice obligation is your responsibility. It is not the responsibility of your Physician, your Hospital or any other provider.

This notification requirement does not apply to injuries incurred by an **Eligible Employee** while on duty for an employing railroad, but the customer services of the company that administers your program are available to answer questions about proposed medical treatment.

How to Give the Required Notice

Notice should be given by telephone. Highmark's toll-free number is 1-866-267-3320; UnitedHealthcare's is 1-888-445-4379. Each company's working days are Monday through Friday, except for State and Federal holidays. UnitedHealthcare's usual hours of operation are from 8:00 a.m. to 7:00 p.m. local time. Highmark's are from 8:30 a.m. to 7:00 p.m. However, you can call at any time, day or night. If you call outside a company's normal hours of operation, you may leave a message with your telephone number on an

answering machine, and your call will be returned within one working day.

What Happens After You Give the Required Notice?

The company administering your program reviews the services for which you have given it notice and determines whether they are **Covered Health Services**, and, if so, whether they are **Medically Appropriate**.

*The ultimate decision on your medical care must be made by you and your **Physician**. Review by care coordination/medical management only determines whether the service or supply is a **Covered Health Service**, and, if so, whether it is **Medically Appropriate**, solely for purposes of deciding what, if any, amounts are payable with respect to the service or supply under the Plan.*

Effects on Benefits

- Benefits are reduced if you do not give the required notice or if the company administering your program determines that the service or supply, although a **Covered Health Service**, is not **Medically Appropriate**. In either case, the benefit will be reduced from 85% to 68% (75% to 60% in areas where the Plan offers the **MMCP** and you select the **CHCB**) of **Eligible Expenses**. If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to 80%.
- No benefits are payable if the company administering your program determines that the service or supply is not a **Covered Health Service**.

If the company administering your program determines that a service is not a **Covered Health Service** or is not **Medically Appropriate**, you or your **Physician** can appeal that determination. See pages 170 through 174 for a description of the appeal process.

Case Management Services

The company administering your program also provides case management services. These services focus on severe illnesses and injuries which could result in long-term hospital confinements. The company administering your program will

determine whether case management services are appropriate in your case.

Through case management services, benefits for alternative treatment may be offered to you or your **Eligible Dependent** when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and **Physician**.

*Care coordination/medical management programs also apply under the **MMCP** and **BHCB**. See page 68 and page 76.*

Disease Management Services

The company administering your program also provides disease management services. These services focus on providing information about certain chronic medical conditions, such as heart failure, coronary artery disease, diabetes, or asthma, and the ways these conditions can be treated or managed. If you have been diagnosed with a chronic medical condition, the company administering your program may contact you to discuss this program. Or you can call Highmark at 1-866-267-3320 from 8:30 a.m. until 7:00 p.m. or UnitedHealthcare at 1-888-445-4379 from 8:00 a.m. until 7:00 p.m., to learn whether you are eligible to participate in a disease management program. Each company's working days are Monday through Friday, excluding State and Federal holidays. Participation is voluntary, and there is no charge to **Covered Family Members** for these services.

Through disease management services, benefits for alternative treatment may be offered to you or your **Eligible Dependent** when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and **Physician**.

Telephonic Access to Nurses and Counselors

The company administering your program provides a toll-free telephone service that puts you in immediate contact with a registered nurse any time, 24 hours a day, seven days a week. These nurses can provide health information for routine or urgent health concerns, such as a recent diagnosis, a minor sickness or injury, or other health-related topics. You can also listen to pre-recorded messages on a variety of medical topics.

This service is available to **Covered Family Members** at no charge. To use it, you can call UnitedHealthcare at 1-866-735-5685 or Highmark at 1-888-258-3428.

Through this service, you may learn about benefits for alternative treatment for you or your **Eligible Dependent** when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and **Physician**.

* * * *

*Exclusions applicable to the Comprehensive Health Care Benefit are set forth under the heading "General Exclusions and Limitations" at pages 116 through 122. Also, your benefits may be reduced if you or your **Eligible Dependent** has health benefits under another plan. These benefit reductions are described under the heading "Coordination of Benefits" at pages 123 through 127. Other limitations with respect to Dependents Health Care Benefits are described on pages 42 through 44.*

MANAGED MEDICAL CARE PROGRAM

The **MMCP** provides payment for a wide range of expenses for **Medical Care**. The section of this booklet, starting on page 88 entitled "Eligible Expenses and Covered Health Services" explains what is covered under the **MMCP**.

Eligible Expenses for **Covered Health Services** that consist of **Mental Health Care** or **Substance Abuse Care**, or for **Prescription Drugs** obtained as part of outpatient Medical Care (except with respect to **Home Health Care Agency** services), are not covered under the **MMCP**. The Plan does cover these **Eligible Expenses**, however, to the extent provided under the **MHSA** (see pages 79 through 90) and the **MPSB** (see pages 108 through 115).

The **MMCP** pays for **Eligible Expenses** at two different benefit levels. One benefit level is for **In-Network Services**. The other is for **Out-of-Network Services**.

A brief comparison of these two benefit levels is shown on pages 6 through 7.

IN-NETWORK SERVICES

All **Eligible Expenses** are paid at 100% for **In-Network Services**, except as follows:

- You must pay \$15 for each office visit. This Office Visit Co-payment applies to each office visit to any **In-Network Provider** except for:
 - Visits to your OB/GYN for treatment of a pregnancy after the initial visit to the same OB/GYN for treatment of the same pregnancy.
 - Visits solely for the administration of an allergy shot.
- You must pay \$15 for each visit to an urgent care center listed in your directory of **In-Network Providers**.
- You must pay at least \$30 for each visit to the emergency room of any **Hospital** whether the **Hospital** is an **In-Network Provider** or an **Out-of-Network Provider**. This \$30 emergency room co-payment applies to **Eligible Expenses** for charges made by the **Hospital** for **Emergency** care received in its emergency room. The co-

payment does not apply if confinement as a **Hospital** inpatient is required.

A **Hospital** that is an **Out-of-Network Provider** may ask you to pay more than the \$30 emergency room co-payment. The **Hospital** may even require payment in full at the time services are rendered. In such a case -- indeed, in any case without regard to whether the **Hospital** is an **In-Network Provider** or an **Out-of-Network Provider** -- if the care you receive meets the applicable Plan definition of an **Emergency** (see page 136), the **MMCP** will reimburse you for the full amount of the **Hospital** charge except for \$15, but if the care you receive does not meet the applicable Plan definition of an **Emergency**, only those benefits provided for **Out-of-Network Services** will be paid.

Obtaining Benefits

To obtain benefits for **In-Network Services**, you or your **Eligible Dependent** must use an **In-Network Provider**. You are not required to choose a Primary Care Physician. Nor are you required to obtain a referral in order to receive benefits for specialist care.

Limit on Patient Liability (Balance Billing)

As long as you receive services from an **In-Network Provider**, or through an **Out-of-Network Authorization** prior to receiving specified services from an **Out-of-Network Provider**, all of your **Eligible Expenses** will be paid in full, except for any applicable co-payments.

An **In-Network Provider** cannot charge you for any **In-Network Services** which are not **Covered Health Services**, unless you agree to pay for them. The Plan does not cover them.

Emergencies

In an **Emergency**, the provider does not have to be an **In-Network Provider**. If your case falls within the Plan's definition of an **Emergency** (see page 136), the **MMCP** will pay benefits at the In-Network level. If, however, your case does not fall within the Plan's definition of an **Emergency**, the **MMCP** will pay benefits at the Out-of-Network level.

To receive the In-Network level of benefits after the **Emergency** has ended, you must use **In-Network Providers**.

OUT-OF-NETWORK SERVICES

All **Eligible Expenses** for **Out-of-Network Services** are paid at the percentages set forth on pages 6 through 7 of this booklet that exceed any applicable deductible if you or your **Eligible Dependents** do not have an **Out-of-Network Authorization**.

*To receive the maximum benefit for **Out-of-Network Services**, you must comply with the care coordination/medical management of the company administering your **MMCP** (see pages 68 through 69.) If UnitedHealthcare administers your **MMCP**, call 1-888-445-4379. If Aetna administers your **MMCP**, call 1-800-821-5615. If Highmark administers your **MMCP**, call 1-866-267-3320.*

Deductibles

There are two types of deductibles for **Out-of-Network Services**, an Individual Deductible and a Family Deductible. Payments made toward satisfying any deductible under the **Out-of-Network Services** portion of the **MMCP** will also count toward satisfying the applicable deductible under the **CHCB**, the **BHCB**, the **Out-of-Network Services** portion of the **MHSA**, and, for those enrolled in the **BHCB**, the **In-Network Services** portion of the **MHSA**.

- The Individual Deductible is \$200. It applies separately to each **Covered Family Member** each calendar year.
- The Family Deductible is \$600. This is the most you and your **Eligible Dependents** will have to pay for Individual Deductibles in any calendar year. This Family Deductible applies no matter how many **Covered Family Members** you have. Only **Eligible Expenses** which count toward a person's Individual Deductible count toward the Family Deductible.

Percentage of Eligible Expenses Payable

Benefits for **Eligible Expenses** for **Out-of-Network Services** are paid as follows:

Before the annual Out-of-Pocket Maximum is met, the **MMCP** pays:

- 75% of **Eligible Expenses**, but only
- 60% of **Eligible Expenses** (a 20% reduction in benefits) if a required notice to the company (Highmark, UnitedHealthcare or Aetna) administering your **MMCP** is not given or if that company determines in performing its care coordination/ medical management function that the service or supply, although a **Covered Health Service**, is not **Medically Appropriate**.

After the annual Out-of-Pocket Maximum is met, the **MMCP** pays:

- 100% of **Eligible Expenses** for the remainder of the calendar year, but only
- 80% of **Eligible Expenses** (a 20% reduction in benefits) if a required notice to the company (Highmark, UnitedHealthcare or Aetna) administering your **MMCP** is not given or if that company determines in performing its care coordination/medical management function that the service or supply, although a **Covered Health Service**, is not **Medically Appropriate**.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum limits the amount of **Eligible Expenses** you will have to pay in a calendar year for **Out-of-Network Services**. Any Out-of-Pocket Maximum satisfied under the **Out-of-Network Services** portion of the **MMCP** will also be considered satisfied under the **CHCB** and under the **Out-of-Network Services** portions of the **MHSA** and **BHCB**.

There are two types of Out-of-Pocket Maximums, Individual and Family.

- The Individual Out-of-Pocket Maximum is \$1,500 each calendar year.

- The Family Out-of-Pocket Maximum is \$3,000 each calendar year. This Family Out-of-Pocket Maximum applies no matter how many **Covered Family Members** you have. Only **Eligible Expenses** which count toward a person's Individual Out-of-Pocket Maximum count toward the Family Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the **Reasonable Charge**.
- Charges you pay that are in excess of specific Plan limits or exclusions or for expenses not covered by the Plan.
- Co-payments you make for **In-Network Services** under the **MMCP** or, during periods when you are enrolled in either the **MMCP** or the **CHCB**, for **In-Network Services** under the **MHSA**.
- Co-payments you make and any other charges you pay under the **MPSB**.
- Charges you pay towards the Individual Deductible under the **CHCB**, the **BHCB**, the **Out-of-Network Services** portions of the **MMCP** and **MHSA**, or, for those enrolled in the **BHCB**, the **In-Network Services** portion of the **MHSA**.
- Charges you pay as a result of the 20% reduction in benefits under the **Out-of-Network Services** portions of the **MMCP** and **BHCB** if a required notice under the applicable care coordination/medical management procedures of the company administering your **MMCP** or **BHCB**, as the case may be, is not given or if that company determines that the service or supply, although a **Covered Health Service**, is not **Medically Appropriate**.
- Charges you pay as a result of the 50% reduction in benefits under the **Out-of-Network Services** portion of the **MHSA** if required **Certification** from ValueOptions is not obtained.

Maximum Benefit

The lifetime maximum benefit payable for **Out-of-Network Services** for you or for any **Eligible Dependent** is \$1,000,000. Any part of it you have used, up to \$5,000, will be restored on each January 1.

This lifetime maximum benefit includes any amount paid under the **CHCB**, for **Out-of-Network Services** under the **MMCP** or **BHCB**, or for **Out-of-Network Services** for **Mental Health Care** under the **MHSA**. It also includes the total amount that counts for purposes of applying the same lifetime maximum benefit under The Railroad Employees National Health and Welfare Plan.

There is no lifetime maximum benefit under the **MPSB**, under the **In-Network Services** portion of the **BHCB**, **MMCP** or, with respect to those in the **CHCB** or **MMCP**, under the **In-Network Services** portion of the **MHSA**.

There is a separate lifetime maximum benefit of \$100,000 for **Out-of-Network Services** for **Substance Abuse Care** under the **MHSA**.

Care Coordination/Medical Management Program

The care coordination/medical management procedures that apply under the **CHCB** also apply to the **Out-of-Network** portion of the **MMCP**. They are described in the **CHCB** section of this booklet at pages 56 through 59. Please review them carefully.

How to Notify Care Coordination/Medical Management

Notice should be given by telephone. Highmark's toll-free number is 1-866-267-3320; UnitedHealthcare's is 1-888-445-4379; Aetna's is 1-800-821-5615. Each company's working days are Monday through Friday, except for State and Federal holidays. UnitedHealthcare's usual hours of operation are from 8:00 a.m. to 7:00 p.m. local time. Highmark's are from 8:30 a.m. to 7:00 p.m. Aetna's are from 8:00 a.m. to 5:00 p.m. However, you can call at any time, day or night. If you call outside a company's usual hours of operation, you may leave a message with your telephone number on an answering machine, and your call will be returned within one working day.

Effects on Benefits

- Benefits are reduced if you do not call care coordination/medical management as required at the company administering your program or if that company determines that the service or supply, although a **Covered Health Service**, is not **Medically Appropriate**. In either case, the benefit will be reduced from 75% to 60% of **Eligible Expenses**. If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to 80%.
- No benefits are payable if care coordination/medical management at the company administering your program determines that the service or supply is not a **Covered Health Service**.

If care coordination/medical management at the company administering your program determines that a service is not a **Covered Health Service** or is not **Medically Appropriate**, you or your **Physician** can appeal that determination. See pages 170 through 174 of this booklet for a description of the appeal procedure.

Case Management Services

The company administering your **MMCP** also provides case management services in connection with your program. These services focus on severe illnesses and injuries which could result in long-term hospital confinements. The company administering your **MMCP** will determine whether the services of case management are appropriate in your case.

Through case management services, benefits for alternative treatment may be offered to you or your **Eligible Dependent** when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and **Physician**.

Disease Management Services

The company administering your program also provides disease management services. These services focus on providing information about certain chronic medical conditions, such as heart failure, coronary artery disease, diabetes, or asthma, and the ways these conditions can be treated or managed. If you have been diagnosed with a chronic medical condition, the company administering your program may contact you to discuss this program. Or you can call Highmark at 1-866-267-3320 from 8:30 a.m. until 7:00 p.m., UnitedHealthcare at 1-888-445-4379 from 8:00 a.m. to 7:00 p.m., or Aetna at 1-866-269-4500, from 8:00 a.m. until 12:00 midnight, to learn whether you are eligible to participate in a disease management program. Each company's working days are Monday through Friday, except for State and Federal holidays. Participation is voluntary, and there is no charge to **Covered Family Members** for these services.

Through disease management services, benefits for alternative treatment may be offered to you or your **Eligible Dependent** when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and **Physician**.

Telephonic Access to Nurses and Counselors

The company administering your program provides a toll-free telephone service that puts you in immediate contact with a registered nurse any time, 24 hours a day, seven days a week. These nurses can provide health information for routine or urgent health concerns, such as a recent diagnosis, a minor sickness or injury, or other health-related topics. You can also listen to pre-recorded messages on a variety of medical topics.

This service is available to **Covered Family Members** at no charge. To use it, you can call UnitedHealthcare at 1-866-735-5685, Highmark at 1-888-258-3428, or Aetna at 1-800-556-1555.

Through this service, you may learn about benefits for alternative treatment for you or your **Eligible Dependent** when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and **Physician**.

* * * *

*Exclusions applicable to the Managed Medical Care Program are set forth under the heading "General Exclusions and Limitations" at pages 116 through 122. Also, your benefits may be reduced if you or your **Eligible Dependent** has health benefits under another plan. These benefit reductions are described under the heading "Coordination of Benefits" at pages 123 through 127. Other limitations with respect to Dependents Health Care Benefits are described on pages 42 through 44.*

BASIC HEALTH CARE BENEFIT

The **BHCB** pays a percentage of **Eligible Expenses** for **Covered Health Services** that consist of **Medical Care** in a calendar year that exceed the applicable deductible.

To receive the highest benefit level, you must comply with care coordination/medical management requirements (see page 76).

Eligible Expenses for **Covered Health Services** that consist of **Mental Health Care** or **Substance Abuse Care**, or for **Prescription Drugs** obtained as part of outpatient **Medical Care** (except with respect to **Home Health Care Agency** services) are not covered under the **BHCB**. The Plan does cover these **Eligible Expenses**, however, to the extent provided under the **MHSA** (see pages 79 through 90) and the **MPSB** (see pages 108 through 115). Individuals covered under the **BHCB** receive different benefits under the **MHSA** and the **MPSB** than individuals covered under the **CHCB** or **MMCP**.

The **BHCB** pays a percentage of **Eligible Expenses** at two different benefit levels. One benefit level is for **In-Network Services**. The other is for **Out-of-Network Services**. A brief comparison of these two benefit levels is shown on page 8.

Deductibles

There are two types of deductibles, Individual and Family. Amounts paid toward satisfying a deductible under the **BHCB** will also count toward satisfying the applicable deductible under the **CHCB**, the **Out-of-Network Services** portions of the **MMCP** and **MHSA**, and, for those enrolled in the **BHCB**, the **In-Network Services** portion of the **MHSA** as well.

The Individual Deductible is \$300. It applies separately to each **Covered Family Member** each calendar year.

The Family Deductible is \$900. This is the most you and your **Eligible Dependents** will have to pay for Individual Deductibles in any calendar year. This Family Deductible applies no matter how many **Covered Family Members** you have. Only **Eligible Expenses** which count toward a person's Individual Deductible count toward the Family Deductible.

Percentage of Eligible Expenses Payable

For **In-Network Services**, the **BHCB** pays:

- 70% of **Eligible Expenses** incurred until the Out-of-Pocket Maximum is reached, but only
- 56% of **Eligible Expenses** (a 20% reduction in benefits) if a required notice to the company (Highmark or UnitedHealthcare) is not given or if that company determines in performing its care coordination/medical management function that, although the service or supply is a **Covered Health Service**, it is not **Medically Appropriate**.

For **Out-of-Network Services**, the **BHCB** pays:

- 50% of **Eligible Expenses** incurred until the Out-of-Pocket Maximum is reached, but only
- 40% of **Eligible Expenses** (a 20% reduction in benefits) if a required notice to the company (Highmark or UnitedHealthcare) is not given or if that company determines in performing its care coordination/medical management function that, although the service or supply is a **Covered Health Service**, it is not **Medically Appropriate**.

For both **In-Network Services** and **Out-of-Network Services**, when the annual Out-of-Pocket Maximum is met, the **BHCB** pays:

- 100% of **Eligible Expenses** for the remainder of the calendar year, but only
- 80% of **Eligible Expenses** (a 20% reduction in benefits) if a required notice to the company (Highmark or UnitedHealthcare) is not given or if that company in performing its care coordination/medical management function determines that, although the service or supply is a **Covered Health Service**, it is not **Medically Appropriate**.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum limits the amount of **Eligible Expenses** you will have to pay in a calendar year.

There are two types of Out-of-Pocket Maximums, Individual and Family.

- The Individual Out-of-Pocket Maximum is \$2,500 each calendar year.
- The Family Out-of-Pocket Maximum is \$5,000 each calendar year. This Family Out-of-Pocket Maximum applies no matter how many **Covered Family Members** you have. Only **Eligible Expenses** which count toward a person's Individual Out-of-Pocket Maximum count toward the Family Out-of-Pocket Maximum.

Payments made toward satisfying the Out-of-Pocket Maximum under the **BHCB** will also count toward satisfying the Out-of-Pocket Maximum under the **CHCB**, the **Out-of-Network Services** portions of the **MMCP** and the **MHSA**, and, for those enrolled in the **BHCB**, the **In-Network Services** portion of the **MHSA**.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the **Reasonable Charge**.
- Charges you pay that are in excess of specific Plan limits or exclusions or for expenses not covered by the Plan.
- Co-payments you make for **In-Network Services** under the **MMCP** or, during periods when you are enrolled in either the **MMCP** or the **CHCB**, for **In-Network Services** under the **MHSA**.
- Co-payments you make or any other charges you pay under the **MPSB**.
- Charges you pay toward the Individual Deductible or the Family Deductible under the **BHCB**, the **CHCB**, the **Out-of-Network Services** portions of the **MHSA** and **MMCP**, or, for those enrolled in the **BHCB**, the **In-Network Services** portion of the **MHSA**.
- Charges you pay as a result of the 20% reduction in benefits under the **Out-of-Network Services** portions of the **MMCP** and **BHCB** if a required notice under the applicable care coordination/medical management procedures of the company administering your **MMCP** or

BHCB, as the case may be, is not given or if that company determines that the service or supply, although a **Covered Health Service**, is not **Medically Appropriate**.

- Charges you pay as a result of the 50% reduction in benefits under the **Out-of-Network Services** portion of the **MHSA** if required ValueOptions **Certification** is not obtained.

Maximum Benefit

This lifetime maximum benefit payable for **Out-of-Network Services** for you or for any **Eligible Dependent** is \$1,000,000. Any part of it you have used, up to \$5,000, will be restored on each January 1.

This lifetime maximum benefit includes any amount paid under the **CHCB**, for **Out-of-Network Services** under the **MMCP**, or for **Out-of-Network Services** for **Mental Health Care** under the **MHSA**.

There is no lifetime maximum benefit under the **MPSB**, under the **In-Network Services** portion of the **BHCB**, **MMCP** or, with respect to those in the **CHCB** or **MMCP**, under the **In-Network Services** portion of the **MHSA**.

There is a separate lifetime maximum benefit of \$100,000 for **Out-of-Network Services** for **Substance Abuse Care** under the **MHSA**.

The amounts counted under The Railroad Employees National Health and Welfare Plan against the lifetime maximum benefit of \$1,000,000 or the separate lifetime maximum benefit of \$100,000 for **Substance Abuse Care** benefits count against the similar lifetime maximum benefits provided under this Plan.

Obtaining Benefits

To obtain benefits for **In-Network Services**, you or your **Eligible Dependent** must receive services from an **In-Network Provider**. See page 139 of this booklet for a definition of "In-Network Provider." You are not required to choose a Primary Care Physician. Nor are you required to obtain a referral in order to receive benefits for specialist care.

An **In-Network Provider** cannot charge you for any **In-Network Services** which are not **Medically Appropriate** unless you agree to pay for them. The Plan does not cover them.

Emergencies

If you have an **Emergency**, the **BHCB** will pay benefits at the **In-Network** level, even if you do not receive care from an **In-Network Provider**. If, however, your case does not fall within the Plan's definition of an **Emergency**, the **BHCB** will pay benefits at the **Out-of-Network** level.

To receive the In-Network level of benefits after the **Emergency** has ended, you must comply with the care coordination/medical management requirements set forth at page 76 of this booklet.

You may use any provider for **Out-of-Network Services**.

Care Coordination/Medical Management

The care coordination/medical management procedures and the case management services that apply under the **CHCB** also apply under the **BHCB**. They are described in the **CHCB** section of this booklet at pages 56 through 59. Please review them carefully.

How to Notify Care Coordination/Medical Management

Notice should be given by telephone. Highmark's toll-free number is 1-866-267-3320. UnitedHealthcare's is 1-888-445-4379. Each company's working days are Monday through Friday, except for State and Federal holidays. UnitedHealthcare's usual hours of operation are from 8:00 a.m. to 7:00 p.m. local time. Highmark's are from 8:30 a.m. to 7:00 p.m. However, you can call at any time, day or night. If you call outside the hours of operation, you may leave a message with your telephone number on an answering machine, and your call will be returned within one working day.

Effects on Benefits

- Benefits are reduced if you do not call care coordination/medical management as required or if it determines that the service or supply, although a **Covered Health Service**, is not **Medically Appropriate**. In either case, the benefit will be reduced from 70% to 56% if you use **In-Network Services** and from 50% to 40% if you use **Out-of-Network Services**.
- If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to 80%.
- No benefits are payable if care coordination/medical management determines that the service or supply is not a **Covered Health Service**.

If care coordination/medical management determines that a service is not a **Covered Health Service** or is not **Medically Appropriate**, you or your **Physician** can appeal that determination. See pages 170 through 174 of this booklet for a description of the appeal procedure.

Disease Management Services

The company administering your program also provides disease management services. These services focus on providing information about certain chronic medical conditions, such as heart failure, coronary artery disease, diabetes, or asthma, and the ways these conditions can be treated or managed. If you have been diagnosed with a chronic medical condition, the company administering your program may contact you to discuss this program. Or you can call Highmark at 1-866-267-3320 from 8:30 a.m. until 7:00 p.m. or UnitedHealthcare at 1-888-445-4379 from 8:00 a.m. until 7:00 p.m., to learn whether you are eligible to participate in a disease management program. Each company's working days are Monday through Friday, excluding State and Federal holidays. Participation is voluntary, and there is no charge to **Covered Family Members** for these services.

Through disease management services, benefits for alternative treatment may be offered to you or your **Eligible Dependent** when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and **Physician**.

Telephonic Access to Nurses and Counselors

The company administering your program provides a toll-free telephone service that puts you in immediate contact with a registered nurse any time, 24 hours a day, seven days a week. These nurses can provide health information for routine or urgent health concerns, such as a recent diagnosis, a minor sickness or injury, or other health-related topics. You can also listen to pre-recorded messages on a variety of medical topics.

This service is available to **Covered Family Members** at no charge. To use it, you can call UnitedHealthcare at 1-866-735-5685 or Highmark at 1-888-258-3428.

Through this service, you may learn about benefits for alternative treatment for you or your **Eligible Dependent** when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and **Physician**.

* * * *

*Exclusions applicable to the **BHCB** are set forth under the heading "General Exclusions and Limitations" at pages 116 through 122. Also, your benefits may be reduced if you or your **Eligible Dependent** has health benefits under another plan. These benefit reductions are described under the heading "Coordination of Benefits" at pages 123 through 127. Other limitations with respect to Dependents Health Care Benefits are described on pages 42 through 44.*

MENTAL HEALTH AND SUBSTANCE ABUSE CARE BENEFIT

The **MHSA**, administered by **ValueOptions**, pays for certain **Eligible Expenses** (see pages 91 through 92) for **Mental Health Care** or **Substance Abuse Care**. This Benefit does not cover **Medical Care**; nor does it cover **Prescription Drugs** obtained as part of outpatient **Mental Health Care** or **Substance Abuse Care**. The Plan does cover these expenses (if they are **Eligible Expenses**), however, to the extent provided under the **CHCB**, **BHCB** or **MMCP** as to **Medical Care** (see pages 52 through 78) and under the **MPSB** as to **Prescription Drugs** (see pages 108 through 115).

Different levels of benefits are paid under the **MHSA** depending upon whether you obtain **In-Network Services** or **Out-of-Network Services**. To receive the highest benefit level, you must use **In-Network Services**. To receive the maximum benefit that is payable when you use **Out-of-Network Services**, you must comply with **ValueOptions Certification** or **Pretreatment Outpatient Assessment** requirements described at pages 87 through 89.

All questions about Plan benefits, rules and procedures with regard to **Mental Health Care** or **Substance Abuse Care**, including the names of **ValueOptions Providers** in your area, or any question about the Plan's definitions of **Mental Health Care** and **Substance Abuse Care** (see page 142 and page 149), or whether the **MHSA** applies to a particular sickness or injury, should be directed to ValueOptions at 1-800-934-7245, or you may visit their website at www.valueoptions.com.

Percentage of Eligible Expenses Payable for Individuals Enrolled in the CHCB or MMCP

For **In-Network Services**, the **MHSA** pays the following for **Eligible Employees** and their **Dependents** who are enrolled in the **CHCB** or **MMCP**:

- 100% of the **Eligible Expenses** for inpatient care. No co-payment by you or your **Eligible Dependent** is required.
- 100% of the **Eligible Expenses** for outpatient care, other than **Prescription Drugs**, after you or your **Eligible**

Dependent makes a \$15 co-payment for each visit to the provider.

*There is no annual deductible with respect to **In-Network Services**.*

*There is no annual Out-of-Pocket Maximum with respect to **In-Network Services**.*

*There is no lifetime limitation on the amount of benefits payable with respect to **In-Network Services**.*

For **Out-of-Network Services**, the **MHSA** pays:

- For inpatient care in a **Hospital**, 75% of the **Eligible Expenses** incurred in a calendar year that exceed the applicable deductible, except that only 38% of the **Eligible Expenses** will be paid if required ValueOptions **Certification** is not obtained.
- For outpatient care, other than at a **Treatment Center** or an **Outpatient Clinic**, rendered by a Doctor of Medicine (M.D.) or a **Psychologist**, 75% of the **Eligible Expenses**, other than **Prescription Drugs**, incurred in a calendar year that exceed the applicable deductible, except that only 38% of the **Eligible Expenses** will be paid if required ValueOptions **Certification** is not obtained.
- For **Treatment Center** and **Outpatient Clinic** services, 75% of the **Eligible Expenses** (see pages 105 through 107 for a description of what expenses for **Treatment Center** services are **Eligible Expenses**) that exceed the applicable deductible, except that only 38% of the **Eligible Expenses** will be paid if ValueOptions **Certification** is not obtained.
- For transportation to and from a **Treatment Center** in connection with each confinement for which benefits are payable, 75% of the **Eligible Expenses** that exceed the applicable deductible, except that only 38% of **Eligible Expenses** will be paid if ValueOptions **Certification** is not obtained. Moreover, no benefits will be paid for transportation to and from a **Treatment Center** other than the one that ValueOptions determines provides the most appropriate and economical treatment program, and the maximum benefit for transportation to and from a **Treatment Center** shall not exceed \$500 per confinement.

*The MHSAs do not cover any outpatient **Out-of-Network Services** (other than **Treatment Center** and **Outpatient Clinic** services, see pages 105 through 107) that are rendered by a provider other than a Doctor of Medicine (M.D.) or a **Psychologist**.*

Percentage of Eligible Expenses Payable for Individuals Enrolled in the BHCB

For **In-Network Services**, the **MHSA** pays the following for **Eligible Employees** and their **Dependents** who are enrolled in the **BHCB**:

- For inpatient care in a **Hospital**, 70% of the **Eligible Expenses** incurred in a calendar year that exceed the applicable deductible, except that only 35% of the **Eligible Expenses** will be paid if required ValueOptions **Certification** is not obtained.
- For outpatient care, other than at a **Treatment Center** or an **Outpatient Clinic**, rendered by a Doctor of Medicine (M.D.) or a **Psychologist**, 70% of the **Eligible Expenses**, other than **Prescription Drugs**, incurred in a calendar year that exceed the applicable deductible, except that only 35% of the **Eligible Expenses** will be paid if required ValueOptions **Certification** is not obtained.
- For **Treatment Center** and **Outpatient Clinic** services, 70% of the **Eligible Expenses** (see pages 105 through 107 for a description of what expenses for **Treatment Center** services are **Eligible Expenses**) that exceed the applicable deductible, except that only 35% of the **Eligible Expenses** will be paid if ValueOptions **Certification** is not obtained.
- For transportation to and from a **Treatment Center** in connection with each confinement for which benefits are payable, 70% of the **Eligible Expenses** that exceed the applicable deductible, except that only 35% of **Eligible Expenses** will be paid if ValueOptions **Certification** is not obtained. Moreover, no benefits will be paid for transportation to and from a **Treatment Center** other than the one that ValueOptions determines provides the most appropriate and economical treatment program, and the maximum benefit for transportation to and from a

Treatment Center shall not exceed \$500 per confinement.

For **Out-of-Network Services**, the **MHSA** pays the following for **Eligible Employees** and their **Dependents** who are enrolled in the **BHCB**:

- For inpatient care in a **Hospital**, 50% of the **Eligible Expenses** incurred in a calendar year that exceed the applicable deductible, except that only 25% of the **Eligible Expenses** will be paid if required ValueOptions **Certification** is not obtained.
- For outpatient care, other than at a **Treatment Center** or an **Outpatient Clinic**, rendered by a Doctor of Medicine (M.D.) or a **Psychologist**, 50% of the **Eligible Expenses**, other than **Prescription Drugs**, incurred in a calendar year that exceed the applicable deductible, except that only 25% of the **Eligible Expenses** will be paid if required ValueOptions **Certification** is not obtained.
- For **Treatment Center** and **Outpatient Clinic** services, 50% of the **Eligible Expenses** (see pages 105 through 107 for a description of what expenses for **Treatment Center** services are **Eligible Expenses**) that exceed the applicable deductible, except that only 25% of the **Eligible Expenses** will be paid if ValueOptions **Certification** is not obtained.
- For transportation to and from a **Treatment Center** in connection with each confinement for which benefits are payable, 50% of the **Eligible Expenses** that exceed the applicable deductible, except that only 25% of **Eligible Expenses** will be paid if ValueOptions **Certification** is not obtained. Moreover, no benefits will be paid for transportation to and from a **Treatment Center** other than the one that ValueOptions determines provides the most appropriate and economical treatment program, and the maximum benefit for transportation to and from a **Treatment Center** shall not exceed \$500 per confinement.

Deductibles

There are two types of deductibles, an Individual Deductible and a Family Deductible. If you are enrolled in the **BHCB**, the deductibles apply to both **In-Network Services** and **Out-of-**

Network Services under the **MHSA**. If you are enrolled in the **CHCB** or **MMCP**, the deductibles apply only to **Out-of-Network Services** obtained through the **MHSA**. Payments made toward satisfying any deductible under the **MHSA** also count toward satisfying the applicable deductible under the **CHCB**, the **BHCB**, and the **Out-of-Network Services** portion of the **MMCP**.

- The amount of the Individual Deductible is \$100 if you and/or your **Eligible Dependents** are enrolled in the **CHCB** or **MMCP**, and \$300 if you and/or your **Eligible Dependents** are enrolled in the **BHCB**. Both apply separately to each **Covered Family Member** each calendar year.
- The Family Deductible is \$300 if you and/or your **Eligible Dependents** are enrolled in the **CHCB** or **MMCP**. The Family Deductible is \$900 if you and/or your **Eligible Dependents** are enrolled in the **BHCB**. The Family Deductible is the most you and your **Eligible Dependents** will have to pay for Individual Deductibles under this Plan in any calendar year. This Family Deductible applies no matter how many **Covered Family Members** you have. Only **Eligible Expenses** which count toward a person's Individual Deductible count toward the Family Deductible.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum limits the amount of **Eligible Expenses** you will have to pay in a calendar year. If you are enrolled in the **BHCB**, the Out-of-Pocket Maximum limits the amount you will have to pay for both **In-Network Services** and **Out-of-Network Services**. If you are enrolled in the **CHCB** or **MMCP**, the Out-of-Pocket Maximum limits the amount you will have to pay for **Out-of-Network Services**.

There are two types of Out-of-Pocket Maximums for **Out-of-Network Services**, Individual and Family.

- The Individual Out-of-Pocket Maximum is \$1,500 each calendar year if you and/or your **Eligible Dependents** are enrolled in the **CHCB** or **MMCP**. The Individual Out-of-Pocket Maximum is \$2,500 if you and/or your **Eligible Dependents** are enrolled in the **BHCB**.
- The Family Out-of-Pocket Maximum is \$3,000 each calendar year if you and/or your **Eligible Dependents** are

enrolled in the **CHCB** or **MMCP**. The Family Out-of-Pocket Maximum is \$5,000 if you and/or your **Eligible Dependents** are enrolled in the **BHCB**. This Family Out-of-Pocket Maximum applies no matter how many **Covered Family Members** you have. Only **Eligible Expenses** which count toward a person's Individual Out-of-Pocket Maximum count toward the Family Out-of-Pocket Maximum.

Payments made toward satisfying the Out-of-Pocket Maximum under the **MHSA** will also count toward satisfying the Out-of-Pocket Maximum under the **CHCB**, the **BHCB** and the **Out-of-Network Services** portion of the **MMCP**.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the **Reasonable Charge**.
- Charges you pay that are in excess of specific Plan limits or exclusions or for expenses not covered by the Plan.
- Co-payments you make for **In-Network Services** under the **MMCP** or, during periods when you are enrolled in either the **MMCP** or the **CHCB**, for **In-Network Services** under the **MHSA**.
- Co-payments you make and any other charges you pay under the **MPSB**.
- Charges you pay toward the Individual Deductible under the **CHCB**, the **BHCB**, the **Out-of-Network Services** portions of the **MMCP** and the **MHSA**, and, for those enrolled in the **BHCB**, the **In-Network Services** portion of the **MHSA** as well.
- Charges you pay as a result of the 20% reduction in benefits under the **Out-of-Network Services** portions of the **MMCP** and **BHCB** if a required notice under the applicable care coordination/medical management procedures of the company administering your **MMCP** or **BHCB**, as the case may be, is not given or if that company determines that the service or supply is not **Medically Appropriate**.
- Charges you pay as a result of the 50% reduction in benefits under the **Out-of-Network Services** portion of

the **MHSA** if required ValueOptions **Certification** is not obtained.

When the annual Out-of-Pocket Maximum is met, the **MHSA** pays 100% of **Eligible Expenses** for the remainder of the calendar year, except that only 50% of **Eligible Expenses** will be paid if required ValueOptions **Certification** is not obtained.

Maximum Benefit

The lifetime maximum benefit payable for **Out-of-Network Services** for **Substance Abuse Care** for you or any **Eligible Dependent** during the period beginning January 1, 1992, and continuing for the rest of your or your **Eligible Dependent's** life is \$100,000. Any part of this lifetime maximum benefit that you have used, up to \$500, will be restored on each January 1.

There is also a lifetime maximum benefit of \$1,000,000 with respect to all amounts paid under the **CHCB**, for **Out-of-Network Services** under the **MMCP** or **BHCB**, and for **Out-of-Network Services** for **Mental Health Care** under the **MHSA**. Any part of this lifetime maximum benefit that you have used, up to \$5,000, will be restored on each January 1.

In addition, the total amount that counted for purposes of applying both of the lifetime maximum benefits described above under The Railroad Employees National Health and Welfare Plan will count for purposes of applying those maximum lifetime benefits under this Plan.

There is no lifetime maximum benefit under the **MPSB**, under the **In-Network Services** portion of the **MMCP**, or, with respect to those enrolled in the **BHCB**, under the **In-Network Services** portion of the **MHSA**.

Obtaining Benefits

In-Network Services

To obtain benefits for **In-Network Services**, you or your **Eligible Dependent** must comply with all of the following requirements:

- Contact ValueOptions to obtain a **ValueOptions Provider** in your area

- in advance of receiving any services covered by the **MHSA**, or within forty-eight hours of first receiving such services in an **Emergency**, and
- Receive **Certified** services from a **ValueOptions Provider** or through an **Out-of-Network Authorization**.

ValueOptions Providers have agreed that they will not charge you or an **Eligible Dependent** for any covered service or supply which ValueOptions has **Certified**, except for the \$15 co-payment, if applicable, with respect to those enrolled in the **CHCB** or **MMCP**, and except for any applicable deductible and co-insurance payment with respect to those enrolled in the **BHCB**.

*If you or an **Eligible Dependent** agrees to receive a **Non-Certified** service or supply from a **ValueOptions Provider**, no benefits will be paid by the Plan and you or the **Eligible Dependent** will be fully responsible for all expenses related to such **Non-Certified** service or supply.*

Out-of-Network Services

To obtain maximum benefits for **Out-of-Network Services**, you or your **Eligible Dependent** must contact ValueOptions:

- In advance of receiving any services covered by the **MHSA**, or within forty-eight hours of first receiving such services in an **Emergency**, and
- Receive **Certified** services from a **Non-ValueOptions Provider**, or obtain a **Pretreatment Outpatient Assessment** with respect to the first ten outpatient visits to the provider.

You can contact ValueOptions by calling 1-800-934-7245 twenty-four hours a day, seven days a week.

*You are responsible for verifying that a provider is a **ValueOptions Provider**. You should not assume that a referral from a **ValueOptions Provider** will always be to another **ValueOptions Provider**. You can verify that the provider is a **ValueOptions Provider** by calling ValueOptions' toll-free number.*

ValueOptions' toll-free number must be called for a **Pretreatment Outpatient Assessment** or **Certification**, with respect to services to be provided by a **Non-ValueOptions Provider**.

The requirement to obtain **Certification** in connection with **Out-of-Network Services** does not apply to injuries incurred by an **Eligible Employee** while on duty for an employing railroad, but ValueOptions is available to answer questions about proposed **Mental Health Care** or **Substance Abuse Care** treatment.

ValueOptions Certification and Pretreatment Outpatient Assessment

In-Network Services

All ValueOptions **Certifications** with respect to **In-Network Services** will be handled directly with ValueOptions by the **ValueOptions Provider** who provides the services. No benefits are payable if ValueOptions determines that the service or supply is not a **Covered Health Service**.

You and your **ValueOptions Provider** may initiate an appeal of a **Non-Certification**. See pages 170 through 174 for a description of the appeal procedures.

Out-of-Network Services

Those inpatient admissions to and stays in **Non-ValueOptions Facilities** which are covered under the **MHSA** are subject to prior and concurrent **Certification** by ValueOptions.

*You are responsible for calling ValueOptions to start the **Certification** process.* Except in the case of an **Emergency**, you or your provider must call for **Certification** prior to an inpatient admission. ValueOptions must also be notified prior to any continued length of stay beyond the time previously **Certified** by ValueOptions during the same admission.

Benefits will be reduced for any inpatient admission to or stay at a **Non-ValueOptions Facility** which ValueOptions has not **Certified**.

You must call and advise ValueOptions prior to any outpatient visit to a **Non-ValueOptions Provider** which is covered under the **MHSA**. During that call, ValueOptions will provide

you with a telephonic **Pretreatment Outpatient Assessment**. You are also responsible for seeing to it that your **Non-ValueOptions Provider** has forwarded to ValueOptions a fully completed outpatient treatment report (OTR) form for proposed outpatient visits and a fully completed psychological testing report form for any psychological tests to be performed.

*If you receive services covered under the **MHSA** from a **Non-ValueOptions Provider** without calling for a **Pretreatment Outpatient Assessment** (with respect to the first ten outpatient visits) or without obtaining a ValueOptions **Certification** (with respect to all other care), benefits will be reduced by 50% of the amount that would otherwise have been payable. This reduction in benefits applies both before and after the annual Out-of-Pocket Maximum is reached.*

No benefits are payable if ValueOptions determines that the service or supply is not a **Covered Health Service**.

*ValueOptions only **Certifies** a service or treatment for purposes of deciding what benefit amount, if any, is payable under the Plan. Any decision regarding the need to obtain the service or treatment involved, like any other medical decision, is your responsibility and that of your provider.*

You or your **Non-ValueOptions Provider** may initiate an appeal of a **Non-Certification** by ValueOptions. See pages 170 through 174 for a description of these appeal procedures.

Notice of ValueOptions Determinations

ValueOptions will provide notice of its **Certification** determinations directly to you, except, when the patient is one of your **Eligible Dependents**, it is administratively feasible to notify him or her directly, and ValueOptions has been informed:

- that the patient is a minor living with a custodial parent or guardian who is not you; or

- of a specific situation and ValueOptions determines that it is otherwise appropriate to provide such **Certification** notice directly to the patient.

Emergencies

In an **Emergency**, you (or your representative) should call ValueOptions immediately. However, if the circumstances prevent an immediate call, then you should go or be taken to the nearest **Facility** for treatment.

ValueOptions must be contacted within forty-eight (48) hours of admittance to the **Facility** for a determination as to whether or not an **Emergency** exists, and if it does not, whether or not the treatment should be **Certified**. If such timely contact is made and ValueOptions determines that an **Emergency** does exist and that the treatment should be **Certified**, the Plan will pay the level of benefits for **In-Network Services** for any services covered under the **MHSA** that are received during the **Emergency**.

If such timely contact with ValueOptions is made as required and **ValueOptions** determines that an **Emergency** does not exist, but that the treatment rendered should be **Certified**, the Plan will pay the level of benefits for **Out-of-Network Services** for any services covered under the **MHSA** rendered by a **Non-ValueOptions Provider**.

If such timely contact with ValueOptions is not made as required, or if ValueOptions determines that the treatment should not be **Certified**, the Plan will pay the level of benefits for any **Out-of-Network Services** covered under the **MHSA** rendered by a **Non-ValueOptions Provider**, reduced by fifty percent (50%).

Benefits Calling Card

You should already have a Benefits Calling Card which identifies the notification requirements. The Card does not guarantee coverage. Coverage for benefits is subject to verification of eligibility and all of the Plan's terms, conditions, limitations and exclusions. You may contact ValueOptions for additional Cards.

Integrated Mental Health Services

ValueOptions also provides integrated mental health services. These services focus on providing information about treating

and managing certain mental health conditions. ValueOptions will contact you if it determines that integrated mental health services are appropriate in your case. Participation is voluntary, and there is no charge to **Covered Family Members** for these services.

Through integrated mental health services, benefits for alternative treatment may be offered to you or your **Eligible Dependent** when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and **Physician**.

* * * *

*Exclusions applicable to this **MHSA** are set forth under the heading "General Exclusions and Limitations" at pages 116 through 122. Also, your benefits may be reduced if you or your **Eligible Dependent** has health benefits under another plan. These benefit reductions are described under the heading "Coordination of Benefits" at pages 123 through 127. Other limitations with respect to Dependents Health Care Benefits are described on pages 42 through 44.*

ELIGIBLE EXPENSES AND COVERED HEALTH SERVICES

(Applicable to the Comprehensive Health Care Benefit, the Basic Health Care Benefit, the Managed Medical Care Program, and the Mental Health and Substance Abuse Care Benefit)

Eligible Expenses are the actual cost to you of the **Reasonable Charges** (defined on pages 146 through 147) for **Covered Health Services**.

A **Covered Health Service** is a service or supply that meets all of the following criteria:

- It is needed because of sickness, injury or pregnancy.
- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrates that the service or supply has a beneficial effect on health outcomes and is based on trials that meet the following designs:
 - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
 - Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- It is a service or supply that is described under the heading "List of Covered Health Services" on pages 90 through 104 of this booklet and is not excluded under "General Exclusions and Limitations" (pages 116 through 122).
- It is provided to a **Covered Family Member** while the Plan is in effect and prior to the date that any of the individual termination conditions set forth in this booklet apply to the patient.

A service or supply is not a **Covered Health Service** just because it is furnished or ordered by your provider. To

determine if they are **Covered Health Services**, the services and supplies you receive will be reviewed

- for the **CHCB** or **BHCB**, by UnitedHealthcare or Highmark, whichever administers your **CHCB** or **BHCB**,
- for the **MMCP**, by Aetna, UnitedHealthcare or Highmark, whichever administers your **MMCP**, and
- for the **MHSA**, by ValueOptions.

A determination that a service or supply is not a **Covered Health Service** may apply to the entire service or supply or to any part of the service or supply.

If you have any question as to whether services or supplies ordered or recommended by your provider are **Covered Health Services**, you may call:

- With respect to benefits under the **CHCB**, **BHCB** or **MMCP** administered by Highmark, call Highmark toll free at 1-866-267-3320.
- With respect to benefits under the **CHCB**, **MMCP** or **BHCB** administered by UnitedHealthcare, call UnitedHealthcare toll free at 1-888-445-4379.
- With respect to benefits under the **MMCP** administered by Aetna, call Aetna toll free at 1-888-332-8742.
- With respect to benefits under the **MHSA**, call ValueOptions toll free at 1-800-934-7245.

List of Covered Health Services

Ambulatory Surgical Center Services

Services given within 72 hours before or after a surgical procedure. The services have to be given in connection with the procedure.

Anesthetics

Birth Center Services

Chemotherapy

Durable Medical Equipment

Durable medical equipment means equipment that meets all of the following criteria:

- It is for repeated use and is not consumable or disposable.
- It is used primarily for a medical purpose.
- It is appropriate for use in the home.

Some examples of durable medical equipment are:

- Appliances that replace a lost body organ or part or help an impaired one to work.
- Orthotic devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.
- Monitoring devices.

*Care coordination/medical management at the company administering your program must be contacted for any purchase or rental costs which exceed \$1,000. It will determine whether the purchase or rental of the equipment is **Medically Appropriate**.*

Hearing Benefit

Up to a maximum payment of \$600 each calendar year for:

- Tests and examinations, including those by an audiologist or a hearing aid dispenser, to diagnose and determine the cause of a hearing loss, and
- Charges for a hearing aid necessary to restore lost, or help impaired, hearing.

Home Health Care Agency Services

- Part-time or intermittent nursing care rendered by or supervised by a registered nurse.
- Part-time or intermittent care by a home health aide.
- Physical therapy, occupational therapy, and speech therapy, each with limits as described below under the headings "Physical Therapy," "Occupational Therapy," and "Speech Therapy," respectively.
- **Prescription Drugs.**
- Medical supplies.
- X-rays and laboratory tests.

Visits made by members of the home health care team for **Out-of-Network Services** under the **MMCP** or **BHCB** will be limited to 40 visits each calendar year.

Hospice Care Services

Up to a maximum payment of \$3,000 for each Course of Care for room, board, care and treatment charged by the **Hospice**.

Up to a maximum payment of \$1,000 for each Course of Care for:

- Counseling for the patient and the patient's Immediate Family. Services must be given by a licensed **Social Worker** or a licensed pastoral counselor.
- Bereavement counseling up to 15 visits for the patient's Immediate Family. Services must be given by a licensed **Social Worker** or a licensed pastoral counselor and given within 6 months after the patient's death.

The **Physician** must certify that the patient is terminally ill with 6 months or less to live.

"Immediate Family" means you or any member of your family who is covered under this Plan.

"Course of Care" means all services given to the patient and the patient's Immediate Family in connection with the terminal illness of the patient.

Any counseling services given in connection with a terminal illness will not be considered as **Mental Health Care** or **Substance Abuse Care**.

Services provided by a licensed pastoral counselor to a member of his/her congregation in the course of his/her normal duties as a pastor or minister will not be considered a **Covered Health Service**.

Hospital Services

Services and supplies provided by a **Hospital** on an inpatient or outpatient basis.

If charges are made for a private room, **Eligible Expenses** will be limited to the **Hospital's** average daily charge for a semi-private room.

*The Plan does not, and generally may not under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Caesarean section, or require that a provider obtain authorization from the Plan, from care coordination/medical management or through any other utilization management procedure for prescribing a length of stay not in excess of the above periods. However, the Plan may pay for a shorter stay if the attending provider (e.g., your **Physician, Nurse-Midwife**, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, the Plan may not set the level of benefits for out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.*

Infertility Treatment

Diagnosis and treatment of infertility, including surgery and drug therapy. This does not include procedures or services to facilitate a pregnancy, such as, but not limited to, in vitro fertilization, embryo transfer, artificial insemination and immuno therapy for infertility.

Jaw Joint Disorders

Up to a lifetime maximum payment of \$1,250 for services for treatment in connection with the temporomandibular joint (jaw joint or "TMJ") and the complex of muscles, nerves and other tissues related to that joint. (This lifetime maximum payment limitation does not apply to **In-Network Services** under the **MMCP** or **BHCB**.)

Only the following services and supplies are covered:

- Fixed or removable appliances.
- Crowns and other restorations or alterations of the tooth structure.
- Adjustments to the appliances, crowns and other restorations or alterations.

Medical Supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood derivatives only if not donated or replaced.

Nursing Services

Services of a trained nurse or a **Nurse-Midwife**, except for outpatient **Out-of-Network Services** of a trained nurse or a **Nurse-Midwife** for **Mental Health Care** or **Substance Abuse Care** administered by ValueOptions. Expenses for outpatient **Out-of-Network Services** of a trained nurse or a **Nurse-Midwife** for **Mental Health Care** or **Substance Abuse Care** administered by ValueOptions are not **Eligible Expenses** under the Plan.

Occupational Therapy

Services of a licensed occupational therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a **Physician**.
- The therapy must be given in accordance with a written treatment plan approved by a **Physician**. The therapist must submit progress reports to the **Physician** at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement in the **Covered Family Member's** condition.

Organ/Tissue Transplants

- Donor Charges

In the case of an organ or tissue transplant, no services or supplies for the donor are considered **Covered Health Services** unless the recipient is a **Covered Family Member**. If the recipient is not a **Covered Family Member**, no benefits are payable for donor charges.

The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a **Covered Health Service** UNLESS the search is made in connection with a transplant procedure arranged by a **Transplant Facility**.

- **Qualified Procedures**

If a Qualified Procedure, listed below, is **Medically Appropriate** and performed at a **Transplant Facility**, the Medical Care and Treatment and Transportation and Lodging provisions set forth below apply:

- Heart Transplants.
- Lung transplants.
- Heart/Lung transplants.
- Liver transplants.
- Kidney transplants.
- Pancreas transplants.

- Kidney/Pancreas transplants.
- Bone Marrow/Stem Cell transplants.
- Other transplant procedures when the company that administers your **CHCB, BHCB** or **MMCP** determines that it is necessary to perform the procedure at a **Transplant Facility**.

- **Medical Care and Treatment**

The following services provided in connection with the transplant are **Covered Health Services**:

- Pre-transplant evaluation for one of the procedures listed above.
- Organ acquisition and procurement.
- **Hospital and Physician fees.**
- Transplant procedures.
- Follow-up care for a period up to one year after the transplant.
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of \$25,000 is payable for all charges made in connection with the search.

- **Transportation and Lodging**

Care coordination/medical management will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem

rate of up to \$50 for one person or up to \$100 for two people.

Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the **Transplant Facility**.

If the **Covered Family Member** who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the \$100 per diem rate.

There is a combined overall lifetime maximum of \$10,000 per **Covered Family Member** for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.

Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a **Physician**.
- The therapy must be given in accordance with a written treatment plan approved by a **Physician**.
- The therapist must submit progress reports to the **Physician** at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement in the **Covered Family Member's** condition.

Physicians' Services

- **Medical Care** and Treatment
 - Hospital, office and home visits.
 - Emergency room services.
- Surgery
 - Surgical procedures to treat a sickness, injury or pregnancy.

- Reconstructive Surgery:
 - Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of a birth defect, a sickness or an accidental injury.
 - Reconstructive breast surgery in connection with a mastectomy as follows:
 - all stages of reconstruction of the breast on which the mastectomy has been performed;
 - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - prostheses and physical complications of mastectomy, including lymphedemas (sometimes referred to as swelling associated with the removal of lymph nodes);

in a manner determined in consultation with the attending **Physician** and the patient.

- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to sickness or accidental injury.
- Cosmetic procedures are excluded from coverage, except for surgeries for injuries sustained while or before the patient is covered by the Plan. Procedures that correct a physical anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a **Covered Family Member** may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.
- Assistant Surgeon Services
 - **Eligible Expenses** for assistant surgeon services are limited to 1/5 of the amount of **Eligible Expenses** for the surgeon's charge

for the surgery. An assistant surgeon must be a **Physician**. Surgical assistant's services are covered at the same or a lesser rate.

- **Multiple Surgical Procedures**

Multiple surgical procedures means more than one surgical procedure performed during the same operative session. **Eligible Expenses** for multiple surgical procedures are limited as follows:

- **Eligible Expenses** for a secondary procedure limited to 50% of the **Eligible Expenses** that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
- **Eligible Expenses** for any subsequent procedure are limited to 50% of the **Eligible Expenses** that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

Prescription Drugs

Prescription Drugs other than those obtained from a pharmacy or by mail order.

Preventive Health Care

MMCP and BHCB In-Network Services

Expenses for the health care services listed below are covered under the **In-Network Services** portion of the **MMCP** and **BHCB** when given by an **In-Network Provider** in accordance with accepted principles of practice in the United States at the time of service. Under the **MMCP**, the \$15 Co-payment for each office visit will apply to these services. Under the **BHCB**, **Eligible Expenses** for the services in excess of any applicable deductible are covered at the percentages set forth on page 72 of this booklet:

- Routine physical exams for you and your **Eligible Dependent** spouse, including diagnostic tests and immunizations.
- Child preventive care services given in connection with routine pediatric care, including immunizations.

- Phenylketonurial blood tests (PKU) for infants under the age of one year.
- One routine well-woman exam every calendar year. A well-woman exam may be given by any gynecologist listed in your directory of **In-Network Providers**. A well-woman exam includes the following:
 - Breast examination and/or mammogram.
 - Pelvic examination.
 - Pap smear.
- Office visits for female employees and the wives of male employees related to the prevention of pregnancy, including prescription contraceptive drugs approved by the U.S. Food and Drug Administration administered during those visits.
- Prescription contraceptive devices approved by the U.S. Food and Drug Administration.

MMCP and BHCB Out-of-Network Services

Eligible Expenses in excess of any applicable deductible for the health care services listed below are covered under the **Out-of-Network Services** portions of the **MMCP** and **BHCB**:

- Routine childhood (generally age 6 and under) immunizations for Diphtheria, Pertussis or Tetanus (DPT), measles, mumps, rubella and polio.
- Phenylketonurial blood tests (PKU) for infants under the age of one year.
- One routine pap smear each calendar year.
- One baseline mammogram for women age 35 through 39.
- One mammogram for women age 40 through 49 every two years, or more frequently if recommended by a **Physician**.
- One annual mammogram for women age 50 or over.
- One annual digital rectal examination age 40 or over.

- One annual stool blood slide test after age 49.
- One proctosigmoidoscopy every three years after age 49.
- Office visits for female employees and the wives of male employees related to the prevention of pregnancy, including prescription contraceptive drugs approved by the U.S. Food and Drug Administration administered during those visits.
- Prescription contraceptive devices approved by the U.S. Food and Drug Administration.

CHCB Services

Eligible Expenses in excess of any applicable deductible for the health care services listed below are covered under the **CHCB**:

- Routine childhood (up to age 18) immunizations, including boosters, for Diphtheria, Pertussis or Tetanus (DPT), measles, mumps, rubella and polio.
- Phenylketonurial blood tests (PKU) for infants under the age of one year.
- One routine pap smear each calendar year.
- One baseline mammogram for women age 35 through 39.
- One mammogram for women age 40 through 49 every two years, or more frequently if recommended by a **Physician**.
- One annual mammogram for women age 50 or over.
- One annual digital rectal examination age 40 or over.
- One annual stool blood slide test after age 49.
- One proctosigmoidoscopy every three years after age 49.
- One routine physical examination (including diagnostic testing and immunization in connection with that examination) given each calendar year. No deductible or otherwise applicable percentage of **Eligible Expenses** payable will apply. Rather, the **CHCB** will pay 100% of the first \$150 of **Eligible Expenses** involved and 75% of any **Eligible Expenses** in excess of \$150.

- Office visits for female employees and the wives of male employees related to the prevention of pregnancy, including prescription contraceptive drugs approved by the U.S. Food and Drug Administration administered during those visits.
- Prescription contraceptive devices approved by the U.S. Food and Drug Administration.

Psychologists' Services

Services of a **Psychologist** if such services would have been covered if performed by a **Physician**.

Radiation Therapy

Skilled Nursing Facility Care After Hospital Confinement

Services and supplies up to 31 days of confinement following each **Hospital** confinement are covered under the **CHCB**. Services and supplies up to 60 days of confinement following each **Hospital** confinement per calendar year are covered for both **In-Network Services** and **Out-of-Network Services**, combined, under the **MMCP** and **BHCB**.

Separate confinements for the same cause are considered to be one confinement, unless separated by 14 or more days.

If charges are made for a private room, **Eligible Expenses** will be limited to the **Skilled Nursing Facility's** daily charge for a semi-private room.

Speech Therapy

Services given to restore speech. The speech must have been lost or impaired due to one of the following:

- Removal of vocal chords, or
- Cerebral thrombosis (cerebral vascular accident), or
- Brain damage due to injury or organic brain lesion (aphasia).

In addition, with respect to a child under age 3, services given as part of treatment for:

- Infantile autism,
- Developmental delay,

- Cerebral palsy,
- Hearing impairment,
- Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

The therapy must be expected to result in significant, objective, measurable physical improvement in the **Covered Family Member's** condition.

Spinal Manipulations

Services of a **Physician** given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

No benefits are available for any type of therapy, service or supply, including, but not limited to, spinal manipulations by a chiropractor or other **Physician** once the therapy, service or supply ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Transportation Services

(Applies only to BHCB, CHCB, MMCP and Mental Health Care under the MHSA)

Transportation services must be to a **Facility** in your local area. If there are no local **Facilities** equipped to provide the care needed, transportation service to the nearest **Facility** outside your local area qualified to give the required treatment is covered.

Treatment Center and Outpatient Clinic Services

(Applies only to Out-of-Network Services under the MHSA)

Services and supplies for **Substance Abuse Care** on an inpatient or outpatient basis in a **Treatment Center** or an **Outpatient Clinic**.

- **Inpatient Benefits**
 - Room, board, care and treatment up to 30 days for each confinement.
 - Benefits will be paid for not more than 2 confinements during your or your **Eligible Dependent's** lifetime.

- If you or your **Eligible Dependent** voluntarily discontinues an approved treatment program before it is completed, not more than \$100 will be paid for each day of that confinement and benefits will not be paid for more than 30 days of that confinement.
- If you or your **Eligible Dependent** used any part of this benefit while covered under The Railroad Employees National Health and Welfare Plan, benefits under this Plan will be determined as if those benefits were used under this Plan.
- **Outpatient Benefits**
 - Services and supplies of a **Treatment Center** or **Outpatient Clinic**, where an overnight stay is not required, for treatment provided by a **Qualified Counselor**. Benefits will not be paid for more than 30 Episodes of Treatment during each benefit period and for more than 2 benefit periods during your or your **Eligible Dependent's** lifetime.
 - The first benefit period starts on the date you or your **Eligible Dependent** incurs the first expense for covered outpatient treatment. It ends 12 months later. The second benefit period starts on the date you or your **Eligible Dependent** incurs the first expense for covered outpatient treatment after the end of the first benefit period. It ends 12 months later.
 - If you or your **Eligible Dependent** used any part of this benefit while covered under The Railroad Employees National Health and Welfare Plan, benefits under this Plan will be determined as if those benefits were used under this Plan.

Episode of Treatment means a period in which service or treatment is rendered to the patient alone, to the patient and Immediate Family, or to the patient's Immediate Family alone, as part of a treatment program.

The Immediate Family means the patient's wife or husband and children, and in the case of a dependent child who is the patient, the parents, brothers and sisters of the patient.

Transportation service to or from a **Treatment Center** in your local area for **Substance Abuse Care** is also covered. If there are no local **Treatment Centers** equipped to provide the care needed, transportation service to the nearest

Treatment Center outside your local area qualified to give the required treatment is covered. In any event, the transportation must be to a **Treatment Center** that is deemed by ValueOptions to provide the most appropriate, effective and economical treatment program for the **Eligible Employee** or **Eligible Dependent**.

Transportation to and from a **Treatment Center** in connection with each confinement covered by the **Out-of-Network Services** portion of the Mental Health and Substance Abuse Care Benefit is limited to a maximum payment of \$500.

ValueOptions Providers' Services for Mental Health Care or Substance Abuse Care
(Applies only to the Mental Health and Substance Abuse Care Benefit)

X-ray and Laboratory Tests

MANAGED PHARMACY SERVICES BENEFIT

The **MPSB** covers **Prescription Drugs** that are **Medically Necessary** and that are given for the treatment or prevention of an injury, sickness or pregnancy. If you or your **Eligible Dependents** are enrolled in the **CHCB** or **MMCP**, there are no deductibles, annual out-of-pocket maximums, or lifetime maximum benefits applicable to the **MPSB**.

If you or your **Eligible Dependents** are enrolled in the **BHCB**, there is an annual **Out-of-Pocket Maximum**, but no deductibles or lifetime maximum benefits, applicable to the **MPSB**.

As part of the **MPSB**, you and your **Eligible Dependents** may receive information about **Prescription Drugs** through the RationalMed program. That program is designed to reduce drug-therapy related hospitalizations and other adverse medical events. It does this by evaluating a patient's medical and pharmacy information against thousands of computerized, evidence-based, health care rules and uses the results of this evaluation to identify patient safety risks, alert health care providers, and track and report on patient outcomes. There is no charge to you for information provided through the RationalMed program.

Through the RationalMed program, benefits for alternative treatment may be offered to you or your **Eligible Dependent** when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and **Physician**.

Out-of-Pocket Maximum

If you are enrolled in the **BHCB**, the Out-of-Pocket Maximum limits the amount of **Eligible Expenses** you will have to pay in a calendar year under the **MPSB**. This Out-of-Pocket Maximum applies separately from any other Out-of-Pocket Maximum under this Plan. Thus, the only amounts that count toward the Out-of-Pocket Maximum under the **MPSB** are amounts you or your **Eligible Dependents** pay as **Eligible Expenses** for **Prescription Drugs** available under the **MPSB** during the period you are enrolled in the **BHCB**. No other charges or co-payments that you or your **Eligible Dependents** pay under this Plan will count toward the Out-of-Pocket Maximum under the **MPSB**.

There are two types of Out-of-Pocket Maximums that apply under the **MPSB**, Individual and Family.

- The Individual Out-of-Pocket Maximum is \$2,000 each calendar year.
- The Family Out-of-Pocket Maximum is \$4,000 each calendar year. This Family Out-of-Pocket Maximum applies no matter how many **Covered Family Members** you have.

If you are enrolled in the **CHCB** or **MMCP**, there are no Out-of-Pocket Maximums that apply to you under the **MPSB**.

Prescription Drug Card Program

This Program, administered by Medco pays for outpatient **Prescription Drugs** filled at either an In-Network Pharmacy or an Out-of-Network Pharmacy. The prescription drug identification card that you will receive under the **MPSB** may be used only at In-Network Pharmacies.

In-Network Pharmacy

An In-Network Pharmacy is any pharmacy that participates in the Medco Pharmacy Network. For more information on which pharmacies participate in the Medco retail network, visit www.medco.com to use the on-line pharmacy locator or call customer service at 1-800-842-0070.

In-Network Pharmacies fill prescriptions for supplies of up to 21 days. In-Network Pharmacies dispense **Generic Drugs** whenever possible. They also dispense **Brand Name Drugs**.

In-Network Pharmacy Benefits for Individuals Enrolled in the CHCB or MMCP

If you or your **Eligible Dependents** are enrolled in the **CHCB** or **MMCP**, your benefits at an In-Network Pharmacy are as follows:

Generic Drugs

If a **Generic Drug** is dispensed, you pay only a \$5 co-payment.

Brand Name Drugs

If a **Brand Name Drug** is dispensed for either of the following reasons, you pay only a \$10 co-payment:

- The **Brand Name Drug** is ordered by your **Physician** by writing "Dispense As Written" on the prescription.
- The **Brand Name Drug** is dispensed because there is no equivalent **Generic Drug**.

If a **Brand Name Drug** is dispensed instead of an equivalent **Generic Drug** for any reason other than those set forth above, you must pay:

- a \$10 co-payment, and
- the difference in cost between the **Generic Drug** and the **Brand Name Drug**.

Any co-payments under the Prescription Drug Card Program and any difference in cost between a **Generic Drug** and **Brand Name Drug** are not **Eligible Expenses** under any other benefit of the Plan.

In-Network Pharmacy Benefits for Individuals Enrolled in the BHCB

If you or your **Eligible Dependents** are enrolled in the **BHCB**, your benefits at an In-Network Pharmacy are as follows:

Generic Drugs

If a **Generic Drug** is dispensed, the **MPSB** pays 70% of the **Eligible Expenses** for the **Prescription Drug**.

Brand Name Drugs

If a **Brand Name Drug** is dispensed, the **MPSB** pays:

- 65% of the **Eligible Expenses** for the **Prescription Drug** if the drug is a **Formulary Drug**.
- 60% of the **Eligible Expenses** for the **Prescription Drug** if the drug is a **Non-Formulary Drug**.

When the annual Out-of-Pocket Maximum (\$2,000 per individual, \$4,000 per family) is met, the **MPSB** pays 100% of the **Eligible Expenses** for the remainder of the calendar year.

Out-of-Network Pharmacy

An Out-of-Network Pharmacy is any pharmacy that does not participate in the Medco Pharmacy Network. If you go to an Out-of-Network Pharmacy, you must pay the entire cost of each prescription at the time it is filled. Then you must submit a claim.

If you or your **Eligible Dependents** are enrolled in the **CHCB** or **MMCP**, the **MPSB** pays 75% of the **Eligible Expenses** for up to a 21-day supply of a **Prescription Drug** that you buy at an Out-of-Network Pharmacy.

If you or your **Eligible Dependents** are enrolled in the **BHCB**, the **MPSB** pays 50% of the **Eligible Expenses** for up to a 21-day supply of a **Prescription Drug** that you buy at an Out-of-Network Pharmacy. Also, once the annual Out-of-Pocket Maximum is met, the **MPSB** pays 100% of the **Reasonable Charge** for up to a 21-day supply that you buy at an Out-of-Network Pharmacy for the remainder of the calendar year.

If you buy a supply of Prescription Drugs for a period in excess of 21 days at an In-Network or Out-of-Network Pharmacy, you will receive no benefits under the Plan.

Mail Order Prescription Drug Program

Under the Mail Order Prescription Drug Program, administered by Medco, you may obtain **Prescription Drugs** by mail.

The **Prescription Drug** must be prescribed for you or one of your **Eligible Dependents**. You or your **Eligible Dependent** must be covered under the Plan when the prescription is received by Medco. If you or your **Eligible Dependent** is not covered under the Plan when a new prescription is received by Medco, this Mail Order Prescription Drug Program will still apply, but only if the following two conditions are met:

- the new prescription was prescribed while you or your **Eligible Dependent** was covered under the Plan, and
- Medco received the prescription before the end of the calendar month following the month coverage was lost.

Mail Order Benefits for Individuals Enrolled in the CHCB or MMCP

Generic Drugs, if available, will be dispensed unless the written prescription otherwise requires.

If a **Generic Drug** is dispensed, you pay only a \$10 co-payment.

If a **Brand Name Drug** is dispensed, you pay only a \$15 co-payment.

These co-payments are not **Eligible Expenses** under any other benefit of the Plan.

Mail Order Benefits for Individuals Enrolled in the BHC

Generic Drugs, if available, will be dispensed.

If a **Generic Drug** is dispensed, the Plan pays 70% of the **Eligible Expenses** for the **Prescription Drug**.

If a **Brand Name Drug** is dispensed, the Plan pays:

- 65% of the **Eligible Expenses** for the **Prescription Drug** if the drug is a **Formulary Drug**.
- 60% of the **Eligible Expenses** for the **Prescription Drug** if the drug is a **Non-Formulary Drug**.

When the annual Out-of-Pocket Maximum (\$2,000 per individual, \$4,000 per family) is met, the **MPSB** pays 100% of the **Eligible Expenses** for the remainder of the calendar year.

Obtaining Your Mail Order Drugs

Mail your original prescription (no copies) or refill slip with the order form in the postage-paid envelope provided by Medco, along with a check or money order for the appropriate co-payment or co-insurance. If you or your **Eligible Dependents** are enrolled in the **BHC**, you can determine your prescription's approximate co-insurance amount by visiting www.medco.com or calling 1-800-842-0070. If you prefer to pay for all of your orders by credit card, you can join Medco's automatic payment program by enrolling online at www.medco.com or by calling 1-800-948-8779.

Complete the information required on the order form. If you are submitting your first prescription, complete the Health Assessment Questionnaire as well.

The prescription must be written for a minimum 22-day supply of the drug and for no greater than the lesser of a 90-day supply, the supply the dispensing pharmacist deems appropriate in the exercise of his/her professional judgment, the quantity recommended by the manufacturer, and the maximum quantity permitted by applicable law.

If you need order forms or Health Assessment Questionnaires, or if you have any questions on how to submit an order, visit www.medco.com or call 1-800-842-0070.

Limitations Under The Managed Pharmacy Services Benefit

The **MPSB** for any prescription filled at an In-Network or Out-of-Network Pharmacy is limited to a 21-day supply of the drug. An In-Network Pharmacy will not fill a prescription for more than a 21-day supply. ***The MPSB pays nothing at all for any prescription filled at an Out-of-Network Pharmacy for more than a 21-day supply of the drug.*** Benefits for supplies of **Prescription Drugs** for more than 21 days are available under the **MPSB** only if the supply is ordered by mail, and then is limited to the quantity described above under the heading "Obtaining Your Mail Order Drugs" on page 112.

If a prescription so provides, however, it may be refilled, except that any request for a refill that is made more than one year after the latest prescription was written will not be granted. Any refills that remain on a prescription expire one year after the original prescription was written.

You may obtain medicines (other than **Prescription Drugs**) under the Mail Order Prescription Drug Program (if available from Medco by mail pharmacy service), but not under the Prescription Drug Card Program or any other benefit of the Plan. Such medicines must be prescribed for you by a **Physician** and be **Medically Necessary**.

Not Covered

The **MPSB** does not cover any expenses for the following drugs whether they are purchased from an In-Network Pharmacy, Out-of-Network Pharmacy or by mail order:

- Drugs given other than for:
 - the treatment of an injury,
 - the treatment of a sickness,
 - the treatment of a pregnancy,
 - with respect to female employees and the wives of male employees, prevention of a pregnancy.
- Drugs which are not **Medically Necessary**.

- Drugs given in connection with a service or supply which is not a **Covered Health Service**.
- Drugs that are considered investigational because they do not meet generally accepted standards of medical practice in the United States.
- Drugs to treat infertility or vitamin supplements, except when **Medically Necessary** and ordered under the Mail Order Prescription Drug Program. Please note that drug therapy for infertility is a **Covered Health Service** under the **CHCB, BHCB, MMCP** and **MHSA**.
- Nicotine suppressants, except for 180 days of treatment per lifetime under the Mail Order Prescription Drug Program.
- Allergy serum, immunization agents and biological sera.
- Prescribed devices or supplies of any type, including colostomy supplies and contraceptive devices. Please note that prescription contraceptive devices are **Covered Health Services** under the **CHCB** and **MMCP**.
- Drugs given by a **Physician** either in his or her office or as part of a home health care visit.
- Drugs given by a **Hospital** (including take-home drugs), **Skilled Nursing Facility, Home Health Care Agency** or similar place that is not a pharmacy, but has its own drug dispensary.
- Injectables other than insulin, unless they are ordered under the Mail Order Prescription Drug Program.

* * * *

*Exclusions applicable to this **MPSB** are set forth under the heading "General Exclusions and Limitations" at pages 116 through 122. Also, your benefits may be reduced if you or your **Eligible Dependent** has health benefits under another plan. These benefit reductions are described under the heading "Coordination of Benefits" at pages 123 through 127. Other limitations with respect to Dependents Health Care Benefits are described on pages 42 through 44.*

GENERAL EXCLUSIONS AND LIMITATIONS

The Plan does not cover any expenses – even if they are **Eligible Expenses** - incurred for services, supplies or treatment relating to, arising out of, or given in connection with, the following:

- **Another Railroad Plan** - services and supplies for which an **Eligible Dependent** is entitled to benefits as an employee in connection with **Another Railroad Health and Welfare Plan**, except as stated on page 43;
- Completion of claim forms or missed appointments;
- Cosmetic/Reconstructive Surgery; except as specified on page 100, including but not limited to:
 - Abdominoplasty.
 - Breast reduction surgery.
 - Liposuction.
 - Rhytidectomy.
- Cosmetic Services – such as, but not limited, to wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury), hair transplants, hair weaving, or any drug if such drug is used in connection with baldness.
- Counseling Services, Treatment, or Education Services such as, but not limited to:
 - Services given by a pastoral counselor, except as specified under "Hospice Care Services" on pages 94 through 95.
 - Educational rehabilitation, or treatment of learning disabilities, regardless of the setting in which such services are provided.
 - Treatment for personal or professional growth, development, or training or professional certification.
 - Evaluation, consultation, or therapy for educational or professional training or for investigational purposes relating to employment.
 - Examinations, testing, evaluations or treatment which may be required solely for purposes of obtaining or

maintaining employment or insurance or pursuant to judicial order or administrative proceedings.

- Academic education during residential treatment.
- Therapies such as Erhard/The Forum, primal therapy, aversion therapy, bioenergetic therapy, crystal healing therapy.
- Counseling services and/or treatment related to such problems as financial, marital or occupational difficulties, adult anti-social behavior or parent-child relationships.
- Non-abstinence based or nutritionally based chemical dependency treatment.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- **Custodial Care**
- Dental Services – care of and treatment to the teeth, gums or supporting structures except for:
 - **Hospital**, radiology and pathology services while confined as an inpatient in a **Hospital** for dental surgery or within 72 hours of dental surgery,
 - full or partial dentures, fixed bridgework, or repair to natural teeth, if needed because of injury to natural teeth, and
 - charges for treatment of jaw joint disorders specifically provided in the Plan;
- Dependents:
 - a dependent child's pregnancy or the resulting childbirth, abortion or miscarriage;
 - a dependent child's expenses if the child is receiving benefits for the same expenses under the Plan as an **Eligible Employee**;
 - a dependent's work related injury or sickness – services or supplies for which your **Eligible**

Dependent is entitled to indemnity under any worker's compensation or similar law.

- Donor Expenses and Services – expenses incurred by an organ donor except as provided under the heading “**Eligible Employee**” (see pages 22 through 23) and under the description of “Organ/Tissue Transplants” (see pages 97 through 99); services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a **Covered Family Member** under this Plan and is undergoing a covered transplant.
- Ecological or environmental medicine, diagnosis and/or treatment, such as, but not limited to:
 - chelation therapy, except to treat heavy metal poisoning,
 - chemical analysis of hair or nails,
 - gastrogram,
 - Heidelberg capsule,
 - cytotoxic, sublingual or wrinkle allergy testing,
 - environmental chemical screening for toxins, and allergens.
- Examinations or treatment ordered by a court in connection with legal proceedings, unless such examinations or treatment otherwise qualify as **Covered Health Services**.
- Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time a determination regarding coverage in a particular case is made under the Plan are:
 - not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use;

or

- subject to review and approval by any institutional review board for the proposed use;

or

- the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If a **Covered Family Member** has a "life-threatening" sickness or condition (one which is likely to cause death within one year of the request for treatment), the company that administers your benefits may determine that an experimental, investigational or unproven service meets the definition of a **Covered Health Service** for the sickness or condition. For this to take place, the company that administers your benefits must determine that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

- Family Members – services, supplies, medical care or treatment given by one of the following members of your family:
 - Your spouse.
 - The child, brother, sister, parent or grandparent of either you or your spouse.
- Government Hospital - treatment in a United States government or agency hospital. However, if the United States government or one of its agencies is authorized by law to charge the Plan for the services provided, then this exclusion will not apply;
- Hearing Services – ear examinations, hearing aids or cochlear implants for diagnosis or treatment of hearing loss, except to the extent needed for repair of damages caused by bodily injury or as set forth under the heading "Hearing Benefit" on page 94 of this booklet.
- Herbal medicine, holistic or homeopathic care, including drugs.
- **Hospital Special Care Areas** – charges made by a **Hospital** for confinement in a special area of the **Hospital** which provides non-acute care, by whatever name called, including but not limited to the type of care given by the

facilities listed below. If that type of facility is otherwise covered under this Plan, then benefits for that covered facility which is part of a **Hospital**, as defined, are payable at the coverage level for that facility, not at the coverage level for a **Hospital**.

- Adult or child day care center.
- **Ambulatory Surgical Center.**
- **Birth Center.**
- Half-way house.
- **Hospice.**
- **Skilled Nursing Facility.**
- **Treatment Center.**
- Vocational rehabilitation center.
- Any other area of a **Hospital** which renders services on an inpatient basis for other than acute care of sick, injured or pregnant persons.
- **Medicare**
 - services and supplies received while you or your **Dependent** is a **Person Eligible Under Medicare** if benefits are provided for such expenses under Part A or Part B of **Medicare**, except to the extent necessary so that the sum of the benefits payable under this Plan and under Part A or Part B of **Medicare** equal the benefits which would have been payable under the Plan alone;
 - services and supplies which are partially or wholly covered under **Medicare** during any period of time for which you or your spouse has rejected this Plan as primary provider of health benefits;
- No Legal Obligation - services and supplies for which the **Covered Family Member** is not legally required to pay:
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.

- Pregnancy Facilitation or Prevention
 - Charges for procedures which facilitate a pregnancy but do not treat the cause of infertility, such as in vitro fertilization, artificial insemination, embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer and tubal ovum transfer.
 - Sterilization procedures, except to avoid a life-threatening condition.
 - Reversal of sterilization.
- Preventive care, including newborn well baby care, except as described under the heading "Preventive Health Care" on pages 101 through 104.
- Private duty nursing services while confined in a **Facility**.
- Services given by volunteers or persons who do not normally charge for their services.
- Services or supplies which are not **Covered Health Services**, including any confinement or treatment given in connection with a service or supply which is not a **Covered Health Service**.
- Services or supplies received before an Employee or his/her Dependent becomes covered under this Plan.
- Sex-change surgery.
- Speech therapy, except as set forth under the heading "Speech Therapy" on pages 104 through 105.
- Stand-by services required by a **Physician**.
- Tobacco dependency.
- Treatment or consultations provided via telephone.
- Vision Services
 - Services for a surgical procedure to correct refraction errors of the eye, except for radial keratotomy, including any confinement, treatment, services, or supplies given in connection with or related to the surgery.

- Eye examinations, glasses or contact lenses for diagnosis or treatment of refractive errors except to the extent needed for repair of damages caused by bodily injury.
- War, declared or undeclared, or international armed conflict.
- Weight reduction or control, including but not limited to: nutritional counseling, membership costs for health clubs, weight loss clinics and similar programs, special foods, food supplements, liquid diets, diet plans or any related products.

COORDINATION OF BENEFITS

This section of your booklet describes how the health care benefits payable under this Plan will be coordinated with health care benefits payable under other plans.

You or any **Eligible Dependent** may be covered under another group health plan. It may be sponsored by another employer who makes contributions or payroll deductions for it. The other plan could also be a government or tax-supported program.

Coordination of Benefits does not apply to:

- **Another Railroad Health and Welfare Plan**, except as set forth under the heading "Dependents Covered Under Another Railroad Health and Welfare Plan" on page 43 of this booklet,
- an individual health insurance policy which a person may purchase with his/her own funds, or
- health benefit plans paid for through payroll deductions unless the plan is an employer-sponsored plan.

How Does Coordination Work?

One of the plans involved will pay benefits first. (That plan is primary.) The other plans will pay benefits next. (These plans are secondary.)

If this Plan is primary, it will pay benefits as if it were the only plan involved. Benefits under this Plan will not be reduced because benefits are payable under the other plans.

If this Plan is secondary, the benefits it pays will be reduced because of benefits payable by other plans primary to this Plan. The amount of benefits this Plan would have paid without this provision will be determined first. Then the amount of benefits payable by other plans primary to this Plan for the same charges will be subtracted from this amount. This Plan will pay the difference, if any.

For example, if an employee participates in the **CHCB** and this Plan is secondary, and if the primary plan pays 50% of the charges covered under this Plan, then this Plan would pay 35% of those charges.

Which Plan is Primary?

There are rules to find out which plan is primary and which plans are secondary when benefits are payable under more than one plan. The rules that usually apply are as follows:

- A plan which has no coordination of benefits provision will be primary to a plan which does have such a provision.
- A plan which covers the person as an employee will be primary to a plan which covers the same person as a dependent.
- If a person is covered as a dependent under two or more plans, then the plan which covers that person as a dependent of the person whose birthday is earlier in the calendar year will be primary to a plan which covers that person as a dependent of a person whose birthday is later in the calendar year.
- If the **Eligible Employee** under this Plan is also covered as a laid-off or retired employee under another plan, then this Plan will be primary to that other plan provided the other plan has this same rule.
- If a determination of which plan is primary cannot be made by any of the above rules, then the plan which has covered the person for the longest time will be primary to all other plans.
- If the birthday rule above would apply except that the other plan does not have the same rule based on birthday, then the rule in the other plan will determine which plan is primary.
- If the birthday rule above would apply except that the person is covered as a dependent under two or more plans of divorced or separated parents, then the rule that applies depends upon whether there is a court order giving one parent financial responsibility for the medical, dental or other health expenses of the dependent child.
- If there is no court decree, the plan of the parent with custody will be primary to the plan of the parent without custody. Further, if the parent with custody has remarried, the order of payment will be as follows:

- The plan of the parent with custody will pay benefits first.
- The plan of the step-parent with custody will pay benefits next.
- The plan of the parent without custody will pay benefits last.
- If there is a court decree, then the plan of the parent with financial responsibility will be primary to any other plan.
- You will have to give information about any other plans when you file a claim.

If Both Wife and Husband Work for a Participating Employer and Are Covered Under This Plan

If a husband or wife is covered under this Plan both as an **Eligible Employee** and as an **Eligible Dependent**, then this Plan will be treated as two separate plans, and the rules previously stated will be used to determine which plan is primary and which plan is secondary.

If a person is covered under this Plan as an **Eligible Dependent** of two **Eligible Employees**, the **Eligible Dependent** benefits will be paid on behalf of each **Eligible Employee** as if there were two separate plans, and the rules previously stated will be used to determine which plan is primary and which plan is secondary.

For the secondary plan, benefits will be determined under what is commonly known as a "make whole" Coordination of Benefits approach, namely:

- First determine the **Eligible Expenses**.
- Then subtract the amount paid by the primary plan.
- The secondary plan pays the difference, provided the difference is no more than the amount that would have been paid without this provision.

If Husband or Wife Is Covered Under The Railroad Employees National Early Retirement Major Medical Benefit Plan ("ERMA" or "GA-46000") or as an Employee Under The Railroad Employees National Health and Welfare Plan and the Other Is Covered as an Employee Under This Plan

The rules previously stated will determine which plan is primary and which plan is secondary.

For the secondary plan, benefits will be determined under the "make whole" approach as follows:

- First determine the **Eligible Expenses**.
- Then subtract the amount paid by the primary plan.

The secondary plan pays the difference, provided the difference is no more than the amount that would have been paid without this provision.

Coordination of Benefits Under the Managed Pharmacy Services Benefit

If you or your **Eligible Dependent** has primary coverage for **Prescription Drugs** under another health plan, – *for this purpose, Medicare Part D is not considered "another health plan"* – you must follow the procedures shown below in seeking benefits under the Prescription Drug Card Program portion of the **MPSB** for prescriptions up to a 21-day supply (there is no benefit under this Program if the prescription supply exceeds 21 days):

- You must pay the full price of the prescription at the pharmacy whether it is an In-Network Pharmacy or an Out-of-Network Pharmacy.
- You must submit the claim to your or your **Eligible Dependent's** primary medical plan.
- Attach the Explanation of Benefits form received from the primary health plan and a copy of the itemized receipt to Medco's Coordination of Benefits (COB) claim form and return them to Medco. You can request Medco COB claim forms online at www.medco.com or by calling 1-800-842-

0070. The forms show the address to which you should mail these papers.

If you or your **Eligible Dependents** are enrolled in the **CHCB** or **MMCP**, you will be reimbursed for the difference, if any, between what the primary health plan paid and 75% of the **Eligible Expenses** for the drug. If you or your **Eligible Dependents** are enrolled in the **BHCB**, you will be reimbursed the difference, if any, between what the primary health plan paid and 50% of the **Eligible Expenses** for the drug.

Remember, there is no benefit if you buy a supply of **Prescription Drugs** at either an In-Network Pharmacy or an Out-of-Network Pharmacy for a period in excess of 21 days regardless of whether you or your **Eligible Dependents** are enrolled in the **CHCB**, the **MMCP**, or the **BHCB**.

The provisions "If Both Wife and Husband Work for a Participating Employer etc." (see page 125) and "If Husband or Wife is Covered Under The Railroad Employees National Early Retirement Major Medical Benefit Plan ("ERMA" or "GA-46000") or as an Employee Under the Railroad Employees National Health and Welfare Plan, etc." (see page 126) do not apply to the coordination of benefits under the Prescription Drug Card Program.

There is no coordination of benefits provision applicable to the Mail Order Prescription Drug Program or to **Medicare** Part D. This means that benefits under the Mail Order Prescription Drug Program will be paid as if there were no other coverage, and, unless you or your spouse has rejected this Plan as primary to **Medicare** as provider of health benefits, benefits under both the Mail Order Prescription Drug Program and the Prescription Drug Card Program will be paid as if there were no **Medicare** Part D.

OPTING OUT OF PLAN COVERAGE

You may "opt out" of "foreign-to-occupation" Employee Health Care Benefits (i.e., Benefits other than for on-duty injuries) and Dependent Health Care Benefits under the Plan if you certify that you have medical, mental health/substance abuse and prescription drug coverage for yourself (except with respect to on-duty injuries) and your dependents under a group health plan or health insurance policy other than the Plan. For example, if your spouse is enrolled in a group health plan provided by his or her employer that provides medical, mental health/substance abuse and prescription drug coverage for you, your spouse and your other dependents, you could make the requisite certification. Forms for making this certification and electing to opt out are provided by UnitedHealthcare. UnitedHealthcare will also let you know when you must send a properly completed certification and election form to UnitedHealthcare for your opt-out election, if you choose to make one, to be effective.

If you opt out, the Plan will not pay Health Care Benefits for you (except with respect to on-duty injuries) or for your spouse or other dependents. So, before you decide to opt out, please carefully compare the benefits available under the Plan with those available under the other group plan or policy that covers you and your family.

Note that even if you opt out, you will remain covered under the Plan for Health Care Benefits for your on-duty injuries and for life and accidental death and dismemberment benefits. The Plan's life and accidental death and dismemberment benefits are described in a separate booklet.

If you opt out, you will not be required to make the employee contributions described on page 20 that are required for all employees who have foreign-to-occupation Employee Health Care Benefits or Dependent Health Care Benefits under the Plan. As a result, this amount will not be deducted from your wages. Also, in most cases, you will receive a taxable bonus of \$100 per month in every month that your opt-out election is in effect if your employer is required to make a payment to the Plan in that month for your life and accidental death and dismemberment insurance. When your employer is required to make such a payment, it is usually because you rendered the **Requisite Amount of Compensated Service** or received the **Requisite Amount of Vacation Pay** in the prior month.

You will not be paid this bonus, however, if:

- You are on authorized leave under the Family and Medical Leave Act of 1993 on the date the bonus would otherwise be paid in any given month and did not render the **Requisite Amount of Compensated Service** or receive the **Requisite Amount of Vacation Pay** during the prior month, or
- Your spouse is also a railroad employee who participates in this Plan or in The Railroad Employees National Health and Welfare Plan, or
- Your spouse is a railroad retiree who participates in the Railroad Employees National Early Retirement Major Medical Benefit Plan ("ERMA").

An election to opt out generally stays in effect until the end of the calendar year in which it is made. Plan coverage is reinstated as of the beginning of the next calendar year unless you opt out for that year by completing and returning a new certification and election form within the time allowed for you to do so.

If you opt out for any calendar year, you will not, in most cases, be permitted to revoke that election and re-enroll for Plan coverage before the beginning of the next calendar year. But there are some important exceptions to this rule:

- If your other health insurance coverage is COBRA continuation coverage, you may re-enroll for Plan coverage when the COBRA coverage is exhausted.
- If your other health plan coverage is not COBRA continuation coverage, you may re-enroll for Plan coverage if that other coverage is terminated as a result of loss of eligibility for it (including losing such eligibility as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or if employer contributions toward that coverage are terminated.
- If you marry a person who is your tax dependent, or if you acquire a new tax dependent through marriage, birth, adoption or placement for adoption, you will be allowed to re-enroll for Plan coverage. Generally, a tax dependent is

anyone whom you are entitled to list as a dependent on your federal income tax return.

If you have made an opt-out election and are permitted to revoke it and re-enroll for Plan coverage, you can do so by completing a revocation form that UnitedHealthcare will send you upon your request. You must return that form, properly completed, to UnitedHealthcare no later than 30 days after the event that permits you to revoke your opt-out election. If you do not properly complete and return the revocation form within thirty (30) days of this event, you may not change your election until the beginning of the next calendar year.

In general, if you are permitted to revoke your opt-out election and re-enroll for Plan coverage during a calendar year, you will be re-enrolled as of the first day of the calendar month after UnitedHealthcare receives your completed revocation form. For that reason, it is important to send your revocation form to UnitedHealthcare as promptly as you can.

If the reason that you are permitted to revoke your opt-out election is that you acquired a new tax dependent through birth, adoption or placement for adoption, then the revocation will be retroactively effective to the first day of the calendar month in which that event occurred. (Note that this retroactive coverage does not apply in the case of marriage.) As a result, you may be required to make a retroactive contribution to the Plan and to refund any \$100 "opt-out" bonus that you received for that month. Any contributions and refunds will be deducted from your wages.

Some special rules apply when both you and your spouse are railroad employees who participate in this Plan and/or The Railroad Employees National Health and Welfare Plan, or your spouse is a railroad retiree who participates in ERMA.

First, if both you and your spouse are **Eligible Employees** with dependent coverage under this Plan, only the person whose birthday occurs earlier in the calendar year may opt out.

Second, if you are an **Eligible Employee** with dependent coverage under this Plan and your spouse is a railroad employee with employee and/or dependent coverage under The Railroad Employees National Health and Welfare Plan, only one of you may opt out of coverage under the applicable

Plan. You and your spouse may decide which of you will opt out of coverage.

Third, if you opt out on the basis that your spouse is employed by a participating railroad and has employee and/or dependent health care coverage under this Plan or The Railroad Employees National Health and Welfare Plan (or has retiree coverage under ERMA), you will not receive the \$100 per month bonus. Nor will you be required to make the monthly contribution to the Plan that would otherwise be deducted from your wages.

Fourth, for purposes of the "make whole" Coordination of Benefits rules under this Plan, The Railroad Employees National Health and Welfare Plan and ERMA, employees who opt out will be treated as if they had not done so. These "make whole" COB rules will continue to apply as if no opt-out election had been made.

If you decide to opt out, the decision applies to your entire family. If you are a Hospital Association member who must look to the Hospital Association for your health care benefits, your election to opt out will apply to your coverage under the Hospital Association and your dependent coverage under the Plan. You cannot give up employee coverage only or dependent coverage only.

For purposes of determining eligibility for coverage under ERMA, an employee who is not covered under this Plan by reason of having opted out will be treated as if he or she had not opted out.

RELEASE OF MEDICAL INFORMATION

Any company that administers Health Care Benefits under the Plan may release medical information about the **Covered Family Member** to any other person or organization that is authorized by the Plan to receive it and that requests such information to enable it to accurately determine what benefits are payable under the Plan.

Furthermore, to the extent permissible under applicable law, before you may receive Health Care Benefits under the Plan, each **Covered Family Member** may be required to agree with each of his/her other health providers that the provider may release medical information to any of the companies that administer health care benefits under the Plan that the company considers necessary to enable it to accurately determine what benefits are payable under the Plan.

For further information on when the Plan may disclose medical information, see "Notice of Privacy Practices" at pages 180 through 188 of this booklet.

INTERPRETING PLAN PROVISIONS

Each of the companies that administer Health Care Benefits under the Plan has discretionary authority to determine whether and to what extent **Eligible Employees** and **Eligible Dependents** are entitled to benefits that the company administers and to construe all relevant terms, limitations and conditions set forth in this booklet or in any other document or instrument pursuant to which the Plan is established or maintained. A company administering Health Care Benefits under the Plan shall be deemed to have properly exercised this discretionary authority unless the company has acted arbitrarily or capriciously.

V

Definitions

(These definitions apply when the following terms are used in this booklet.)

Ambulatory Surgical Center

A specialized facility which is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an ambulatory surgical center by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which the facility is located or
- Where licensing is not required, it meets all of the following requirements:
 - It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) and permits a surgical procedure to be performed only by a **Physician** who, at the time the procedure is performed, is privileged to perform the procedure in at least one **Hospital** in the area.
 - It provides at least one operating room and at least one post-anesthesia recovery room.
 - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
 - It has trained personnel and necessary equipment to handle emergency situations.
 - It has immediate access to a blood bank or blood supplies.
 - It provides the full-time services of one or more registered nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room.

Another Railroad Health and Welfare Plan

A health and welfare plan established pursuant to agreement between a railroad or railroads and a labor organization or labor organizations other than this Plan, The Railroad Employees National Health and Welfare Plan, and The Railroad Employees National Early Retirement Major Medical Benefit Plan ("ERMA"). Also, a hospital association is not **Another Railroad Health and Welfare Plan**.

BHCB

The Plan's Basic Health Care Benefit.

Birth Center

A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which the facility is located.
- Where licensing is not required, it meets all of the following requirements:
 - It is operated and equipped in accordance with any applicable state law.
 - It is equipped to perform routine diagnostic and laboratory examinations.
 - It has trained personnel and necessary equipment available to handle foreseeable **Emergencies**.
 - It is operated under the full-time supervision of a doctor of medicine (M.D.) or registered nurse (R.N.).
 - It maintains a written agreement with at least one **Hospital** in the area for immediate acceptance of patients who develop complications.
 - It is expected to discharge or transfer patients within 24 hours following delivery.

BlueCross BlueShield Participating Provider

A provider who has agreed to negotiated charges for covered services under the **CHCB** administered by Highmark.

BlueCross BlueShield PPO Provider

A provider who has agreed to negotiated charges for **In-Network Services** under the **MMCP** and **BHCB** administered by Highmark.

Brand Name Drug

A **Prescription Drug** which is or was at one time under patent protection.

Certification, Certifies, or Certified

A decision by ValueOptions to approve as **Medically Appropriate** an inpatient admission, an inpatient length of stay, or inpatient or outpatient treatment.

CHCB

The Plan's Comprehensive Health Care Benefit.

COBRA

Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Family Members

Eligible Employees and their **Eligible Dependents** who are covered under the Plan.

Covered Health Services

Those services and supplies described under the heading "Eligible Expenses and Covered Health Services" on pages 91 through 107.

Custodial Care

Care made up of services and supplies that meets one of the following conditions:

- Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
- Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

Care that meets one of the conditions above is custodial care regardless of any of the following:

- Who recommends, provides or directs the care.
- Where the care is provided.
- Whether or not the patient can be or is being trained to care for himself/herself.

Eligible Dependent

An individual described under the heading "Eligible Dependents" on pages 23 through 24 of this booklet.

Eligible Employee

An individual described under the heading "Eligible Employees" on pages 22 through 23 of this booklet.

Eligible Expenses

The actual cost to you of the **Reasonable Charges** for **Covered Health Services** or for **Prescription Drugs** that are covered under the **MPSB**.

Emergency

*For purposes of the **BHCB**, **CHCB** and **MMCP**, the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:*

- The patient's health would be placed in serious jeopardy.
- Bodily function would be seriously impaired.
- There would be serious dysfunction of a bodily organ or part.

*For purposes of the **MHSA**, a situation in which one or more of the following circumstances are present:*

- The patient is in imminent or potential danger to harm himself, herself, or others as a result of a sickness or injury covered by the **MHSA**;

- The patient shows symptoms (e.g. hallucinations, agitation, delusions, etc.) resulting in impairment in judgment, functioning and/or impulse control, severe enough to endanger the welfare of himself, herself, or others;
- There is an immediate need for **Mental Health Care** or **Substance Abuse Care** resulting from or in conjunction with a sickness or injury covered by the **MHSA**, such as an overdose, suicide attempt or detoxification.

Facility

*For purposes of the **BHCB**, **CHCB** and **MMCP**, an **Ambulatory Surgical Center** or a **Hospital**.*

*For purposes of the **MHSA**, a **ValueOptions Facility**, or a **Non-ValueOptions Facility**.*

Formulary Drug

A **Brand Name Drug** that appears on a preferred list of medications (commonly called a "formulary"). This list includes a wide selection of medications, offering you a choice while helping to contain the cost to the Plan of its prescription drug benefits. For more information about the formulary applicable to the Plan, visit www.medco.com or call 1-800-842-0070.

Full Medicare Coverage

Coverage for all the benefits provided under **Medicare** Hospital Insurance (Part A) and Medical Insurance (Part B). For purposes of coverage under this Plan, each **Person Eligible Under Medicare** shall be deemed to have **Full Medicare Coverage**.

Full Medicare Coverage will include any benefits not provided under **Medicare** to the extent that any payment under **Medicare** is reduced because of benefits paid in accordance with any plan of insurance regulated by or through action of any automobile reparations act of any government, any policy or plan which includes automobile medical benefits, or the provisions of any liability insurance policy or plan.

Generic Drug

A **Prescription Drug** which is a multi-source drug which has never been under patent protection.

Home Health Care Agency

An agency or organization which provides a program of home health care and which fully meets one of the following three tests:

- It is approved under **Medicare**, or
- It is established and operated in accordance with applicable licensing and other laws, or
- It meets all of the following criteria:
 - It has the primary purpose of providing a home health care delivery system bringing supportive services to the home.
 - It has a full-time administrator.
 - Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available.

Hospice

An agency that provides counseling and incidental medical services for a terminally ill individual. The agency must meet all of the following tests:

- It is approved under any required state or governmental Certificate of Need.
- It provides 24 hour-a-day, 7 day-a-week service.
- It is under the direct supervision of a **Physician**.
- It has a social-service coordinator who is licensed in the area in which it is located.
- The main purpose of the agency is to provide **Hospice** services.
- It has a full-time administrator.

- It is established and operated in accordance with any applicable state laws.

A part of a **Hospital** that meets the criteria set forth above will be considered a **Hospice** for purposes of this Plan.

Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which meets one of the following three tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations, or
- It is approved by **Medicare** as a hospital, or
- It meets all of the following criteria:
 - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of **Physicians**;
 - It continuously provides on the premises 24 hour-a-day nursing service by or under the supervision of registered nurses; and
 - It is operated continuously with organized facilities for operative surgery on the premises.

In-Network Provider

*For purposes of the **MMCP**, a provider participating in a managed medical care network of UnitedHealthcare, Aetna or Highmark, whichever administers your **MMCP** in a geographical area in which the Plan offers (has approved) a managed medical care network.*

*For purposes of the **BHCB**, a provider participating in the managed medical care network of UnitedHealthcare or Highmark, whichever administers your **BHCB** in a geographical area in which the Plan offers (has approved) a managed medical care network.*

*For purposes of the **MHSA**, a **ValueOptions Provider**.*

In-Network Services

*For purposes of the **MMCP**, **Medically Appropriate Covered Health Services** received from a provider participating in a Plan-approved network of the company that administers your **MMCP**, or pursuant to an **Out-of-Network Authorization**.*

*For purposes of the **BHCB**, **Medically Appropriate Covered Health Services** received from a provider participating in a Plan-approved network of the company that administers your **BHCB**.*

*For purposes of the **MHSA**, **Medically Appropriate Covered Health Services** received from a **ValueOptions Provider** or pursuant to an **Out-of-Network Authorization**.*

Level of Care

The duration, frequency, location, intensity and/or magnitude of a treatment setting, treatment plan, or treatment modality, including, but not limited to:

- acute care facilities;
- less intensive inpatient or outpatient alternatives to acute care facilities such as residential treatment centers, group homes or structured outpatient programs;
- outpatient visits; or
- medication management.

Medical Care

Treatment of a sickness, injury or pregnancy when such sickness, injury or pregnancy:

- shows a clinically significant physiological syndrome or pattern;
- substantially or materially impairs a person's ability to function in one or more major life activities; and
- is identified under one of the specific code numbers listed in either the Diagnostic Statistical Manual IV published by the American Psychiatric Association, or published in the International Classification of Diseases, Ninth Edition, Clinical Modification, published by the United States

Department of Health and Human Services, that have been accepted for inclusion as **Medical Care** by the Plan.

Medically Appropriate

A **Covered Health Service** which has been determined

- with respect to the **CHCB** and **BHCB**, by the company that administers your **CHCB** or **BHCB**, as the case may be (UnitedHealthcare or Highmark),
- by the company that administers your **MMCP** (Aetna, Highmark or UnitedHealthcare) with respect to the **MMCP**, or
- by ValueOptions with respect to the **MHSA**,

to be the appropriate **Level of Care** that can safely be provided for the specific covered individual's diagnosed condition in accordance with the professional and technical standards adopted by the company making the determination.

Medically Necessary

A Prescription Drug which has been determined by Medco, with respect to the **MPSB**, to be:

- a therapeutic response provided for and consistent with the symptoms or proper diagnosis and treatment for the specific covered individual's illness, disease or condition;
- prescribed in accordance with generally accepted principles of **Medical Care**, **Mental Health Care** or **Substance Abuse Care** practice in the U.S. at the time prescribed;
- safe and effective according to accepted clinical evidence generally recognized by **Medical Care**, **Mental Health Care**, or **Substance Abuse Care** professionals or publications; and
- not primarily for the convenience of the covered individual, his/her family, or the provider.

Medicare

The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act.

Mental Health Care

Treatment of a sickness or injury when such sickness or injury:

- shows a clinically significant behavioral or psychological syndrome or pattern;
- substantially or materially impairs a person's ability to function in one or more major life activities; and
- is identified under one of the specific code numbers listed in either the Diagnostic Statistical Manual IV published by the American Psychiatric Association, or its equivalent code published in the International Classification of Diseases, Ninth Edition, Clinical Modification, published by the United States Department of Health and Human Services, that have been accepted for inclusion as **Mental Health Care** by the Plan.

Some examples of services and supplies that do not fall within the definition of **Mental Health Care** are:

- Treatment of congenital and/or organic disorders, including, but not limited to Organic Brain Disease, Pervasive Developmental Disorder, Alzheimer's Disease, autism and mental retardation.
- Treatment for stress, co-dependency, sexual addiction, and chronic pain when not a part of **Mental Health Care**.
- Treatment for smoking cessation, weight reduction, obesity, stammering, or stuttering.

MHSA

The Plan's Mental Health and Substance Abuse Care Benefit.

MMCP

The Plan's Managed Medical Care Program.

MPSB

The Plan's Managed Pharmacy Services Benefit.

Non-Certification or Non-Certified

A decision by ValueOptions not to approve as **Medically Appropriate** an in-patient admission, an inpatient length of stay, or inpatient or outpatient treatment.

Non-Formulary Drug

Any **Brand Name Drug** that does not appear on the preferred list.

Non-ValueOptions Facility

A **Hospital** or **Treatment Center** that is not a **ValueOptions Facility**.

Non-ValueOptions Provider

A **Non-ValueOptions Facility** or a **Non-ValueOptions Therapist**.

Non-ValueOptions Therapist

A licensed or certified psychiatrist or other Doctor of Medicine (M.D.), or a **Psychologist**, who is not a **ValueOptions Therapist**.

Nurse-Midwife

A person who is certified to practice as a **Nurse-Midwife** and who:

- is licensed as a registered nurse by the appropriate board of nursing having responsibility for such licensure under the laws of the jurisdiction where such person renders services, and
- has completed a program for the training of **Nurse-Midwives** approved by the appropriate regulatory authority having responsibility for such programs under the laws of the jurisdiction where such program is provided.

Out-of-Network Authorization

A determination made

- With respect to the **MHSA**, by ValueOptions, or

- With respect to the **MMCP**, by the company that administers your **MMCP**,

that **Covered Health Services** provided by an **Out-of-Network Provider** shall be covered at the level of benefits payable for **In-Network Services**.

Out-of-Network Provider

For purposes of the **MMCP**, a provider not participating in the managed medical care network of the company that administers your **MMCP**.

*For purposes of the **BHCB**, a provider not participating in the UnitedHealthcare PPO network if UnitedHealthcare administers your **BHCB**, and, if Highmark administers your **BHCB**, a provider who is not a **BlueCross BlueShield PPO Provider**.*

For purposes of the **MHSA**, a **Non-ValueOptions Provider**.

Out-of-Network Services

Covered Health Services received from an **Out-of-Network Provider**, unless such services are received pursuant to an **Out-of-Network Authorization**.

Outpatient Clinic

A facility which provides an outpatient program of effective medical and therapeutic **Substance Abuse Care** and meets all of the following requirements:

- It is licensed, certified or approved as a substance abuse treatment facility by the appropriate agency of the state in which it is located.
- It provides a program of treatment approved by the attending **Physician**, a duly qualified alcohol rehabilitation counselor, an alcoholism para-professional or a certified addictions counselor.
- It has or maintains a written, specific and detailed regimen requiring full-time participation by the patient.

Person Eligible under Medicare

You or your **Eligible Dependent** if **Medicare** benefits are primary to Plan benefits (see "Important Notice about the Plan and Medicare" on pages 175 through 179).

Physician

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Chiropody (D.S.C.).
- Doctor of Chiropractic (D.C.).
- Doctor of Dental Surgery (D.D.S.).
- Doctor of Medical Dentistry (D.M.D.).
- Doctor of Osteopathy (D.O.).
- Doctor of Podiatry (D.P.M.).
- Physicians Assistant when operating under the direction of one of the above Doctors.

Prescription Drugs

The following will be considered **Prescription Drugs**:

- Federal Legend Drugs. These are all medical substances which the Federal Food, Drug and Cosmetic Act requires to be labeled "Caution - Federal Law prohibits dispensing without prescription."
- Drugs which require a prescription under State law but not under Federal law.
- Compound Drugs. These are drugs that have more than one ingredient. At least one of the ingredients has to be a Federal Legend Drug or a drug which requires a prescription under State law.
- Injectable insulin, when prescribed by a **Physician**.
- Needles and syringes, when prescribed by a **Physician**.

Pretreatment Outpatient Assessment

The telephonic pretreatment assessment performed at the time a call is made to ValueOptions by an **Eligible Employee** or **Eligible Dependent** (or his/her representative) with respect to any **Mental Health Care** or **Substance Abuse Care** problem. This telephonic pretreatment assessment will be made by ValueOptions with respect to all outpatient **Out-of-Network Services** and will include a discussion and evaluation of proposed outpatient therapy.

Psychologist

A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Qualified Counselor

A qualified alcohol rehabilitation counselor, an alcoholism para-professional or a certified addiction's counselor.

Qualified Medical Child Support Order

A medical child support order as defined in clause (B) of 29 U.S. Code §1169(a)(2) that meets the requirements of clause (A) of that provision, i.e., §1169(a)(2).

Reasonable Charge

- For services rendered by a provider under a negotiated discount arrangement made available to the Plan through Aetna, Coalition America, Highmark, Medco, UnitedHealthcare, or ValueOptions, an amount that does not, as determined by the entity through which the discount arrangement is made available to the Plan, exceed the negotiated amount. Examples of providers who have these arrangements are:
 - **BlueCross BlueShield Participating Providers**
 - **BlueCross BlueShield PPO Providers**
 - **In-Network Providers**

- **UnitedHealthcare Preferred Providers**

- For all other services, an amount measured and determined by the appropriate benefits administrator or by Coalition America by comparing the actual charge with the charges made, and/or with the amounts reimbursed to providers for charges made, for similar services and supplies provided to individuals of similar age, sex, circumstances and medical condition in the locality concerned.
- In determining the **Reasonable Charge** for a service or supply that is:
 - unusual; or
 - not often provided in the area; or
 - provided by only a small number of providers in the area;

factors such as the following may be taken into account:

- the complexity;
- the degree of skill needed;
- the type or specialty of the provider;
- the range of services or supplies provided by a **Facility**;
- the prevailing charge in other areas; and
- the prevailing payment for such services in other areas.

Requisite Amount of Compensated Service

Compensated service rendered for an aggregate of at least seven (7) calendar days during a calendar month. This "seven-day" rule will be applied in accordance with the terms of the collective bargaining agreement providing for it, including any side letter to such agreement dealing with application of the rule.

Requisite Amount of Vacation Pay

Vacation Pay received for an aggregate of at least seven (7) calendar days during a calendar month. This "seven-day" rule will be applied in accordance with the terms of the collective bargaining agreement providing for it, including any side letter to such agreement dealing with application of the rule.

Skilled Nursing Facility

A facility approved by **Medicare** as a Skilled Nursing Facility.

If not approved by **Medicare**, a facility that meets all of the following tests:

- It is operated under applicable licensing and other laws.
- It is under the supervision of a **Physician** or registered nurse (R.N.) who is devoting full time to supervision.
- It is regularly engaged in providing room and board and continuously provides 24 hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or sickness.
- It is authorized to administer medication to patients on the order of a **Physician**.
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

A part of a **Hospital** that meets the criteria set forth above will be considered a **Skilled Nursing Facility** for purposes of this Plan.

Social Worker

A person who specializes in clinical social work and is licensed or certified as a social worker by the appropriate authority.

Speech Therapist

A person who is licensed as a speech therapist.

Substance Abuse Care

Treatment of a sickness or injury when such sickness or injury:

- shows a clinically significant behavioral or psychological syndrome or pattern;
- substantially or materially impairs a person's ability to function in one or more major life activities; and
- is identified under one of the specific code numbers listed in either the Diagnostic Statistical Manual IV published by the American Psychiatric Association, or its equivalent code published in the International Classification of Diseases, Ninth Edition, Clinical Modification, published by the United States Department of Health and Human Services, that have been accepted for inclusion as **Substance Abuse Care** by the Plan.

Therapist

A **ValueOptions Therapist** or a **Non-ValueOptions Therapist**.

Transplant Facility

A **Hospital** that the company that administers your benefits specifically designates as a transplant facility. A **Transplant Facility** has entered into an agreement with the company to render **Covered Health Services** for the treatment of specified diseases or conditions. A **Transplant Facility** may or may not be located within your geographic area. The fact that a **Hospital** is a network hospital does not mean that it is a **Transplant Facility**.

Treatment Center

A facility that provides a program of effective medical and therapeutic treatment for **Substance Abuse Care** and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a **Physician**.

- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A part of a **Hospital** that meets the criteria set forth above and provides **Substance Abuse Care** that is similar to that which is ordinarily provided by a **Treatment Center**, will be considered a **Treatment Center** for the purposes of this Plan.

UnitedHealthcare Preferred Provider

A provider who has agreed to negotiated charges for covered services under the **CHCB** or **BHCB** administered by UnitedHealthcare.

Vacation Pay

- **Vacation Pay** received after an **Eligible Employee** is furloughed will not continue coverages or benefits after coverage ends.
- **Vacation Pay** received after an employment relationship has terminated will not continue coverage or benefits after coverage ends. This includes **Vacation Pay** received after an **Eligible Employee** has resigned, is dismissed or has given up employment rights for retirement.

ValueOptions Facility

A state licensed or authorized institution, program or other health facility which has entered into an agreement with ValueOptions as an independent contractor to provide covered services to you or your **Eligible Dependents**.

ValueOptions Provider

A **ValueOptions** Facility or **ValueOptions** Therapist.

ValueOptions Therapist

A licensed or certified psychiatrist, **Psychologist**, psychiatric **Social Worker**, or other licensed or certified mental health or substance abuse practitioner who has entered into an agreement with ValueOptions as an independent contractor to provide covered services to you or your **Eligible Dependents**.

VI

CLAIM INFORMATION

HOW TO FILE A CLAIM FOR COMPREHENSIVE HEALTH CARE BENEFITS OR BASIC HEALTH CARE BENEFITS IF HIGHMARK ADMINISTERS YOUR CHCB OR BHCB

Necessary Pre-Approval

In order to receive full benefits for certain services as part of the **CHCB** or **BHCB** administered by Highmark, you must notify Highmark and obtain a determination, before you receive the services, as to whether they are **Covered Health Services** and, if so, whether they are **Medically Appropriate**. The services for which this pre-approval is required, and the process for requesting it, are described at pages 56 through 59.

If you receive services under the **CHCB** from a **BlueCross BlueShield Participating Provider** (or you receive **In-Network Services** from a **BlueCross BlueShield PPO Provider** under the **BHCB**), all you need to do in most cases is present your Highmark identification card. The Provider will bill the local BlueCross BlueShield Plan directly. Highmark will send you copies of the payment record. The Provider will bill you for any charges not covered by the **CHCB** or the **In-Network Services** portion of the **BHCB** and for any applicable deductible and coinsurance amount payable by you.

Post-Services Claims for Reimbursement or Payment

If you receive services from a provider other than a **BlueCross BlueShield Participating** or **PPO Provider**, or you receive **Out-of-Network Services** under the **BHCB** from any provider, you will receive a bill for them. To claim your benefits, unless the provider submits your claim for you, send a copy of the bill to:

Highmark
Railroad Dedicated Unit
P.O. Box 890381
Camp Hill, PA 17089-0381

and be sure it includes all of the following information:

- the name of the enrolled person who was treated;
- your name and your group and identification numbers;
- a description of the symptoms that were observed or a diagnosis; and
- a description of the services and the dates on which they were given.

The same procedure should be followed with bills for hospital or professional provider care you receive outside the United States.

HOW TO FILE A CLAIM FOR COMPREHENSIVE HEALTH CARE BENEFITS OR BASIC HEALTH CARE BENEFITS IF UNITEDHEALTHCARE ADMINISTERS YOUR CHCB OR BHCB

Necessary Pre-Approval

In order to receive full benefits for certain services as part of the **CHCB** or **BHCB** administered by UnitedHealthcare, you must notify UnitedHealthcare and obtain a determination, before you receive the services, as to whether they are **Covered Health Services** and, if so, whether they are **Medically Appropriate**. The services for which this pre-approval is required, and the process for requesting it, are described at pages 56 through 59.

Post-Service Claims for Reimbursement or Payment

If you receive services from **UnitedHealthcare Preferred Providers**, they will file your medical claims for you. If you receive services from other providers, send your claims to:

UnitedHealthcare
P. O. Box 30985
Salt Lake City, UT 84130-0985

Your claims will be processed in the UnitedHealthcare Claim Office in Kingston, New York. The Salt Lake City address is for claim submission purposes only.

In order for UnitedHealthcare to process your claims promptly, the following information is necessary:

- the name and UHC member identification number of the **Eligible Employee**,
- the patient's name and relationship to the **Eligible Employee**,
- The plan number assigned by UnitedHealthcare: GA-690100,
- the diagnosis,
- an itemized statement of the services rendered, and dates of and charges for those services.

UnitedHealthcare does not provide claim forms specific to this Plan. UnitedHealthcare will accept standard claim forms generally accepted by medical benefits administrators.

HOW TO FILE A CLAIM FOR MANAGED MEDICAL CARE PROGRAM BENEFITS IF UNITEDHEALTHCARE OR AETNA ADMINISTERS YOUR MMCP

Necessary Pre-Approval

In order to receive full benefits for certain **Out-of-Network Services** under the **MMCP** administered by UnitedHealthcare or Aetna, you must notify whichever of the two companies that administers your **MMCP** and obtain a determination, before you receive the services, as to whether they are **Covered Health Services** and, if so, whether they are **Medically Appropriate**. The services for which this pre-approval is required, and the process for requesting it, are described at pages 56 through 59.

You do not need to file a claim form when you receive **In-Network Services** under the **MMCP**. To be reimbursed for **Out-of-Network Services**, however, you must complete and submit a claim.

If you are filing a claim for **Out-of-Network Services** under the **MMCP** administered by UnitedHealthcare, you should provide the same information and follow the same mailing instructions that are set forth on pages 154 through 155 for filing claims under the **CHCB** or the **BHCB** administered by UnitedHealthcare.

Post-Service Claims for Reimbursement or Payment

If you are filing a claim for **Out-of-Network Services** under the **MMCP** administered by Aetna, you must complete and submit a claim form and send itemized bills to:

Aetna
P.O. Box 981106
El Paso, TX 79998-1106

Be sure to include the employee's name and Aetna member identification number with each claim submission. To obtain a claim form from Aetna, contact Member Services at 1-888-332-8742.

HOW TO FILE A CLAIM FOR MANAGED MEDICAL CARE PROGRAM BENEFITS IF HIGHMARK ADMINISTERS YOUR MMCP

Necessary Pre-Approval

In order to receive full benefits for certain **Out-of-Network Services** under the **MMCP** administered by Highmark, you must notify Highmark and obtain a determination, before you receive the services, as to whether they are **Covered Health Services** and, if so, whether they are **Medically Appropriate**. The services for which this pre-approval is required, and the process for requesting it, are described at pages 56 through 59.

If you receive services from a **BlueCross BlueShield PPO** or **Participating Provider**, all you need to do is present your Highmark identification card and the Provider will bill the local BlueCross BlueShield Plan directly. Highmark will send you copies of the payment record. With respect to **In-Network Services** received from a **BlueCross BlueShield PPO Provider**, the Provider may bill you for any charges not covered by the **MMCP** and for any co-payment payable by you. With respect to **Out-of-Network Services**, the Provider's bill to you will include any applicable deductible amount and coinsurance payable by you.

Post-Service Claims for Reimbursement or Payment

If you receive **Out-of-Network Services** from a provider other than a **BlueCross BlueShield PPO** or **Participating Provider**, you will receive a bill for such services. To claim your benefits, send a copy of the bill to:

Highmark
Railroad Dedicated Unit
P.O. Box 890381
Camp Hill, PA 17089-0381

and be sure it includes all of the following information:

- the name of the enrolled person who was treated;
- your name and your group and identification numbers;

- a description of the symptoms that were observed or a diagnosis; and
- a description of the services and the dates on which they were given.

The same procedure should be followed with bills for hospital or professional provider care you receive outside the United States.

HOW TO FILE A CLAIM FOR MENTAL HEALTH AND SUBSTANCE ABUSE CARE BENEFITS

Necessary Certification

In order to receive full benefits for certain services as part of the **MHSA**, you must notify ValueOptions and obtain a **Certification** before you receive the services. The services for which **Certification** is required, and the process for requesting **Certification**, are described at pages 87 through 89.

Post-Service Claims for Reimbursement or Payment

In-Network Services

When you or your **Eligible Dependent** receives **In-Network Services** covered under the **MHSA**, the **In-Network Provider** who renders the services will file the claim for you.

Out-of-Network Services

When you or your **Eligible Dependent** receives **Out-of-Network Services** under the **MHSA**, you or your **Eligible Dependent** is responsible for ensuring that the claim is filed with ValueOptions. Please ask your provider to give you a universal claim form. You may use it to submit your claim. If your provider does not have the form, call ValueOptions and one will be sent to you. The form should be fully completed by you and your provider.

The ValueOptions address is:

ValueOptions
Railroad Claims Unit
P.O. Box 850
Latham, NY 12110

HOW TO FILE A CLAIM FOR PRESCRIPTION DRUGS OBTAINED AT AN OUT-OF- NETWORK PHARMACY

If you fill your prescription at an Out-of-Network Pharmacy, you must file a claim form with Medco. You can obtain a claim form by visiting www.medco.com or calling 1-800-842-0070. You must complete the claim form and send it to Medco at the address printed on the form.

You do not need to file a claim form when you fill your prescription at an In-Network Pharmacy.

TOLL-FREE TELEPHONE SERVICE

Toll-free service is available as follows:

Basic Health Care Benefit

Highmark: 1-866-267-3320
UnitedHealthcare: 1-888-445-4379

Care Coordination/Medical Management

Highmark: 1-866-267-3320
UnitedHealthcare: 1-888-445-4379
Aetna: 1-888-332-8742
ValueOptions: 1-800-934-7245

Comprehensive Health Care Benefit

Highmark: 1-866-267-3320
UnitedHealthcare: 1-888-445-4379

Managed Medical Care Program

Aetna: 1-888-332-8742
Highmark: 1-866-267-3320
UnitedHealthcare: 1-888-445-4379

Managed Pharmacy Services Benefit

Medco:

For the Prescription Drug
Card Program 1-800-842-0070

For the Mail Order Prescription
Drug Benefit 1-800-842-0070

Mental Health and Substance Abuse Care Benefit

ValueOptions: 1-800-934-7245

PROOF OF LOSS

The companies administering the Plan's various Health Care benefits may:

- require bills for **Hospital** confinement and other services as part of the proof of claim.
- examine you or your **Eligible Dependent** in connection with the claim.
- require proof of disability if
 - coverage is being continued under the provisions applicable to Disabled Employees (see pages 29 through 30), or
 - you believe your child meets the requirements set forth for a disabled child in the definition of an **Eligible Dependent** (see pages 23 and 24), and
 - you or an **Eligible Dependent** is eligible for benefits after coverage ends (see pages 42 through 44).
- require proof of student status if you believe your child meets the requirements for a student in the definition of an **Eligible Dependent** (see pages 23 and 24).
- require periodic information as to whether a spouse or child is employed and is covered under another plan (see "Coordination of Benefits" section beginning on page 123).

Proof must be furnished no later than 90 days after the loss for which the claim is made. If it is not reasonably possible to furnish the proof in this time, it must be furnished at the earliest reasonably possible date.

Payment of Claims

Benefits are payable to or on behalf of the **Eligible Employee**, except that

- If an employer or other person or organization has paid or is obligated to pay the **Eligible Employee's** health care expenses, Employee Health Care Benefits may be paid to such employer or other person or organization.

- If the benefits have been assigned, they will be paid to the assignee (except under the **MPSB** or under the **BHCB**, **CHCB**, or **MMCP** administered by Highmark), and the **Eligible Employee** will receive an Explanation of Benefits.
- If the benefits are for **In-Network Services** covered under the **MMCP** or **MHSA**, they will be paid directly to the appropriate **In-Network Provider**.
- With respect to a situation where it is administratively feasible to make payment to someone other than the **Eligible Employee**, and the company that administers your **CHCB**, **BHCB** or **MMCP**, as the case may be (with respect those benefits), Medco (with regard to the Prescription Drug Card Program of the **MPSB**), or ValueOptions (with regard to the **MHSA**) has been informed:
 - that the patient is a minor living with a custodial parent or guardian who is not the **Eligible Employee**, or
 - of a specific situation and the company that administers the program involved (**CHCB**, **BHCB**, **MMCP**, **MHSA** or the **MPSB**) determines that it is otherwise appropriate to send the payment and Explanation of Benefits to someone other than the **Eligible Employee**,

the Plan may but shall not be obligated to pay such other person.

- If the Plan has received and accepted a **Qualified Medical Child Support Order**, benefits will be paid to, or at the direction of, a custodial parent.

Right of Reimbursement

If you or your **Eligible Dependent** incurs expenses as a result of bodily injury or sickness in circumstances giving rise to a right of recovery against a third party tortfeasor, other than your employer, any payment under the Plan is subject to the following conditions:

- The Plan, by virtue of payment of benefits, automatically acquires the right to be reimbursed by you, if you or your **Eligible Dependent** recovers from the third party tortfeasor, for damages all or part of which are recovered on account of the expenses incurred as a result of the bodily injury or sickness.
- The amount to be reimbursed by you shall equal but not exceed the amount of such benefits, less the proportionate amount of legal fees and expenses incurred by you or your **Eligible Dependent** in making recovery. Reimbursement shall be made from the first dollar of the amount determined pursuant to the preceding sentence, regardless of whether you are made whole for any losses you suffered as a result of the injury or sickness involved.
- The Plan shall also be subrogated to and succeed to your, or your **Eligible Dependent's**, right of recovery against any third party tortfeasor, other than your employer, and in its discretion may exercise such right to the extent of such benefits paid.

SPECIAL NOTICE CONCERNING CLAIMS AGAINST A PARTICIPATING RAILROAD FOR ON-DUTY INJURIES

The following is excerpted from the October 22, 1975 Health and Welfare Agreement:

In case of an injury or a sickness for which an Employee who is eligible for Employee benefits and may have a right of recovery against the employing railroad, benefits will be provided under the Policy Contract, subject to the provisions hereinafter set forth. The parties hereto do not intend that benefits provided under the Policy Contract will duplicate, in whole or in part, any amount recovered from the employing railroad for hospital, surgical, medical or related expenses of any kind specified in the Policy Contract, and they intend that benefits provided under the Policy Contract will satisfy any right of recovery against the employing railroad for such benefits to the extent of the benefits so provided. **Accordingly, benefits provided under the Policy Contract will be offset against any right of recovery the Employee may have against the employing railroad for hospital, surgical, medical or related expenses of any kind specified in the Policy Contract. (Art. III, Sec. A.)**

PROCESSING OF CLAIMS AND BENEFIT DETERMINATIONS

If, in order to receive full benefits, you request required pre-approval or **Certification** of services involving urgent care, you will receive verbal notification followed by a written or electronic Explanation of Benefits informing you of the determination made with regard to your request. For all other claims, you will receive a written or electronic Explanation of Benefits informing you of the benefit determination. The Explanation of Benefits will be written in a manner that can be understood by you. If the decision is adverse to you, the Explanation of Benefits will contain the reasons for the decision, references to specific Plan provisions that explain the decision, an explanation of any additional material or information that may be necessary and why that information is necessary, a description of the applicable appeal procedure and time limits (see below), including the expedited procedures for claims involving urgent care, and a statement about your rights to bring an action in court if the decision is still adverse to you once you complete the appeal process. The Explanation of Benefits will also include information about any rule, guideline, protocol, or similar criterion that was relied upon in making a decision adverse to you, or a statement that such information will be provided at no charge upon request. If a determination adverse to you is based on a judgment about medical necessity, experimental treatment, or a similar Plan exclusion or limitation, the Explanation of Benefits will include either an explanation of the scientific or clinical judgment involved or a statement that such an explanation will be provided to you at no charge upon request.

Urgent Care Claims

If you are requesting required pre-approval or **Certification** for care or treatment in order to obtain full benefits under the **CHCB**, the **BHCB**, the **MHSA**, or the **Out-of-Network Services** portion of the **MMCP** (or both the **Out-of-Network Services** and **In-Network Services** portions of the **MMCP** if your **MMCP** is administered by Highmark), and if a delay in granting of your request could seriously jeopardize your life or health or your ability to regain maximum function, or if, in the opinion of a **Physician** who knows your medical condition, you are in severe pain that cannot be managed adequately without the care or treatment being sought, the following will apply.

- A health care professional with knowledge of your medical condition may act as your authorized representative for the purpose of your request.
- If your request was not made properly, you will be provided with verbal notification of the proper procedure for making the request as soon as possible, but no later than 24 hours from the receipt of your request.
- If your request is made properly and all necessary information is included, you will be provided with verbal notification of the determination made upon your request as soon as possible, but no later than 72 hours from the receipt of your request.
- If additional information is required to make a determination on your request, you will be provided with verbal notification of the additional information required to complete your request as soon as possible, but no later than 24 hours from receipt of your request.
 - You will have 48 hours after receipt of this notification to provide the additional information.
 - You will then be provided with verbal notification of the determination on your request as soon as possible, but no later than 48 hours after the earlier of:
 - the receipt of the additional information; or
 - the end of the 48-hour period in which you have to provide the additional information.
- If an urgent care request for ongoing treatment was previously approved for a period of time or a number of treatments, and you request an extension of that treatment, you will be provided with verbal notification of the determination on your request as soon as possible, but no later than 24 hours from the receipt of your request, provided your request is made at least 24 hours before the termination of care. Otherwise, you will be provided with verbal notification of the determination no later than 72 hours from the receipt of your request.
- For all requests for required pre-approval or **Certification** of services involving urgent care, a written or electronic copy of the determination will be sent to you within 3 days following verbal notification.

- Your request will no longer be processed as involving urgent care if you go ahead and receive the care or treatment for which you seek pre-approval or **Certification**. Instead, your request will be processed as a post-service claim for reimbursement.

Non-Urgent Care Claims

Pre-Service

If, in order to receive full benefits under the **BHCB**, **CHCB**, **MHSA**, or the **Out-of-Network Services** portion of the **MMCP** (or both the **Out-of-Network Services** and **In-Network Services** portions of the **MMCP** if your **MMCP** is administered by Highmark), your request required pre-approval or **Certification** of care or treatment that does not involve urgent care, the following will apply:

- If your request was not made properly, you will be notified verbally or in writing within 5 days from the receipt of your request of the proper procedure for making the request.
- If your request is made properly, a notice of determination regarding your request will be sent to you no later than 15 days after receipt of your request. The benefits administrator charged by the Plan to process your request may take an additional 15 days to make a determination if such administrator determines that such an extension is necessary for reasons beyond its control and notifies you of this extension within 15 days from the receipt of your request. This notice will give you the reason for the extension and the date by which the administrator's determination will be made.
- If an extension is necessary because additional information is required to make the determination, you will be notified of the specific information that is needed.
 - You will have 45 days after receipt of this notice to provide the additional information.
 - The period for making a determination on your request will be suspended until you either provide the necessary information or until the 45-day period for you to provide the information ends, whichever comes first.

- If a request to pre-approve or **Certify** ongoing treatment was previously approved for a period of time or a number of treatments, and the appropriate benefits administrator wants to reduce or terminate the treatment, you will be notified promptly.
- Your request will no longer be processed as a pre-service request if you go ahead and receive the care or treatment for which you seek pre-approval or **Certification**. Instead, your request will be processed as a post-service claim for reimbursement.

Post-Service

When you seek reimbursement or payment for care or treatment that you have already received, your claim will be handled as follows:

- You will ordinarily be notified as to whether your claim will be paid or denied no later than 30 days after the receipt of your claim.
- The benefits administrator charged by the Plan to process your claim may take an additional 15 days to make a benefit determination if the administrator determines that such an extension is necessary due to matters beyond its control and notifies you of this extension within 30 days from the receipt of your claim. This notice will give you the reason for the extension and the date by which the benefit determination will be made.
- If additional information is required to make a benefit determination, the notice will state this and identify the additional information required.
 - You have 45 days after receipt of this notice to provide the additional information.
 - The period for making a benefit determination on your claim will be suspended until you either provide the necessary information or until the 45-day period for you to provide the information ends, whichever comes first.

Informal Inquiries Following Claim Denials

A "claim" is a request for required pre-approval or **Certification**, or for reimbursement or payment for care or treatment you have already received. If a claim has been denied in full or in part, and you have questions about the reasons for the denial or you disagree with the reasons, you may make an informal inquiry by telephone about the reasons for the denial to:

- ValueOptions with respect to the **MHSA** Benefit;
- UnitedHealthcare or Highmark, as the case may be, with respect to the **CHCB** or **BHCB**;
- Aetna, Highmark or UnitedHealthcare, as the case may be, with respect to the **MMCP**; and
- Medco with respect to the **MPSB**.

The Explanation of Benefits that you receive denying your claim in whole or in part will set forth the name and telephone number of the appropriate office to contact if you would like to make an informal inquiry concerning your claim for benefits. You are not required to make an informal inquiry before you initiate any formal appeal, but an informal inquiry could lead you to understand better the reasons for the claim denial, or it could result in a change in the way your claim is handled. Informal inquiries concerning claim denials must be made within 60 days after you receive your Explanation of Benefits and will be addressed promptly.

Formal Appeals of Claim Denials

If you are dissatisfied with the handling of your claim following informal inquiry, or even if you do not make an informal inquiry, you may make a formal written appeal to:

- ValueOptions with respect to the **MHSA** Benefit;
- Highmark or UnitedHealthcare with respect to the **CHCB** or **BHCB**;
- Highmark, Aetna or UnitedHealthcare, as the case may be, with respect to the **MMCP**; and
- Medco with respect to the **MPSB**.

Your Explanation of Benefits will include information explaining how to initiate this formal appeal and the name and address of the office to which the formal appeal should be sent. All formal appeals must be initiated by a written request for a formal appeal, unless you are appealing a denial of your request for pre-approval of urgent care, in which case you may initiate your appeal verbally. Your request for a formal appeal must be submitted within one hundred eighty (180) days after you receive your Explanation of Benefits or, if you make a timely informal telephone inquiry concerning the denial of your claim, within one hundred eighty (180) days after you make that informal inquiry.

You may submit additional information with your written request for formal appeal. You may also submit issues and comments in writing. You are also entitled, upon request and at no charge, to receive access to and copies of all documents, records, and other information relevant to your claim, although in some cases approval may be needed for the release of confidential information such as medical records. The decision made on your appeal will take into account all comments, documents, records, and other information you submit relating to your claim, regardless of whether the information was submitted or considered as part of the initial determination on your claim.

The Plan has engaged an independent review agency, MCMC, LLC to handle certain further appeals. If you are dissatisfied with the results of any initial appeal of your claim denial to Highmark, Aetna, UnitedHealthcare, or ValueOptions, you may file an additional appeal with MCMC. Your request for an appeal to MCMC must be submitted within ninety (90) days after you receive the results from your initial appeal, and the process for filing an appeal to MCMC will be included with the results from your initial appeal.

With respect to the **MPSB**, if you are dissatisfied with the results of any initial appeal of your claim denial to Medco, you may file an additional appeal with Medco. Your request for an appeal to Medco must be submitted within ninety (90) days after you receive the results from your initial appeal, and the process for filing an appeal to Medco will be included with the results from your initial appeal.

All decisions following formal appeals will be made without any deference to the initial decision on your claim. The individual who decides your formal appeal will not be the

same person who initially decided your claim, nor a subordinate of that person. If the benefits decision under review is based on a medical judgment, the individuals reviewing your appeal will consult with a health care professional who has appropriate training and experience. That health care professional will not be a person who was consulted in connection with the initial decision on your claim nor a subordinate of a person consulted on the initial decision.

You will be notified of the decision on your formal appeal in writing or electronically (except as noted below). The written or electronic notice will specify the reasons for the decision and will be written in a manner calculated to be understood by you, and will contain a reference to specific plan provisions relevant to the decision, as well as a statement that you may receive, upon request and at no charge, reasonable access to and copies of documents and information relevant to your claim for benefits. The notice will also include a description of your right to bring an action under ERISA Section 502(a), along with any rule, guideline, or protocol relied on in deciding your appeal, or an offer to provide such rule, guideline or protocol at no charge upon request. The notice will also identify any medical experts whose advice was obtained on behalf of the Plan in connection with your claim, even if the advice was not relied on in making a benefit decision. A decision on your formal appeal will be final, except that you may appeal that decision to a court (see below).

Urgent Care Appeals

Your appeal may require prompt action if you are appealing the denial of your request for required pre-approval or **Certification** for care or treatment under the **BHCB, CHCB, MHSA**, or the **Out-of-Network Services** portion of the **MMCP** (or both the **Out-of-Network Services** and **In-Network Services** portions of the **MMCP** if your **MMCP** is administered by Highmark), and if a delay in the approval of benefits for that care or treatment could seriously jeopardize your life or health or your ability to regain maximum function, or if, in the opinion of a **Physician** who knows your medical condition, you are in severe pain that cannot be managed adequately without the care or treatment being sought. In these situations:

- Your appeal need not be in writing. You or your **Physician** can request a review by telephone. All necessary

information, including the decision, will be transmitted verbally, by telephone, by facsimile, or by similar means.

- You will be notified verbally as soon as possible, but no later than 72 hours from receipt of your appeal.
- Your appeal will no longer be processed as appealing a denial of a request for pre-approval or **Certification** for urgent care or treatment if you go ahead and receive the care or treatment for which you seek pre-approval or **Certification**. Instead, your appeal will be processed as a post-service claim for reimbursement.

Non-Urgent Care Appeals

Pre-Service

If you are appealing the denial of your request for required pre-approval or **Certification** for non-urgent care or treatment under the **BHCB**, **CHCB**, **MHSA**, or the **Out-of-Network Services** portion of the **MMCP** (or both the **Out-of-Network Services** and **In-Network Services** portions of the **MMCP** if your **MMCP** is administered by Highmark), or the termination or reduction of benefits for non-urgent care or treatment, your appeal will be handled as follows:

- A decision following the review of your appeal by the benefits administrator charged by the Plan to perform such review will be sent to you within 15 days from the day your appeal of the denial is received.
- If you file a further appeal with MCMC or with Medco (**MPSB** claims), a decision will be sent to you within 15 days from the day your appeal is received by MCMC or Medco.
- Your appeal will no longer be processed as appealing a denial of a request for pre-approval or **Certification** for non-urgent care or treatment if you go ahead and receive the care or treatment for which you seek pre-approval or **Certification**. Instead, your appeal will be processed as a post-service claim for reimbursement.

Post-Service

If you are appealing the denial of benefits for care or treatment that you have already received, your appeal will be handled as follows:

- A decision following the review of your appeal by the benefits administrator charged by the Plan to perform such review will be sent to you within 30 days after your appeal of the denial is received.
- If you file a further appeal with MCMC or with Medco (**MPSB** claims), a decision will be sent to you within 30 days after your appeal is received by MCMC or Medco.

Judicial Actions

You must exhaust the appeals process described in this booklet before you file a lawsuit on any claim involving the Plan. If you file a lawsuit over a claim without completing the appeals process described above, the Plan will ask that your lawsuit be dismissed. You may not sue on your claim more than three years from the time proof of claim is required. However, if any applicable law requires that you have more time to bring suit, you will have the time allowed by that law.

VII

Additional Information

IMPORTANT NOTICE ABOUT THE PLAN AND MEDICARE

Medicare Eligibility

There are four ways a person can become eligible for **Medicare**:

1. on the first day of the month the person attains age 65,
2. on the first day of the 29th month following the day the person is found to be totally and permanently disabled under either the Railroad Retirement Act or the Social Security Act,
3. for persons with end stage renal disease, on the earliest of:
 - the first day of the third month after the month the person begins a course of maintenance dialysis treatments, or
 - the first day of the month the person is admitted to an approved hospital for a kidney transplant or procedures preliminary to a transplant, or
 - the first day of the month the person participates in a self-dialysis training program in a **Medicare**-approved training facility, or
4. when the person meets the eligibility requirements of a disabled child.

The Railroad Retirement Board or the Social Security Administration can provide details about **Medicare** eligibility. Both agencies annually publish "Medicare and You," which gives valuable information about **Medicare**.

Order Of Benefits – Who Pays First

If an **Eligible Employee** or an **Eligible Dependent** is also eligible for **Medicare**, the following rules determine whether the Plan, or **Medicare**, is the primary payer.

Medicare Eligibility due to Age or Disability

If the person is eligible for **Medicare** due to age or disability:

- the Plan is primary while the **Eligible Employee** is actively working, or if not actively working, meets all of the following conditions:
 - Retains employment rights in the railroad industry;
 - Has not had his or her employment terminated by his/her employer;
 - Is not receiving disability payments from an employer for more than 6 months;
 - Is not receiving disability benefits from Social Security or under the Railroad Retirement Act;
 - Has Plan coverage that is not COBRA continuation coverage.

A person eligible for **Medicare** can reject the Plan as primary payer of health benefits. If Plan benefits are rejected, the Plan cannot provide any benefits for services and supplies covered by **Medicare**, even if the **Medicare** benefit is less than the benefit which would have been payable under the Plan. In this case, **Eligible Expenses** under the Plan are limited to services and supplies wholly uncovered by **Medicare**. The person must notify UnitedHealthcare in writing to reject Plan benefits.

Medicare Eligibility due to End Stage Renal Disease

If the person is eligible for **Medicare** due to end stage renal disease, the Plan is primary during the first 30 months of **Medicare** eligibility. After 30 months, **Medicare** becomes primary.

Dual Medicare Eligibility

If a person has dual eligibility for **Medicare** (is eligible due to age or disability, and also due to end stage renal disease), the end stage renal disease rule applies.

*If **Medicare** benefits are paid primary to Plan benefits, it is essential that the person be enrolled in **Medicare** Parts A and B. If the person fails to enroll, Plan benefits will be*

*determined as if the person has enrolled. A person failing to enroll will not receive **Medicare** benefits, and Plan benefits will not be increased to make up for this loss of **Medicare** benefits.*

*The Plan will reimburse the **Eligible Employee** for any **Medicare** premium paid during any month in which **Medicare** is primary (except during the final year of Employee-only coverage available to Disabled Employees). You may obtain a form to claim a refund of **Medicare** premiums by writing to:*

*UnitedHealthcare
Railroad Administration
P. O. Box 150453
Hartford, CT 06115-0453*

*The Plan will also reimburse the **Eligible Employee** for both Part A and Part B **Medicare** premiums paid during a period when a person is not eligible for premium free Part A **Medicare**.*

Medicare Enrollment

Part A Medicare

For most people, there is no premium for Part A **Medicare** (Hospital Insurance). A person eligible for **Medicare** due to age or disability should enroll for Part A **Medicare** as soon as first eligible, even if the Plan provides primary benefits.

If neither you or your spouse has the required age or years of service to be eligible for benefits under the Railroad Retirement Act or the Social Security Act, the person eligible for **Medicare** will be required to pay a monthly premium for Part A **Medicare**. If this is the case, see the section below about Part B **Medicare**. As soon as you or your spouse become eligible for benefits under the Railroad Retirement Act or the Social Security Act (even if you do not actually apply for those benefits), this premium for Part A **Medicare** is no longer required.

If the person is eligible for **Medicare** due to end stage renal disease, see the Special Rule described below.

Part B Medicare

There is a monthly premium required for Part B **Medicare** (Medical Insurance).

If **Medicare** is primary, benefits under the Plan will be reduced by any amount payable under **Medicare**. If the person does not enroll in Part B **Medicare**, the Plan will estimate the amount that would have been paid by Part B **Medicare** had the person enrolled, and will reduce its benefits by that estimated amount. Therefore, when **Medicare** is primary, the person should enroll for Part B **Medicare** when he or she enrolls for Part A **Medicare**.

A person who has rejected Plan benefits should also enroll for Part B **Medicare**.

If the Plan is primary, the person has two options:

1. Enroll in Part B **Medicare** as a secondary benefit.
2. Delay enrollment in Part B **Medicare**.

If the person delays enrollment in Part B **Medicare**, the person may enroll during an 8-month period that begins in the month in which the **Eligible Employee** ceases to be covered by the Plan or would have ceased to be covered by the Plan had he/she not elected COBRA coverage. There is no penalty or waiting period for enrollment during this 8-month period.

If the person delays enrollment in Part B **Medicare**, and does not enroll during this 8-month period, the person may enroll during any subsequent general enrollment period. A general enrollment period is held each January 1 through March 31. **Medicare** coverage begins July 1 of the year of enrollment. A surcharge is required for each year the enrollment is delayed beyond the end of this 8-month period.

If the person is not eligible for premium free Part A **Medicare**, this information about Part B **Medicare** also applies to Part A **Medicare**.

Special Rule for Persons with End Stage Renal Disease

The Plan is primary during the first 30 months of **Medicare** eligibility. The person has two options:

1. Enroll in both Parts A and B **Medicare** when first eligible.
2. Delay enrollment in both Parts A and B **Medicare** until the 31st month of **Medicare** eligibility.

If the person delays enrollment in Part B **Medicare** only, the person can later enroll in Part B **Medicare** during a general enrollment period, and will have to pay a premium surcharge for late enrollment.

Refund of Medicare Premiums

The Plan will refund a person's Part B **Medicare** premium for any month in which the person's **Medicare** benefits are paid primary to Plan benefits (excluding any month during the last calendar year of Employee Health Care Benefits for a Disabled Employee).

The Plan will also refund a person's Part A and Part B **Medicare** premiums during any month in which the person is required to pay a premium for Part A **Medicare**, even if Plan benefits are paid primary to **Medicare** benefits.

Medicare premiums are not reimbursed by the Plan when:

- the person's Plan benefits are paid primary to **Medicare** benefits (unless the person must also pay a premium for Part A **Medicare**);
- the person is covered as a Disabled Employee, in the final year of eligibility for Employee Health Care Benefits; or
- the person has rejected the Plan as primary payer of health benefits.

A form to request a refund of **Medicare** premiums can be obtained from:

UnitedHealthcare
Railroad Administration
P. O. Box 150453
Hartford, CT 06115-0453

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Plan is required by law to protect the privacy of your protected health information. As used in this section of your booklet, "Plan" refers not only to the Plan itself, but also to any agents or contractors acting on its behalf, including those entities that the Plan has retained to administer the benefits it provides. Federal law prohibits the Plan from disclosing your health information to an agent or contractor unless that agent or contractor has agreed in writing to maintain the privacy of your health information.

The Plan is required to provide this notice. It explains how the Plan uses protected health information about you and when the Plan discloses that information to others. Federal law requires the Plan to use and disclose your protected health information only as described in this notice. The Plan is also required by law to honor your rights with respect to your protected health information that are described in this notice.

The term "protected health information" as used in this notice includes any personal information that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. The provisions of this notice apply to protected health information that is created by the Plan or received by the Plan from others.

If the Plan changes its privacy practices, it will provide notice of the change to you within 60 days by direct mail.

How the Plan Uses and Discloses Your Protected Health Information

Required Uses and Disclosures

The Plan must use and disclose your protected health information to provide information:

- To you or a representative with the legal right to act for you;
- To the Secretary of the Department of Health and Human Services, if necessary, to ensure that your privacy is protected; and
- When required by law; for example, a court could order the Plan to disclose protected health information in its possession for the purpose of litigation.

Permitted Uses and Disclosures

The Plan has the right to use and disclose protected health information to pay for your health care and manage the provision of benefits to you. The Plan will use or disclose your protected health information only as permitted by law, including the federal Privacy Rule for protected health information. For example, the Plan may, consistent with the Privacy Rule, use or disclose your protected health information for the following purposes:

- Payment. Payment activities include, among other things, collecting contributions due to the Plan and paying for health care services provided to you. For example, the Plan may receive information from a doctor concerning treatment provided to you. The Plan may review that information to evaluate whether the treatment is eligible for coverage under the Plan. The Plan may also use your protected health information for purposes of making preauthorization determinations for certain types of benefits.
- Treatment. The Plan may use or disclose protected health information for the purpose of assisting health care professionals in their efforts to provide you with medical treatment. For example, the Plan may disclose your protected health information to facilitate referrals between

doctors or to coordinate your treatment among health care providers.

- Health Care Operations. The Plan may use or disclose protected health information as necessary to operate the Plan and to manage coverage under the Plan. For example, the Plan may use your protected health information to analyze trends in the coverage it provides or to set contribution levels. Other ways in which your protected health information may be used for health care operations include quality assessment and improvement activities, audits of performance under the Plan, cost management and planning-related analyses, review of the qualifications of health care professionals, administration of Plan activities in general, and arrangement for medical review or legal services. The Plan may disclose your protected health information to others for the purpose of conducting health care operations. For example, the Plan may contact your doctor to suggest a disease management or wellness program that could help improve your health.
- Communications with You. The Plan may contact you to provide information about health related products or services such as alternative medical treatments available to you under the Plan. The Plan may use your protected health information to identify programs and treatments that would be most beneficial to you. The Plan may also contact you to provide appointment reminders for your medical treatment.
- Disclosures to the Governing Committee. The Plan is governed by a Governing Committee. The Committee is described at page 189 of this booklet. The Plan may share statistical information about usage under the Plan and enrollment and disenrollment information with the Governing Committee. In addition, the Plan may share other protected health information with the Governing Committee solely for purposes of plan administration. Neither the Plan nor the Governing Committee will share your protected health information with your employer without your express written authorization or as may be permitted under applicable law.

Other Uses and Disclosures Permitted by Law

The Plan may, consistent with the federal Privacy Rule for protected health information, use or disclose your protected health information for the following purposes under limited circumstances:

- Disclosure for Public Health Purposes. The Plan may be required to disclose your protected health information for public health activities, such as reporting disease outbreaks or adverse reactions caused by a prescription drug.
- Disclosure to Persons Involved with Your Care. The Plan may disclose your protected health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- Disclosure to Report Abuse, Neglect or Domestic Violence. The Plan may be required to disclose your protected health information to government authorities, including a social service or protective service agency, to help them identify and aid victims of abuse, neglect, or domestic violence.
- Disclosure for Health Oversight Activities. The Plan may be required to disclose your protected health information to government officials responsible for overseeing health insurers, health care providers, government benefit programs, or civil rights laws relating to health care.
- Disclosure in Judicial or Administrative Proceedings. The Plan may be required to disclose your protected health information in response to a court order, search warrant or subpoena or other lawful process.
- Disclosure to Law Enforcement Officials. The Plan may be required to disclose your protected health information to law enforcement officials for limited purposes, such as missing person investigations.
- Disclosure to Avoid a Serious Threat to Health or Safety. The Plan may be required to disclose your protected health information to public health agencies.

- Disclosure for Workers Compensation. The Plan may be required to disclose protected health information arising out of job-related injuries pursuant to applicable laws.
- Disclosure for Specialized Government Functions. The Plan may be required to disclose limited information for military and veteran activities, national security and intelligence activities, and the protective services for the President and other public officials.
- Use or Disclosure for Research Purposes. The Plan may use or disclose protected health information for research purposes subject to limitations imposed by law.
- Disclosure to Coroners or Medical Examiners. The Plan may disclose protected health information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. The Plan may also disclose information to funeral directors as necessary to carry out their duties.
- Disclosure for Organ Procurement Purposes. The Plan may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.

Whenever the Plan discloses your protected health information for a purpose permitted by the federal Privacy Rule, it is required to disclose only the minimum amount of information necessary to serve that purpose.

If none of the above reasons applies, **then the Plan must get your written authorization to use or disclose your protected health information.** Once you authorize disclosure of your protected health information, the Plan cannot guarantee that the person to whom the information is provided will not disclose the information. You may revoke your written authorization, unless the Plan has already acted based on your authorization. To revoke an authorization, contact the privacy officer identified below.

In some states, state law may impose restrictions on the use or disclosure of protected health information more stringent than those described in this notice. For example, some states may require plans to obtain a person's express authorization before using or disclosing his or her protected health information for the purposes described above. The Plan will

comply with such state laws to the extent they apply to the Plan.

Your Rights with Respect to Your Protected Health Information

The following are your rights with respect to your protected health information.

- Restrictions on Uses and Disclosures of Your Protected Health Information. You have the right to ask the Plan to agree to restrictions on the uses or disclosures it makes of your protected health information for purposes of treatment, payment, or health care operations. You also have the right to ask the Plan to impose restrictions on disclosures of your protected health information to family members or to others who are involved in your health care or payment for your health care. While the Plan will try to honor your request and will permit requests consistent with its policies, the Plan is not required to agree to any restriction. If the Plan determines that it cannot accommodate your request to restrict uses or disclosures of your protected health information for the purposes of treatment, payment, or health care operations, the Plan will provide you with reasonable notice of its decision.
- Restrictions on Methods of Communications from the Plan. You have the right to ask the Plan to restrict its communications with you to a more confidential mode of communication or to contact you at a different address. The Plan will accommodate reasonable requests to communicate in a confidential format.
- Inspection of Protected Health Information. You have the right to inspect and obtain a copy of your protected health information maintained by the Plan. You also may receive a summary of this protected health information. A request to inspect or copy your protected health information must be made in writing to the address provided below. In certain limited circumstances, the Plan may deny your request to inspect and copy your protected health information. The Plan may impose a reasonable fee reflecting the actual costs of copying, mailing or preparing a summary of your protected health information.

- Amendment of Protected Health Information. You have the right to ask the Plan to amend protected health information it maintains about you if you believe that the information is inaccurate or incomplete. You must make such a request in writing to the address provided below. If the Plan denies your request, you may have a statement of your disagreement added to your protected health information.
- Accounting of Disclosures of Protected Health Information. You have the right to ask the Plan to provide you with an accounting of disclosures of your protected health information made by the Plan during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) made for treatment, payment, and health care operations purposes; (iii) made to you or pursuant to your authorization; (iv) made to correctional institutions or law enforcement officials; or (v) other disclosures for which federal law does not require the Plan to provide an accounting.

How to Exercise Your Rights

- Contacting the Plan. For further information about the privacy of your protected health information, to obtain a copy of this notice, or to ask the Plan to agree to restrict the ways in which it uses or discloses your protected health information, contact one of the Plan's two privacy compliance officers. Their names, addresses and telephone numbers are as follows:

Daniel Elliott
United Transportation Union
14600 Detroit Avenue
Cleveland, OH 44107
Tel: (216) 228-9400

Joseph Epstein
1901 L Street, N.W. Suite 500
Washington, D.C. 20036
Tel: (202) 862-7200

- Filing a Complaint. If you believe your privacy rights have been violated, you may file a written complaint with the Plan at either of the following addresses:

c/o Daniel Elliott
United Transportation Union
14600 Detroit Avenue
Cleveland, OH 44107

c/o Joseph Epstein
1901 L Street, N.W. Suite 500
Washington, D.C. 20036

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. The Plan will not take any action against you for filing a complaint.

- Exercising Your Rights With Respect to Your Protected Health Information. You are entitled to inspect, copy or amend your protected health information maintained by or on behalf of the Plan, to request an accounting of disclosures of your protected health information, or to ask that communications from the Plan be made in a confidential manner or place.
- If your request is made in connection with the Plan's Comprehensive Health Care Benefit, Basic Health Care Benefit, or Managed Medical Care Program administered by UnitedHealthcare, please contact:

UnitedHealthcare
Customer Service – Privacy Unit
P.O. Box 30985
Salt Lake City, UT 84130
Tel: 1-888-445-4379

- If your request is made in connection with the Plan's Comprehensive Health Care Benefit, Basic Health Care Benefit, or Managed Medical Care Program administered by Highmark, please contact:

Highmark
Railroad Dedicated Unit
P.O. Box 890381
Camp Hill, PA 17089-0381
Tel: 1-866-267-3320

- If your request is made in connection with the Plan's Managed Medical Care Program administered by Aetna, please contact:

Aetna
PO Box 981106
El Paso, TX 79998-1106
Tel: 1-888-332-8742

- If your request is made in connection with the Plan's Managed Pharmacy Services Benefit, please contact:

Medco Health
Privacy Services Unit
P.O. Box 800
Franklin Lakes, NJ 07417
Tel: 1-800-987-5237

- If your request is made in connection with the Plan's Mental Health and Substance Abuse Care Benefit, please contact:

ValueOptions
P.O. Box 10870
Herndon, VA 20170
Att'n: Railroad Quality Management
Tel: 1-800-934-7245

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA")

- **Name of Plan:**

The National Railway Carriers and United
Transportation Union Health and Welfare Plan

- **Plan Identification Numbers:**

Employer Identification Number (EIN): 52-2174651
Plan Number (PN): 510

- **Plan Administrator:**

National Carriers' Conference Committee
Suite 500
1901 L Street, N.W.
Washington, D.C. 20036
Telephone (202) 862-7200

jointly with

United Transportation Union Health and Welfare
Committee
14600 Detroit Avenue
Cleveland, Ohio 44107
Telephone (216) 228-9400

The Plan Administrator has authority to control and manage the operation and administration of the Plan and is the agent for service of legal process. Services of process upon the Plan may also be made by serving its trustee.

- The Plan was established and is maintained pursuant to collective bargaining agreements between certain railroads and the United Transportation Union. The railroads and the United Transportation Union are represented in connection with the establishment and maintenance of the Plan by the National Carriers' Conference Committee and by the United Transportation Union Health and Welfare Committee, respectively. The two Committees administer the Plan. When acting as Plan Administrator, the Committees form a single Committee, called the Governing Committee.

- **Type of administration for the Health Care Benefits provided by the Plan:** Trusteed and Self-Administered.
 - The Plan is administered directly by the Plan Administrator. The Plan's Health Care Benefits are funded directly by the Plan. They are not insured.
 - The Plan's administration is governed by the terms of the Plan Documents. The Summary Plan Description (this booklet) provides a description of the Health Care Benefits that are available under the Plan. In connection with those benefits, the Plan Documents give the various entities that administer the Plan's different Health Care Benefits pursuant to contracts with the Plan Administrator the discretion to construe and interpret the terms of the Plan. If you do not agree with a determination made by any of those entities, you may request a review of your claim. See pages 170 through 174 of this booklet for a description of the appeal procedure.
- **Trustee:**

Suntrust Bank
919 East Main Street, 7th Floor
Richmond, VA 23219
- **Source of contributions to the Plan:** Employer and employee contributions.
 - Employers contribute to the Plan on a monthly basis. The amount of each contribution depends upon the number of qualifying employees who rendered the **Requisite Amount of Compensated Service** during, or received the **Requisite Amount of Vacation Pay** for, the preceding month and the applicable payment rate per employee.
 - Employees also contribute to the Plan on a monthly basis. During any month in which the employee's employer is required to make a contribution to the Plan with respect to foreign-to-occupation Employee Health Care Benefits, or with respect to Dependents Health Care Benefits, for the employee, the employee must also make a contribution to the Plan. Employee contributions are deducted from wages. The amounts of employee contributions are determined pursuant to

a formula set forth in the applicable collective bargaining agreement at page 20 of this booklet.

- Health Care Benefits under the Plan are payable from funds that are held in trust under the Plan and invested by the Plan's trustee until needed to pay such benefits.

- **Date of the end of the Plan Year:**

Each Plan Year ends on a December 31.

- **Claims Procedures:**

See Section VI of this booklet, pages 152 through 174, for information about claim procedures.

- **Plan Termination:**

The right is reserved in the Plan for the Plan Administrator to amend or modify the Plan in whole or in part at any time.

An employer or the UTU has the right to terminate its participation in the Plan at any time by delivery to the Plan Administrator of written notice of such termination, except as such right may be limited by obligations undertaken by the employer or the UTU in collective bargaining agreements.

In the event of termination of the Plan, the assets of the Plan will be used towards payment of obligations of the Plan and any remaining surplus will be distributed in the manner determined by the Plan Administrator to best effectuate the purposes of the Plan in accordance with the applicable regulations under ERISA.

The Plan may terminate as to an employer that fails to pay in a timely fashion the full amount required by the Plan to be paid by the employer during any calendar month. Such termination would be effective as of the first day of the calendar month immediately following the month during which the amount the employer failed to pay was due and payable.

As a Plan participant, you are entitled to certain rights and protections under ERISA, which provides that all Plan participants shall be entitled to:

- **Receive Information About Your Plan and Benefits**
 - Examine, without charge, at the Plan Administrator's office (the office of the National Carriers' Conference Committee or the United Transportation Union Health and Welfare Committee), at the headquarters office of the UTU, at each employer establishment in which 50 or more employees covered by the Plan customarily work, and at the meeting hall or office of each UTU local in which there are 50 or more members covered by the Plan, all documents governing the Plan, including the collective bargaining agreements pursuant to which the Plan was established and is maintained, a list of the employers that sponsor the Plan, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
 - Obtain, upon written request to the Plan Administrator (either National Carriers' Conference Committee or the United Transportation Union Health and Welfare Committee), copies of documents governing the operation of the Plan, including collective bargaining agreements, a list of the employers that sponsor the Plan, and copies of the latest annual report (Form 5500 Series), and updated Summary Plan Descriptions. The Administrator may make a reasonable charge for the copies.
 - Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.
 - Receive, without charge, from the Plan Administrator, upon written request to its address, information as to whether a particular railroad (or other employer) is a sponsor of the Plan (and if so, its or their addresses), and as to whether such railroad is a participating employer with respect to one or more groups of its employees who are represented by the UTU.

However, the Plan Administrator cannot inform you whether you as an individual employee are covered as a participant, because that information is subject to agreements between the railroads and the UTU, to which the Plan Administrator is not a party and as to which it is not informed.

- **Continue Group Health Plan Coverage**

- Continue health care coverage for you or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review pages 35 through 39 of this Summary Plan Description on the rules governing your **COBRA** continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under the Plan, if any, as long as you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan or UnitedHealthcare when you lose coverage under the Plan, when you become entitled to elect **COBRA** continuation coverage, or when your **COBRA** continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

- **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

- **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all

within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights.

- For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, but not until you exhaust the appeals process described in this booklet.
- In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court, but not until you exhaust the appeals process described in this booklet.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- **Assistance with Your Questions**

If you have any questions about the terms of the Plan or about the proper payment of benefits, you may obtain more information from the companies described in this booklet as administering the benefit program in which you participate or contact the Plan Administrator. If you have any questions about whether you are covered, you may obtain that information from your employer.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits

Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

MISCELLANEOUS

Options After Coverage Ends

When coverage ends under this Plan, other coverage may be available as follows:

- Health Care Benefits may be continued under this Plan for a limited period of time under the provisions of **COBRA** (see pages 35 through 39).
- Retired employees who are between 60 and 65 with 30 or more years of railroad service may be eligible for coverage under The Railroad Employees National Early Retirement Major Medical Benefit Plan.
- Certain employees and surviving dependents may enroll for health coverage under Group Policy GA-23111 issued by UnitedHealthcare.

Information about these options can be obtained by writing to UnitedHealthcare's home office at the following address:

UnitedHealthcare
Railroad Administration
P.O. Box 150453
Hartford, CT 06115-0453

It is extremely important that you obtain information about these options before your coverage under this Plan ends. Information about the early retirement plan should be obtained while you are still working. If you wait longer, you may find that you are no longer eligible for one or more of these options.

Identification Cards

All new **Eligible Employees** will receive Plan Identification Cards. To request additional Identification Cards, call the applicable toll free number shown on page 161 of this booklet.

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