BNSF RAILWAY

CLAIMS PROCEDURES

CONTENTS

CLAIMS PROCEDURES

Effective Jan. 1, 2021

CLAIMS PROCEDURES FOR:

- MEDICAL, DENTAL AND VISION CARE PROGRAMS
- HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)
- HEALTH REIMBURSEMENT ACCOUNT (HRA)[1]

Claims procedures are not provided here for the Health Savings Account (HSA), as it is not a benefit under the BNSF Group Benefits Plan. The HSA is a bank account in your name. Procedures for paying expenses from your HSA are determined by the Account Administrator. To ask questions or get details, call the Account Administrator.

See later sections of this chapter for claims procedures related to:

- Dependent Care Reimbursement Account (DCRA).
- Life, Accidental Death & Dismemberment (AD&D), Business Travel Accident and Long Term Disability Insurance Programs; and the Short Term Disability Benefit Program.

There are no claims to file under the Employee Assistance Program (EAP).

Medical Necessity, Compliance with Regulations and Delegation of Authority

A basic requirement of any claim under the Medical, Dental and Vision Care Programs is that the service or supply must be medically necessary. Decisions on medical necessity are made on whether the claim is a pre-service claim, a concurrent care claim, an urgent care claim or a post-service claim, as described in the *Defined Terms* section of this *Claims Procedures* chapter.

Under U.S. Department of Labor (DOL) regulations, if you make a claim under the Medical, Dental or Vision Care Programs, the HCFSA or the HRA (offered as part of the Medical Program), you are entitled to full and fair review of your claim. The procedures described in this section are intended to comply with DOL regulations governing the filing of benefit claims, notification of benefit decisions and appeal of adverse benefit decisions.

[1] *Because of IRS rules, if you enroll in the Medical Program and are enrolled in a government-sponsored health plan for military personnel such as TRICARE, have received benefits under VA in the last three months (except for certain service-connected disabilities), enrolled in Medicare or Medicaid, or are receiving payments under the BNSF Long Term Disability (LTD) Insurance Program, a deposit will be made for you to a Health Reimbursement Account (HRA) instead of a Health Savings Account (HSA).*

The Plan Administrator has delegated the discretionary authority to the Claims Administrators listed in the *Administrative Information* chapter of this SPD to interpret the Medical, Dental and Vision Care Programs, the HCFSA and the HRA, and to make both initial claim determinations and final claim review decisions on ERISA appeals. The Vice President and Chief Human Resources Officer retains the discretionary authority to determine whether you or your dependents are eligible to enroll for coverage or to continue coverage under program terms, or over anything else for which the Plan Administrator has reserved final authority and discretion.

Defined terms: For the meaning of terms in blue, click to see the Defined Terms section.

Links: Click on *blue italic* items to link directly the section or chapter indicated.

 ***Previous view:*** Return to your previous page by right clicking and selecting the "previous view" option. To add the handy "previous view" button to your toolbar, open your Adobe Reader tools and select Page Navigation, then Previous View.

Filing a Claim

Any claim that you file *yourself* must be submitted to the Claims Administrator in writing using the appropriate claim form. Claim forms are available from the Claims Administrator. Your claim must include a description of the services provided and the diagnosis or other information establishing medical necessity. All claims should be reported promptly.

Deadlines for filing claims are:

- ***For benefits under the Medical, Dental and Vision Care Programs*** – 90 days after the date the services were provided. If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim still will be accepted if you file it as soon as possible. Unless you are legally incapacitated, late claims will not be accepted if they are filed more than 24 months after the date of service.
- ***For reimbursement of expenses from the HCFSA*** – Any time up to March 31 following the calendar year in which the expense was incurred. For example, a health care expense incurred in December must be claimed no later than March 31 of the following year. Claims filed after the March 31 deadline will not be considered.
- ***For reimbursement of expenses from the HRA*** – Anytime, as long as you are a salaried employee, or remain covered by a BNSF salaried retiree health care benefit program or BNSF COBRA continuation benefits, and funds remain available in your HRA. However, if you leave BNSF, claims you incur *before* but file *after* your BNSF employment ends must be submitted by March 31 following the calendar year in which employment with BNSF ends.

Automatic Filing of Claims Under the Medical, Dental and Vision Care Programs

If you use an in-network provider under the Medical, Dental or Vision Care Programs, in most cases, claims will be filed for you automatically. Some out-of-network providers also file claims for you. However, there may be

situations where you must file claims yourself. Claims for services under the SurgeryPlus benefit and telemedicine are automatically filed for you by the respective Claims Administrator.

Limited Purpose HCFSA Claims When You Participate in an HSA

If you enroll in the Medical Program with HSA and also enroll in a Health Care Flexible Spending Account (HCFSA), your HCFSA will be a *Limited Purpose HCFSA*. That means that you can use your HCFSA only for eligible dental and vision care expenses that are not paid by the Dental and Vision Care Programs or another plan. IRS Publication 502, available at irs.gov, provides further details. You will have a separate HealthEquity debit card to access your Limited Purpose HCFSA to pay expenses for dental and vision care services. If no Limited Purpose HCFSA balance is available, you will have to use your separate HSA debit card. By using HCFSA dollars first, your risk of forfeiting unused HCFSA money is reduced. If HCFSA dollars remain unspent by Dec. 31, a minimum of $25 up to a maximum of $550 will automatically roll over to the following year's HCFSA.

Limited Purpose HRA Claims When You Participate in an HSA

If you enroll in the Medical Program with HSA and also roll over money from an earlier year in a Health Reimbursement Account (HRA), your HRA will be a *Limited Purpose HRA*. That means you can use your HRA only for eligible expenses that are not paid by the Dental and Vision Care Programs or another plan. You will have a separate HealthEquity debit card to access your Limited Purpose HRA to pay expenses for dental and vision care. If no Limited Purpose HRA balance is available, you may use your separate HSA debit card. This way, HRA dollars, which are not portable,[2] are the first to be used.

Claims When Enrolled in Both an HRA and HCFSA

If you have a balance in an HRA (regardless of whether it is a Limited Purpose or General Purpose HRA) and also are enrolled in an HCFSA (regardless of whether it is a Limited Purpose or General Purpose HCFSA), you use the same HealthEquity debit card to access both accounts. When you swipe your HealthEquity debit card to pay for eligible expenses, dollars are drawn first from your HCFSA. If no HCFSA balance is available, dollars then are drawn from your HRA. By using HCFSA dollars first, your risk of forfeiting unused HCFSA money is reduced. If HCFSA dollars remain unspent by Dec. 31, a minimum of $25 up to a maximum of $550 will automatically roll over to the following year's HCFSA.

Claims When You Do Not Use the Debit Card – All Accounts

You may file an electronic or paper claim for reimbursement of eligible expenses from your HSA, HCFSA or HRA. Log in to myhealthequity.com. Choose the Claims & Payments tab, then the Request Reimbursement link and follow the prompts to submit a claim for reimbursement.

[2] *Your HRA balance is available to you as long as you are a salaried employee, or remain covered by a BNSF salaried retiree health care benefit program or BNSF COBRA continuation benefits; otherwise, you forfeit any balance.*

Save Documentation of Expenses
For documentation of expenses that were claimed but not reimbursed under your medical, dental or vision care benefits, be sure to save the Explanation of Benefits (EOB) provided by the Claims Administrator (or the deductible receipt for SurgeryPlus procedures) and related receipts. You will need these records in case you must provide proof of an expense to HealthEquity for HRA or HCFSA claims, or to the IRS for HSA distributions.

Notification of Initial Benefit Determination

Except as noted later in this section for HCFSA and HRA debit card transactions, and for the Medical Program's SurgeryPlus benefit, each time a claim is submitted,[3] you or your representative will receive a written Explanation of Benefits (EOB) explaining how much was paid and whether the claim was denied, in whole or in part. If any part of a claim is denied, the Claims/Account Administrator will provide a written notice of the denial and the reason for the denial. The Claim Denial Notice will:

- Explain the specific reason(s) for the denial;
- Provide the specific reference to the program, HCFSA or HRA provisions that are the reason for the denial;
- Describe any additional information necessary to reverse the denial, or to complete an incomplete claim, and explain why this information is necessary; and
- Explain the program, HCFSA or HRA claim review procedures, any applicable time limits and your right to bring a civil action under Section 502(a) of ERISA following a final denial on appeal;

If the Claims/Account Administrator used internal guidelines, protocols or other information, the notice will describe this. If you request, the Claims/Account Administrator will provide, free of charge, a copy of the rule, guideline, protocol or other information, as well as reasonable access to documents, records and other data on the claim.

If the claim denial was based on a professional opinion, including decisions on whether a service is experimental, investigational or not medically necessary or appropriate, the Claims/Account Administrator will provide an explanation of the scientific or clinical opinion used in the decision, applying the terms of the program, and an explanation for the denial.

For urgent care claims, the notice will also describe the expedited review process.

For claims under the Medical Program, the notice will also include:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings;

[3] *Does not apply to Health Savings Account (HSA) withdrawals. The HSA is a bank account that you own.*

- The reason for the denial, including the denial code and its corresponding meaning, as well as a description of the Medical Program's standard, if any, that was used in denying the claim;
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review process.

Debit Card Transactions

For HCFSA and HRA debit card transactions, a written EOB is not provided. If the processing of a debit card transaction was denied, you may call HealthEquity, the Claims/Account Administrator for the HCFSA and HRA. In addition, you can see a list of completed HealthEquity debit card transactions for your HCFSA or HRA by accessing your account online at my.healthequity.com or by requesting a statement from the Claims/Account Administrator. If the processing of an HCFSA or HRA debit card transaction is denied, you may file a claim appeal as described in the section above entitled Filing a Claim. If a claim is denied because you failed to provide appropriate documentation, you will need to reimburse HealthEquity for the amount of the claim. If you disagree, you have the right to appeal as explained in the following section.

SurgeryPlus Benefits

Notification of your approval for the 100% SurgeryPlus benefit (after you pay any remaining Medical Program annual deductible) will be provided by SurgeryPlus upon confirming that your prospective treatment or procedure has been accepted by a SurgeryPlus physician. For any deductible you pay, SurgeryPlus will provide a receipt for your records and notify the Medical Program Claims Administrator of the payment.

Timeframes for Deciding Initial Benefit Claims and Appeals

Urgent Care Claims

The Claims Administrator will decide an initial urgent care claim or appeal as soon as possible, but no later than 72 hours of receipt. With respect to your initial urgent care claim, if necessary information is missing or you failed to follow the program's procedures for filing urgent care claims, the Claims Administrator will tell you within 24 hours what information is needed or the procedures to follow. You will be given at least 48 hours to respond to the Claims Administrator. The Claims Administrator will decide the claim within 48 hours after the earlier of the Claim Administrator's receipt of the requested information, or the end of the period of time given to you to provide the requested information. A request for an expedited appeal may be submitted orally or in writing and all necessary information, including the appeal determination, will be transmitted by telephone, facsimile or other similar method.

Timeline
For a timeline view, see Summary Timetable for Claims and Appeals later in this chapter.

Pre-Service Claims

The Claims Administrator will provide a written decision on the initial pre-service claim within 15 days or the appeal of a pre-service claim within 30 days, including requests for pre-determination (advance approval) for medical and dental services. With respect to your initial pre-service claim, if more time is needed because of matters beyond the Claims Administrator's control, you will be notified within 15 days of the Claims Administrator receiving the claim. This notice will tell you the date a decision is expected, which will be no more than 30 days after the Claims Administrator received the claim.

If more time is needed to determine your initial pre-service claim because necessary information is missing, the Claims Administrator will tell you within 15 days or, if you failed to follow the program's procedures for filing urgent care claims, within five days. The Claims Administrator will tell you what information is needed or the procedures to follow. You must provide that information within 45 days of being notified. The Claims Administrator will notify you within 15 days after the end of that additional period or after receiving your information, whichever is sooner.

Post-Service Claims

The Claims Administrator will decide an initial post-service benefit claim within 30 days or appeal within 60 days of receipt. With respect to your initial post-service claim, if more time is needed to make a decision because of matters beyond the Claims Administrator's control, the Claims Administrator will tell you within 30 days of receiving the claim. This notice will include the date you can expect a determination, which will be no more than 45 days after the Claims Administrator received the claim.

If more time is needed to determine your initial post-service claim because necessary information is missing, the Claims Administrator will tell you within 30 days what is needed. You must provide that information within 45 days of being notified. The Claims Administrator will notify you within 15 days after the end of that additional period or after receiving your information, whichever is sooner.

Ongoing Course of Treatment (Concurrent Care) Claims

You will be notified of any reduction or termination of an approved ongoing course of treatment sufficiently in advance of the reduction or termination to allow you to appeal and receive a determination on appeal before the benefit is reduced or terminated. A request to extend approval of an ongoing course of treatment will be decided based on the type of claim – either urgent care, pre-service or post-service. If urgent care, the Claims Administrator will decide within 72 hours; if pre-service, the decision will be made within 15 days; and if post-service, the decision will be within 30 days. However, if your request is for urgent care and is made at least 24 hours before the approved time period or number of treatments expires, the Claims Administrator will decide within 24 hours.

If Your Claim Is Denied – *Claim Appeal Procedure*

Programs included in the BNSF Group Benefits Plan, except the Dependent Care Reimbursement Account (DCRA) under BNSF's Cafeteria Plan, are subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA has special rules that you or your representative must follow to appeal a claim denial, as explained in the following sections.

Internal and External Review Processes for Medical Program Claims
The appeal process under the BNSF *Medical Program* consists of both an internal and an external review. Generally, the appeal first is processed through an internal review. However, if you are in an urgent care situation, you may be allowed to proceed with an expedited external review at the same time the internal review process is conducted.

Only the internal review (appeal) process applies to other programs of the BNSF Group Benefits Plan, except the DCRA as noted above.

Timeline
For a timeline view, see Summary Timetable for Claims and Appeals later in this chapter.

Request for Internal Review (Appeal) of Denied Claims

You or your representative may appeal any complete or partial claim denial, including any denial of a pre-service (pre-notification / pre-determination / advance claim review) claim. You or your representative should file a written appeal as soon as you receive a claim denial, but *no later than 180 days* from the date you receive the denial. You will forfeit any right to an appeal or to file suit if you do not meet this 180-day deadline. In the case of a reduction or termination of a previously approved course of treatment, the appeal must be made within 30 days from the date you received the denial. If the claim is an urgent care claim, you may appeal and receive an expedited decision. Please see *Timeframes for Deciding Initial Benefits Claims and Appeals* above.

A person not involved in the initial decision, and who is not a subordinate of someone who made the initial decision, will decide your appeal. The review of your denied claim will not be influenced by the initial decision and will take into account all information submitted by you, regardless of whether it was considered in the initial decision.

Along with your written appeal request, you may submit any additional documents, issues and comments for consideration during the review of your denied claim. If appropriate, you also should include any clinical information from your health care professional supporting your appeal.

If you or your representative requests, the Claims Administrator will provide reasonable access to and copies of all documents, records and other information on your claim, free of charge, including:

- Information relied upon in making the denial;
- Information submitted, considered or generated during the denial decision, whether or not it was used in making the decision;

- Descriptions of the administrative processes and safeguards used in the denial decision;
- Statements of policy or guidance concerning the denied treatment option or benefit, without regard to whether such statement was relied upon in making the benefit determination; and
- The identity of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in the denial decision.

In deciding an appeal of any claim denial that is based in whole or in part on a medical judgment, including determinations as to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional will not be the individual who was consulted in connection with the initial denial or a subordinate of such individual.

For claims under the Medical Program, you will be provided, free of charge, with any new or additional evidence considered by the Claims Administrator, and any new or additional rationale for a denial, sufficiently in advance of the deadline for notification of the external review decision to give you a reasonable opportunity to respond prior to that deadline.

Your appeal should be addressed to the appropriate Claims Administrator. See the *Claims and Account Administrators for the Group Benefits Plan* section of the *Administrative Information* chapter of this SPD.

Notification of Decision on Appeal

The Claims Administrator will notify you in writing of its final decision within 72 hours for an urgent care claim, 30 days for a pre-service claim, or 60 days for a post-service claim. The notification will include the following:

- The specific reasons for the appeal decision;
- A reference to the specific program provision(s) that are the basis of the decision;
- A statement that you may receive, upon request and without charge, reasonable access to or copies of all documents, records and other information relevant to your claim;
- A statement that you may receive, upon request and without charge, a copy of any internal rule, guideline, protocol or similar data relied on in denying your appeal, and/or an explanation of the scientific or clinical judgment for a decision based on a medical necessity, experimental treatment or other similar exclusion or limit; and
- A statement that you have a right to bring a civil action in federal court under Section 502 of ERISA. Such civil action may be brought only if all administrative remedies have been exhausted.

For claims under the Medical Program, the notice will also include:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings;
- The reason for the denial, including the denial code and its corresponding meaning, as well as a description of the Medical Program's standard, if any, that was used in denying the claim and a discussion of the decision;
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review process.

Request for External Review of Denied Medical Claims *(Medical Program Only)*

You may request an external review of a claim denied *under the Medical Program* if:

- You are appealing a final claim denial or the Claims Administrator's confirmation of a previous claim denial;
- Your request for external review is made within four months of the claim denial; and
- Your claim meets the following eligibility requirements for external review:
  - The Claims Administrator does not strictly adhere to all claim determination and appeal requirements under federal law; or
  - The Medical Program's standard levels of appeal have been exhausted;

  and

  - The coverage denial is based on medical judgment, including that the service or supply is not medically necessary, is experimental or investigational, resulted from the application of any utilization review, or is a rescission of coverage.

Within five business days of receiving your request for external review, the Claims Administrator will conduct a preliminary review of your claim to determine if:

- You were eligible for benefits under the Medical Program at the time claimed expenses were incurred;
- You have exhausted (or deemed exhausted) the Medical Program's internal review process; and
- You have provided all of the information necessary for an external review.

Within one business day of completing its preliminary review, the Claims Administrator will advise you of its findings. If your request is not eligible for external review, the Claims Administrator will explain why your claim is not eligible and provide contact information for the Employee Benefits Security Administration (EBSA). If the request is not complete, the notification will describe information needed for completion and you will be allowed to provide the additional information within the four-month filing period or within the 48-hour period following receipt of the notification.

If your request is eligible, an Independent Review Organization (IRO) will be assigned the external review of your claim and will advise you of its assignment and of your right, within 10 business days, to submit any additional information. You will be notified of a decision to uphold or reverse the adverse determination within 45 days after receipt of the request for an external review.

If your physician confirms that a delay would jeopardize your health, an expedited external review will be completed within 72 hours after the date of receipt of the request for an expedited external review.

In addition to the information provided by you and the Claims Administrator, the IRO will consider:

- Your medical records;
- Your attending health care professional's recommendations;
- Reports from appropriate health care professionals;
- The terms of the Medical Program;
- Appropriate practice guidelines and clinical review criteria; and
- The opinion of the IRO's clinical reviewer(s).

The decision of the IRO is binding on the Claims Administrator, BNSF and the program. You will not be charged a professional fee for the review.

The external review process will comply with applicable state and/or federal law requirements. Contact the Claims Administrator if you need further details.

The Claims Administrator's decision on appeal is final and binding for all claims except Medical Program claims that are subject to external review. Benefits will be paid only if the Claims Administrator decides, in its sole discretion, that you are entitled to them. If you continue to disagree, you may exercise your ERISA rights. However, you first must exhaust all of your administrative remedies described in this SPD before filing suit for any benefits covered by ERISA. You may not begin a lawsuit later than one year after being notified of the Claims Administrator's final decision. See the chapter of this SPD titled *Your Rights Under ERISA*.

Summary Timetable for Claims and Appeals

The following chart shows a timetable view of the above timeframes for deciding *initial* benefit claims and appeals under the Medical Program. See the separate, following chart for claims under the SurgeryPlus benefit.

Type of Notice	Urgent Care Claim	Pre-Service Claim	Post-Service Claim	Ongoing Course of Treatment (Concurrent Care) Claim
Initial Claim Determination (by Claims Administrator)	72 hours	15 days	30 days	72 hours if urgent care, 15 days if pre-service or 30 days if post-service[4]
⬇ Extensions	None	15 days	15 days	As appropriate to type of claim
⬇ Additional Information Request (by Claims Administrator)	24 hours[5]	15 days[6]	30 days	As appropriate to type of claim
⬇ Response to Additional Information Request (by Claimant)	48 hours	45 days	45 days	As appropriate to type of claim
⬇ Claim Determination After Additional Information Request (by Claims Administrator)	48 hours	15 days	15 days	As appropriate to type of claim
⬇ Request for Appeal (by Claimant)	180 days	180 days	180 days	As appropriate to type of claim
⬇ Appeal Determinations (by Claims Administrator)	72 hours	30 days	60 days	As appropriate to type of claim
⬇ Extensions	None	None	None	

[4] *If you or your representative makes a concurrent care claim no later than 24 hours before the expiration of a previous claim's allowed length of stay or length of treatment and the claim involves urgent care, the Claims Administrator must make its decision within 24 hours of receiving the new claim. You will be notified of any reduction or termination of an approved ongoing course of treatment sufficiently in advance of the reduction or termination to allow you to appeal and receive a determination on appeal before the benefit is reduced or terminated.*

[5] *If a claim is improperly filed, the Claims Administrator must notify you within this 24-hour period.*

[6] *If a claim is improperly filed, the Claims Administrator must notify you by the fifth day of this 15-day period.*

SurgeryPlus Benefit	
Appeal of Pre-surgery Assessment (by Claimant)	At timing of the patient's choosing, patient may appeal non-acceptance by a SurgeryPlus physician who determines either the procedure is not medically necessary, or the patient is not suitable for proposed treatment, including necessary travel, by requesting a second opinion with another SurgeryPlus physician.
Appeal of 2nd Pre-surgery Assessment (by Claimant)	At timing of the patient's choosing, patient may appeal non-acceptance by the second SurgeryPlus physician due to the reasons stated above, by seeking services under the Medical Program's Blue Cross Blue Shield- or Cigna LocalPlus-administered coverage.
Post-service Claim for Procedure Outside SurgeryPlus Episode of Care (by Claimant)	For elective procedures not authorized by SurgeryPlus but performed during the episode of care, claimant may submit a claim for related expenses under the Medical Program's Blue Cross Blue Shield- or Cigna LocalPlus-administered coverage. To be considered, the claim normally must be submitted to BCBS or Cigna within 90 days after the date the services were provided. (See Filing a Claim in this SPD chapter for more about deadlines.)

Coordination with Other Plans Except Medicare and TRICARE

Some people have other health coverage in addition to coverage under the BNSF Medical, Dental and Vision Care Programs. In these cases, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including BNSF's Medical, Dental and Vision Care Programs, have Coordination of Benefits (COB) rules.

Under the BNSF COB rules, the amount normally reimbursed under these programs may be reduced to take into account payments made by other plans.

Note that employees who have any other medical coverage are not eligible for coverage under the Medical Program, unless the other plan is also a qualified high deductible health plan. The BNSF Medical Program will coordinate its benefits with other plans as summarized below.

Order of Benefit Determination

Here's how the order in which the various plans will pay benefits is decided:

1. A plan with no rules for coordination with other benefits will pay its benefits before a plan that contains these rules.
2. In the case of a dependent child whose parents are divorced or separated:
   - If there is a court decree stating that the parents shall share joint custody, without stating that one of the parents is responsible for the child's health care expenses, the rules provide that the primary plan will be the plan of the parent whose birthday falls earlier in the calendar year or, if both parents have the same birthday, the plan that has covered the parent for the longest amount of time.

- If there is a court decree that makes one parent financially responsible for the child's health care expenses, the plan that covers the child as a dependent of this parent will pay benefits before any other plan that covers the child.
- When there is no court decree: If the parent with custody of the child has not remarried, the plan that covers the child as a dependent of the parent with custody will pay benefits before the plan that covers the child as a dependent of the parent without custody.
- If the parent with custody of the child has remarried, the plan that covers the child as a dependent of the parent with custody will pay benefits before the plan that covers the child as a dependent of the step-parent. The plan that covers the child as a dependent of the step-parent will pay benefits before the plan that covers the child as a dependent of the parent without custody.

3. A plan that covers the person as an active employee of an employer will pay benefits before any plan that covers the person as a dependent.
4. A plan that covers the person as a laid-off or retired employee, or as a dependent of such a person, will pay benefits after any plan that covers the person as other than a laid-off or retired employee, or a dependent of such person. This does not apply if the other plan does not have a provision relating to laid-off or retired employees.
5. A plan that covers the person because of a federal or state law governing benefits continuation, such as COBRA, will pay benefits after any other plan that covers the person based on any other eligibility requirements.

   If the other plan does not have a provision regarding benefits continuation under federal or state law, the previous paragraph will not apply.

The general rule when the BNSF program is secondary is that the benefits otherwise payable under a program for all expenses incurred in a calendar year will be reduced by all other plan benefits payable for those expenses. When the COB rules of a program and another plan agree that the program pays benefits before the other plan, the benefits of the other plan will be ignored. When COB rules operate to reduce the total amount of benefits otherwise payable under these programs, each benefit will be reduced appropriately.

Other Health Care Plan

Other health care plan or other plan means any other plan of health care expense coverage under:

- Group insurance;
- Any other type of coverage for persons in a group (this includes both insured and uninsured plans); or
- No-fault auto insurance required by law but not provided on a group basis. Only the minimum level of benefits required will be considered.

Effect on Benefits of the Program

When the BNSF program is secondary, the maximum benefits payable, when combined with benefits already paid by other health care plans, will not be more than

what the program would have paid had it been the only plan responsible for coverage. In other words, the total benefits normally payable under the program will be reduced by the amount of benefits paid by all other plans for the same services and supplies. Benefits payable under other plans include benefits that would have been paid if a proper claim had been made for them.

> ***Example:*** Assume the BNSF program pays second at an 80% coinsurance rate, your deductible has already been met, and you have a $1,000 hospital bill plus a $400 surgery bill, for a total of $1,400. The program will calculate benefits as though you had no other coverage, and then subtract the amount paid by the other plan from this benefits payable amount. If the other plan pays 80% of these bills, or $1,120, the BNSF program will pay nothing on these bills ($1,400 x 80% = $1,120 – $1,120 paid by the other plan = $0). The total paid by both plans is the amount that would have been payable under the BNSF program.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under the programs and other plans. The Claims Administrator has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount that should have been paid under a BNSF program. If so, the Claims Administrator may reimburse that plan and treat the payment as a benefit paid under the BNSF program. The Claims Administrator will not have to pay that amount again. The term "payment made" includes reasonable cash value of the benefits provided in the form of services.

Coordination with TRICARE

If you are enrolled in TRICARE, the BNSF Medical Program will provide coverage and pay benefits before your TRICARE benefits are calculated. This applies whether you are actively working or are covered as a former employee, such as while you are receiving BNSF Long Term Disability Insurance Program benefits.

Coordination with Medicare Benefits

Coordination When the Employee Is Actively Working

If you become eligible for coverage under Medicare by reaching age 65 *while you are actively working*, the BNSF Medical Program will still provide coverage and pay benefits *before* your Medicare benefits are calculated. In other words, the BNSF Program will be primary to Medicare.

In addition, if you are actively working and cover your dependents, the Medical Program will provide coverage and pay benefits before your spouse's age-based Medicare benefits are considered and before your covered dependent's disability-based Medicare benefits are considered.

If you or a covered dependent is Medicare-eligible due to End Stage Renal Disease (ESRD), the Medical Program will pay benefits before Medicare for the first 30 months after becoming eligible for Medicare based on ESRD.

Please note that you will receive any applicable credit toward your deductible and/or out-of-pocket limit for Medical Program expenses even if Medicare subsequently pays those expenses as a secondary payer.

If anything above conflicts with federal regulations under Medicare, the federal regulations will control. If the spouse has coverage through a current or former employer, the COB provisions above may also apply.

Coordination When the Employee Is Not Actively Working (Does Not Have Current Employment Status)

If you become eligible for coverage under Medicare and you have *not actively worked* for at least six months (such as while you are receiving Disability Program benefits), the BNSF Medical Program will provide coverage and pay benefits *after* your Medicare benefits are calculated. In other words, Medicare will be primary to this program.

In addition, if you are not actively working and cover your spouse, the BNSF Medical Program will provide coverage and pay benefits *after* your spouse's Medicare benefits are considered.

Exception: If an enrolled dependent who is not eligible for Medicare due to age or disability is diagnosed with End Stage Renal Disease (ESRD) and requires dialysis, this program will pay benefits before Medicare during the first 30 months following the diagnosis.

If any of these rules conflicts with federal regulations under Medicare, the federal regulations will control.

Benefits When Medicare Is Primary for Non-Actively Working Covered Persons (Without Current Employment Status)

Generally, you become eligible for Medicare at the earlier of:

1. Age 65,
2. 24 months after the effective date of your Railroad Retirement Disability or Social Security Disability, or
3. If you have End Stage Renal Disease and meet certain requirements.

You are automatically enrolled in Medicare Part A (Hospital Insurance) when you become eligible, and in Medicare Part B (Medical Insurance) unless you waive (do not enroll in) it. *If you do not have current employment status, the BNSF Medical Program calculates benefits as if you and your Medicare-entitled spouse (or dependents) are actually enrolled in Medicare Parts A and B, even if you do not apply for Social Security or Railroad Retirement benefits or waive Medicare Part B*

For this reason, **if you are not an active employee and do not have current employment status, you should be certain that you (and any dependent entitled to Medicare due to disability or renal disease) are covered under Medicare Parts A and B.**

The BNSF Medical Program will coordinate your claims and the claims for your Medicare-entitled spouse (or dependents) with Medicare. When a claim is submitted to the Claims Administrator, you also must submit the Medicare Explanation of Benefits (EOB). The benefits the Medical Program would pay in the absence of Medicare and the amount Medicare will pay (or would pay if you were enrolled) are calculated separately. If the Medical Program's amount is greater, the program will pay that amount minus the Medicare amount. If the Medicare amount is equal to or greater than this program's amount, the program will not pay any benefit. Additional detail is provided in *Clarification of Non-Duplication of Benefits* below.

Coordination with Medicare can be complicated because the BNSF Medical Program and Medicare may consider different services and supplies to be eligible for benefits and will apply their own definitions, such as medical necessity and reasonable and customary charges. If you have any questions about the benefits for a specific claim, you should contact the Claims Administrator. See *Claims and Account Administrators Under the Group Benefits Plan* in the *Administrative Information* chapter.

Medicare Part A

Providers covered under Medicare Part A (hospitals, skilled nursing facilities, hospices, etc.) currently accept the Medicare allowable amount as payment in full under Medicare Part A, *if the provider accepts assignment from Medicare*. Certain home health care services also are covered under Medicare Part A. *If you do not choose to use a Medicare provider who accepts assignment, you may be responsible for paying additional amounts.* You should ask the medical provider if he/she accepts assignment from Medicare prior to incurring costs.

Medicare Part B

Medicare also has approved amounts it will pay for covered medical services and supplies under Part B (doctor office visits, etc.). Providers who accept assignment from Medicare will consider Medicare's allowable amount as payment in full. *The BNSF Medical Program treats the amount approved by Medicare under Part B as the allowable expense and will not consider any excess charge.* Therefore, you should be certain your medical provider accepts Medicare assignment.

The Medical Program bases any reimbursement on what Medicare Part B pays or would have paid, even when your medical provider does not accept Medicare Part B assignment.

If the provider does not accept Medicare assignment, you may be required to pay more of the cost.

If a provider charges you more than the Medicare-approved Part B amount, this is called balance billing. That is, you are billed directly for the additional charges. Providers who do not accept Medicare assignment cannot legally balance bill you more than 15% above the Medicare allowable amount. You will be responsible for paying the additional 15%, and the Medical Program will not reimburse you, nor will this amount be applied to your deductible or out-of-pocket maximum. *You should always ask a physician or other medical care provider whether it balance bills before you choose to receive services that are covered under Medicare Part B.*

Clarification of Non-Duplication of Benefits Clause

The BNSF Medical Program pays benefits using a non-duplication of benefits method. The Claims Administrator will determine what the program would pay in the absence of Medicare. Then, if the program amount is greater, the program will pay that amount minus the amount Medicare paid (or would have paid). If the Medicare amount is equal to or greater than the BNSF program amount, the program will not pay any benefit.

> ***Example:*** Assume your deductibles with Medicare and the Medical Program are satisfied, and you submit a $1,000 bill to both plans. Medicare pays $800 (80%) as the primary carrier. In the absence of Medicare coverage, the Medical Program would pay $800 (80%). However, the program, as a secondary carrier with a non-duplication of benefits clause, will pay only the difference between what is paid by Medicare and what would have been paid by the program. Often that amount, as shown in this example, will be $0.

Creditable Coverage under Medicare Part D

The BNSF Medical Program provides creditable coverage under the Medicare Prescription Drug, Improvement, and Modernization Act. Therefore, each year that you are enrolled in the program, you will receive a creditable coverage notice. *This creditable coverage notice is important.* If you choose not to sign up for Medicare Part D (prescription drug coverage) while you are covered under the BNSF Medical Program, you can provide the creditable coverage notices if you later enroll in Medicare Part D, and you will not pay a premium penalty to Medicare because of late enrollment. For a copy of the Medical Program's current Medicare Part D creditable coverage notice, contact Employee Services at 817-593-6400 or email benefits.update@bnsf.com.

CLAIMS PROCEDURES FOR DEPENDENT CARE REIMBURSEMENT ACCOUNT (DCRA)

Filing a Claim for Reimbursement

You have two options for filing claims for reimbursement under your DCRA: electronic or paper. For electronic filing, log on to my.healthequity.com and follow the instructions for Request Reimbursement (electronic filing). For paper claim filing, log on to my.healthequity.com, click on the Docs & Forms link and select the DCRA Reimbursement Form. Complete the form and submit it to HealthEquity for reimbursement. You must incur expenses prior to filing for reimbursement.

Reimbursement Amount

When your complete DCRA claim is received by the Claims Administrator, your DCRA balance is checked to determine how much is available for reimbursement. If the amount of the claim is greater than your available balance, you will be reimbursed only for the amount that is available in your DCRA. Payments are issued daily by HealthEquity. When the next DCRA deposit is posted (next pay cycle), you will be reimbursed for the remainder of the claim, up to the amount of the deposit. This process automatically continues until the entire claim has been paid or until the amount you have contributed for the entire calendar year has been distributed to you.

Deadline for Filing Claims

You may file a claim for reimbursement from your DCRA anytime up to March 31 following the calendar year in which the expense was incurred. For example, an expense incurred in December must be claimed no later than March 31 the following year. Claims filed after the March 31 deadline will not be considered.

CLAIMS PROCEDURES FOR:

- LIFE AND AD&D INSURANCE PROGRAM
- BUSINESS TRAVEL ACCIDENT INSURANCE PROGRAM
- STD BENEFIT AND LTD INSURANCE PROGRAMS

Compliance with Regulations and Delegation of Authority

Under Department of Labor (DOL) regulations, claimants who are covered employees and dependents are entitled to full and fair review of any claims made under the Life and AD&D, Business Travel Accident (BTA) and Long Term Disability (LTD) Insurance Programs; and the Short Term Disability (STD) Benefit Program. The procedures described in this section govern the filing of benefit claims, notification of benefit decisions and appeal of decisions.

The Plan Administrator has delegated the discretionary authority to the Claims Administrators listed in the *Administrative Information* chapter of this SPD to interpret the programs and to make both initial claim determinations and final claim review decisions on ERISA appeals. The Plan Administrator retains the discretionary authority to determine whether you and/or your dependents are eligible to enroll for coverage and/or to continue coverage under program terms.

Filing a Claim

To make a claim, you will need to request the appropriate claim form as follows:

- Life and AD&D Insurance Program – Call the BNSF Benefits Center at 833-277-8051.
- BTA Insurance Program – Call the BNSF Employee Helpline at 800-234-1283, Option 6.
- STD Benefit Program – Call the Claims Administrator, MetLife, at 800-638-2242.
- LTD Insurance Program – Call the Claims Administrator, MetLife, at 800-638-2242.

Send your completed claim form to the Claims Administrator at the address shown on the form.

A claim must be submitted to the Claims Administrator in writing using the appropriate claim form. Your claim must include proof of the nature and extent of the loss. All claims should be reported promptly within the deadlines described in the immediately following sections for each type of claim.

For additional contact information, see *Claims and Account Administrators for the Group Benefits Plan* in the *Administrative Information* chapter of this SPD.

Process for Life, AD&D and BTA Insurance Claims

Life, AD&D and BTA Insurance Claim Process

Written notice of a claim for life insurance benefits, AD&D benefits or BTA benefits must be submitted to the Claims Administrator within 90 days after any loss covered by the policy occurs, or as soon as reasonably possible. The Claims Administrator will review the claim within a reasonable period of time, but not later than 90 days after receipt.

However, if more time is needed to make a determination, the Claims Administrator will notify you or your beneficiary in writing before the end of the initial 90-day period. The notice will state the special circumstances requiring the extension and the date by which a determination is expected. This will be no more than 90 days after the end of the initial 90-day period.

If, through no fault of your own, notice cannot be given within that time, it must be given as soon as reasonably possible.

If the Claims Administrator requires additional information to make a determination, the 90-day period is suspended while the Claims Administrator waits for the additional information. If the information is needed because you have not submitted sufficient information to the Claims Administrator to process your claim, you will receive a notice in writing specifying the nature of the information needed and an explanation as to why it is needed.

Determinations based on disabled status under life insurance coverage will be made in accordance with the claims and appeals procedures applicable to the LTD Insurance Program.

Process for STD Benefit and LTD Insurance Claims

STD Benefit Claim Process

If you become ill or disabled and your absence has exceeded or is expected to exceed five consecutive calendar days, you or your representative must call the Claims Administrator at 800-638-2242 to file a claim for the STD benefit.

LTD Insurance Claim Process

If you are receiving an STD benefit, the Claims Administrator will monitor your disability and begin the LTD claim process automatically if/when it becomes necessary. If you are reasonably sure that you will be eligible to receive LTD benefit payments at the end of your STD leave, and you have not been contacted by the Claims Administrator about continuing to LTD, you should call the Claims Administrator directly at 800-638-2242. If you do not receive information or instructions describing how to submit your claim from the Claims Administrator within 15 days of calling the Claims Administrator, you may send a letter to the Claims Administrator describing your condition.

You must provide written proof that you are disabled within three months after the end of the 182-day LTD Benefit Waiting Period. No LTD benefits will be paid under the LTD Program for claims submitted more than one year after you became disabled. This limitation will not apply if you can show:

- It was not reasonably possible to give written proof that you are disabled within one year; and
- You gave the Claims Administrator satisfactory proof that you are disabled as soon as reasonably possible.

You must provide, at your own expense, proof that you are disabled. This includes the date you became disabled, why you are disabled and your physician's prognosis. You must sign a release and HIPAA authorization allowing the Claims Administrator to obtain medical records and financial information for your LTD claim. You must apply for Other Income Benefits that are available to you, as defined under the program, including benefits under the Railroad Retirement or Social Security Acts.

Notification of Initial STD and LTD Benefit Determination

The Claims Administrator will review the claim and notify you or your representative of the determination within 45 days after receiving your claim.

However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, two 30-day extensions of time are permitted. The Claims Administrator will notify you in writing of the special circumstances requiring extension before the end of the first 45-day period and, if necessary, the reasons for the second extension before the end of the first 30-day extension period. The notice will include the date by which the Claims Administrator expects to render a decision, the standards on which entitlement to a benefit is based, the unresolved issues and the additional information needed to resolve those issues. This extension period allows the Claims Administrator more time to review your claim.

If the Claims Administrator determines that information related to the claim is incomplete, the Claims Administrator will notify you or your representative in writing within the initial 45-day period. If you have not submitted sufficient information to the Claims Administrator to process your claim, the written notice will specify the nature of the information needed and an explanation as to why it is needed. You or your representative must provide the specified information within 45 days after receiving the notice. If the Claims Administrator determines in its sole discretion that a medical examination is necessary, you will be given the time of the appointment and the physician's name and address. While the Claims Administrator waits for the additional information, the 45-day period to make a determination will be suspended. When the information is received, the Claims Administrator has the remainder of the original 45-day period to process the claim.

The above time limits for claim determinations will also apply to life insurance coverage claims to the extent that payment of life insurance benefits is conditioned on disabled status (e.g., waiver of premium benefits under Optional Life Insurance coverage).

Payment of Claims

Life, AD&D and BTA Insurance Claim Payment

Once a claim for a Life, AD&D or BTA insurance benefit has been approved, you or your beneficiary will receive payment (or begin receiving installment payments if arranged with the life insurance Claims Administrator). If there are questions about the amount of benefit payable, you or your beneficiary should ask the Claims Administrator to explain the method used to calculate the benefit. If there is disagreement over the amount of the benefit, you or your beneficiary should follow the *Claim Appeal Procedure* in this chapter.

STD Benefit and LTD Insurance Claim Payment

If your STD or LTD claim is approved, you will receive benefits. If you have questions about the amount of STD or LTD benefits you receive, ask the Claims Administrator for an explanation of the benefit calculation. If you do not agree with the amount of the benefit, you should follow the *Claim Appeal Procedure* below.

If Your Claim Is Denied

If a claim is denied in whole or in part under the Life and AD&D or BTA Programs, the Claims Administrator will send you or your beneficiary a written notice that states:

- The specific reason(s) for denial of the claim;
- A specific reference to the provision(s) of the insurance contract or program that are the basis for the denial;
- A description of any additional material or information needed by the Claims Administrator to reverse the denial, or in the case of an incomplete claim, to complete the claim, and an explanation of why it is needed;
- An explanation of the program's claim appeal procedures and applicable time limits; and
- A statement regarding your right to bring a civil action under Section 502(a) of ERISA following a denial on appeal.

If a claim is denied in whole or in part under the LTD Insurance or STD Benefit Programs or due to a determination of disabled status under the life insurance benefit, the Claims Administrator will send you or your beneficiary a written notice that states:

- The specific reason(s) for denial of the claim and discussion of the decision, including an explanation of the basis for disagreeing with or not following: any RRB or SSA disability determination; the views of a treating health care professional or vocational professional who evaluated a claimant; and the views of medical or vocational experts whose advice was obtained by the Claims Administrator in connection with the denial, without regard to whether the advice was relied upon;
- If the adverse benefit determination is based upon a medical necessity, an experimental treatment or similar exclusion or limit, an explanation of the judgment for the determination or a statement that such explanation will be provided free of charge upon request;

- Either the specific internal rules, guidelines, protocols, standards or other similar criteria relied upon in making the determination or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist;
- A specific reference to the provision(s) of the insurance contract or program that are the basis for the denial;
- A description of any additional material or information needed by the Claims Administrator to reverse the denial, or in the case of an incomplete claim, to complete the claim, and an explanation of why it is needed;
- An explanation of the program's claim appeal procedures and applicable time limits;
- If you request, the Claims Administrator will provide, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim; and
- A statement regarding your right to bring a civil action under Section 502(a) of ERISA following a denial on appeal.

Claim Appeal Procedure

The Life and AD&D, BTA, LTD Insurance and STD Benefit Programs are subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA has special rules that must be followed when you or your beneficiary chooses to appeal a benefit claim decision (denied claim).

Life, AD&D and BTA Claim Appeals

If a claim under the Life and AD&D or BTA Insurance Programs has been denied in whole or in part, you or your beneficiary may request a review of your claim. You or your beneficiary should file a written request for appeal as soon as you receive a denial of benefits, but *no later than 60 days* from the date you receive notice. You may forfeit any right to appeal the denial if you do not meet this important deadline.

Along with a written request for a review, you may submit any additional information you believe should be considered during the review. The review will take into account all information submitted by you without regard to whether it was considered in the initial determination. Upon request, you or your beneficiary will be provided reasonable access to and copies of documents, records and other information relevant to your claim, free of charge.

Address the request for an appeal to:

Life and AD&D Insurance	BTA Insurance
Metropolitan Life Insurance Company Group Insurance Claims Review One Madison Avenue New York, New York 10010	ACE North America Claims P.O. Box 5122 Scranton, PA 18505-0554

The Claims Administrator has the discretionary authority to review all claims and to make final determinations based on the terms of the insurance policy that has been issued to the program.

The Claims Administrator will review the claim and respond with a final determination within 60 days. If more time is needed to review the claim, you or your beneficiary will be notified of the special circumstances requiring an extension and the date by which a decision should be made. In no event will the total period for review of the claim exceed 120 days.

Notification of Decision on Appeal

The Claims Administrator will notify you in writing of its final decision. If your claim is denied on appeal, the notice will include the following:

- The specific reasons for the appeal decision;
- A reference to the specific Life, AD&D or BTA Insurance Program provision(s) on which the decision was based;
- A statement regarding the claimant's right, upon request and without charge, to a copy of documents, records and other information relevant to the claim; and
- A statement regarding your right to bring a civil action under Section 502(a) of ERISA following a denial on appeal.

Claims Related to Disability

The Life and AD&D Insurance Program may apply special rules for processing claims relating to a disability, like a claim for Life Insurance Premium Waiver. Please contact the Claims Administrator for more details in this situation.

The Claims Administrator's decision on appeal is final and binding. Benefits under the Life, AD&D and BTA Insurance Programs will be paid only if the Claims Administrator decides, in its sole discretion, that you are entitled to them. If you continue to disagree with the decision, you may exercise *Your Rights Under ERISA* as described in the chapter of that name. **However, you first must exhaust all of your administrative remedies described in this SPD before filing suit for any benefits covered by ERISA. You may not begin a lawsuit later than one year after being notified of the Claims Administrator's final decision.**

STD and LTD Claim Appeals

If you receive a written notice of a partial or complete denial of claim for an STD or LTD benefit, you or your representative may request a review by giving written notice to the Claims Administrator *within 180 days* of the receipt of the denial.

If your request is not made *within 180 days*, you will have waived your right to a review of the claim. The Claims Administrator has the discretionary authority to review all claims, and to make final determinations based on the STD Benefit Program for STD claims and the terms of the insurance policy that has been issued to the LTD Insurance Program for LTD claims.

The review on appeal will not give any favor to the initial decision and will take into account all information submitted by you, regardless of whether it was considered in the initial decision. A person not involved in the initial decision, and who is not a subordinate of someone who made the initial decision, will decide your appeal.

Along with your written appeal request, you may submit any additional documents, issues and comments for consideration during the review of your denied claim. If appropriate, you also should include any clinical information from your health care professional supporting your appeal.

The Claims Administrator will provide reasonable access to and copies of all documents, records and other information regarding your claim, free of charge including:

- Information relied upon in making the benefit determination;
- Information submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon in making the benefit determination;
- Descriptions of the administrative processes and safeguards used in making the benefit determination;
- Statements of policy or guidance concerning the denied benefit, without regard to whether such statement was relied upon in making the benefit determination; and
- The identity of any expert whose advice was obtained in connection with the denial, whether or not the advice was relied upon in the denial decision.

You also may submit written comments, records, documents and other information for your appeal, whether or not this information was submitted in connection with the initial claim. If the claim involves medical judgment, the Claims Administrator will consult with medical or vocational experts who have appropriate training and experience in the field of medicine involved in the medical judgment, and who were not consulted in connection with the claim denial or the subordinate of the individual who made the claim denial, in connection with deciding your claim for benefits.

You will be provided, free of charge, with any new or additional evidence considered, relied upon or generated by the Claims Administrator, and any new or additional rationale for a claims denial, sufficiently in advance of the deadline for notification of the appeal decision to give you a reasonable opportunity to respond

prior to that deadline. You will be afforded a reasonable opportunity to respond to such new or additional evidence or rationale received pursuant to this section and sufficiently in advance of the deadline for the final determination. The Claims Administrator will consider any response from you. If your response causes the Claims Administrator to generate additional report(s) containing new or additional evidence, the additional report(s) will be furnished to you as soon as possible and sufficiently in advance of the deadline for a decision. The Claims Administrator will also consider any further response from you based on any additional reports. If the new evidence or rationale for denial is not provided to you as described above, the Claims Administrator cannot rely on that evidence or rationale in denying the appeal.

The Claims Administrator must strictly adhere to all ERISA procedural requirements when processing a disability claim (except for certain minor errors). If you feel a violation of the procedural requirements has occurred, you are entitled, upon request, to an explanation of the violation from the Claims Administrator. The Claims Administrator has 10 days to respond to your request.

You may file a suit for benefits in court under Section 502(a) of ERISA, even before the program's procedures are exhausted, if the Claims Administrator does not follow the procedures for processing your disability claims. In that case, a court may choose to hear your claim independently and not give special deference to the Claims Administrator's decision. If the Claims Administrator feels that any procedural error made could be considered minor, the Claims Administrator is allowed to put forth that evidence to the court. If the court determines that the errors are in fact minor and refuses to review your claim, your claim will be considered as refiled on appeal.

Notification of Decision on Appeal

The Claims Administrator will review your claim and respond with a final determination within 45 days after receiving your request. If more time is needed, you will be notified of the special circumstances requiring an extension of time and the date by which a decision will be made. In no event will the total review period exceed 90 days.

The above time limits for determinations on appeal will also apply to life insurance coverage claims to the extent that payment of life insurance benefits is conditioned on disabled status (e.g., waiver of premium benefits under life insurance coverage).

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

- The specific reasons for the appeal decision;
- A reference to the specific provision(s) of the insurance contract or program on which the determination on review was based;
- A statement that the claimant is entitled to receive, upon request and without charge, reasonable access to or copies of all documents, records and other information relevant to the determination;

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: any RRB or SSA disability determination; the views of a treating health care professional or vocational professional who evaluated a claimant; and the views of medical or vocational experts whose advice was obtained by the Claims Administrator in connection with the denial, without regard to whether the advice was relied upon;

- If the adverse benefit determination is based upon a medical necessity, an experimental treatment or similar exclusion or limit, an explanation of the judgment for the determination or a statement that such explanation will be provided free of charge upon request;

- Either the specific internal rules, guidelines, protocols, standards or other similar criteria relied upon in making the determination or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and

- A statement regarding your right to bring a civil action under Section 502(a) of ERISA following a denial on appeal and any limitation period on your right to bring such action.

A decision by the Claims Administrator on appeal will be final and binding. Benefits under the STD Benefit Program or LTD Insurance Program will be paid only if the Claims Administrator decides, in its sole discretion, that you are entitled to them. If you continue to disagree with the decision, you may exercise *Your Rights Under ERISA*, as described in the chapter of that name in this SPD. **However, you first must exhaust all of your administrative remedies described in this SPD before filing suit for any benefits covered by ERISA, unless your claim is deemed exhausted pursuant to 81 Fed. Reg. 92316. You may not begin a lawsuit later than one year after being notified of the Claims Administrator's final decision.**

Where applicable, any notice you receive regarding claims and appeals under the STD Benefit Program or LTD Insurance Program will be provided in a culturally and linguistically appropriate manner, advise of the availability of language services, and may be provided in an alternative language upon request.

Any disputes that arise under the STD Benefit Program or LTD Insurance Program are not governed by any of the procedures of the Railway Labor Act or any collective bargaining agreement dispute resolution procedure.

SUBROGATION AND RIGHT OF RECOVERY

Subrogation

Immediately upon paying or providing any benefit, the BNSF Group Benefits Plan will be subrogated to all rights of recovery a covered person has against any responsible party with respect to any payment made by the responsible party to a covered person due to a covered person's injury, illness or condition to the full extent of benefits provided or to be provided by the Plan.

Reimbursement

In addition, if a covered person receives any payment from any responsible party or insurance coverage as a result of an injury**,** illness or condition, the BNSF Group Benefits Plan has the right to recover from, and be reimbursed by, the covered person for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount the covered person receives from any responsible party.

Constructive Trust

By accepting benefits (whether payment is made to the covered person or made on behalf of the covered person to any provider) from the BNSF Group Benefits Plan, the covered person agrees that if he or she receives any payment from any responsible party as a result of an injury, illness or condition, he or she will serve as a constructive trustee over the funds that constitute the payment. Failure to hold those funds in trust will be deemed a breach of the covered person's fiduciary duty to the BNSF Group Benefits Plan.

Lien Rights

The BNSF Group Benefits Plan will automatically have an equitable lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition for which the responsible party is liable. The lien will be imposed upon any recovery whether by settlement, judgment or otherwise related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the covered person; the covered person's representative or agent; the responsible party; the responsible party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First Priority Claim

By accepting benefits from the BNSF Group Benefits Plan (whether payment is made to the covered person or on behalf of the covered person to any provider), the covered person acknowledges the Plan's recovery rights are a first priority claim against all responsible parties and are to be paid to the Plan before any other claim for the covered person's damages. The Plan will be entitled to full reimbursement on a first-dollar basis from any responsible party's payments, even if that payment to the Plan will result in a recovery to the covered person that is insufficient to make the covered person whole or to compensate the covered person in part or in whole for the damages sustained. The Plan is not required to participate in, or pay court costs or attorney fees to, any attorney hired by the covered person to pursue the covered person's damage claim. The Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, attorney's fees, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

Applicability of All Settlements and Judgments

The terms of this entire Subrogation and Right of Recovery section will apply to all benefits paid by the Plan, and the BNSF Group Benefits Plan is entitled to full recovery regardless of:

- Whether any liability for payment is admitted by any responsible party; and
- Whether the settlement or judgment received by the covered person:
  - Identifies the benefits the BNSF Group Benefits Plan provided, or
  - Purports to allocate any portion of the settlement or judgment to payment of expenses other than medical expenses.

The BNSF Group Benefits Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

Cooperation

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

The covered person must not do anything to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of these Subrogation and Right of Recovery provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The covered person acknowledges that the BNSF Group Benefits Plan has the right to conduct an investigation regarding the injury, illness or condition to identify any responsible party. The Plan reserves the right to notify any responsible party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this Subrogation and Right of Recovery provision is ambiguous, or if questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

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

Recovery of Overpayment

If you or a beneficiary receives a benefit payment from the BNSF Group Benefits Plan that exceeds the benefit payment that should have been made, the Claims Administrator may recover the excess paid from one or more of the persons it has paid or any other person or organization that may be responsible for the benefits or services provided. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services. If this recovery is not possible, you or the beneficiary will be required to return the excess amount. If the excess amount is not returned, the Claims Administrator and/or Plan Administrator reserve the right to deduct this amount from future benefits payable to you or a beneficiary under the BNSF Group Benefits Plan, or otherwise collect the excess amount.

Special Provision: Another way that plan overpayments are recovered from in-network providers is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Claims Administrator. Under this process, the Claims Administrator reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when the Claims Administrator recovers overpayments for other plans administered by the Claims Administrator. This right does not affect any other right of recovery the Plan may have with respect to overpayments.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. The BNSF Group Benefits Plan has the right to pay any health benefits to the service provider. This will be done unless you have told the Claims Administrator otherwise by the time you file the claim.

The Plan may pay up to $1,000 of any benefit to any of your relatives whom it believes are fairly entitled. This may be done if the benefit is payable to you and you are a minor or are otherwise unable to give a valid release. It also may be done if a benefit is payable to your estate.

Records of Expenses

You should keep complete records of health care expenses for each covered person. They will be required when a claim is made. Very important are:

- Names of physicians, dentists and others who furnish services.
- Dates expenses are incurred.
- Explanations of Benefits (EOBs) received from insurers showing claimed expenses, benefits paid and amounts due from you.
- Copies of all bills and receipts.

WHO TO CALL ABOUT YOUR BENEFITS

For questions about your claims or claims procedures, call the Claims Administrator for the benefit program in question. Phone numbers are listed in the *Administrative Information* chapter of this SPD.

For questions about eligibility for benefits or enrolling in any of the programs of the BNSF Group Benefits Plan, call the BNSF Benefits Center at 833-277-8051. Benefits Center representatives are available Monday through Friday, 7 a.m. to 7 p.m. Central time.

DEFINED TERMS

Defined Terms Are in Three Sections

Select a section:

Defined Terms For:

- ***Medical, Dental and Vision Care Programs***
- ***Health Care Flexible Spending Account (HCFSA)***
- ***Health Reimbursement Account (HRA)***
- ***Dependent Care Reimbursement Account (DCRA)***

About These Terms

The following definitions of certain words and phrases will help you understand the provisions to which the definitions apply.

Some definitions apply in a special way to specific benefits or provisions. So, if a term that is defined in another chapter of this SPD also appears as a defined term listed here, the definition in the other chapter will apply to that specific chapter rather than the definition below.

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Adverse benefit determination – A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. Also includes a rescission (retroactive cancellation) of medical or disability coverage not attributed to a failure to timely pay premiums.

Assignment – The transference of a right or interest from one person or entity to another.

BNSF, company, employer – Burlington Northern Santa Fe, LLC, 2301 Lou Menk Drive, Fort Worth, TX 76131, and participating subsidiary companies.

Claim – Any request for a benefit. A communication regarding benefits that is not made according to these procedures will not be treated as a claim. Routine requests for information regarding your benefits under the Plan and other similar inquiries will not be considered a benefit claim that requires processing under ERISA. If you wish to make a claim for benefits under the Plan in accordance with your rights under ERISA, you must do so in writing to the appropriate Claims Administrator as described in this SPD.

Claimant – An individual covered by the Medical (including HRA), Dental or Vision Care Program or HCFSA. You become a claimant when you make a request for benefits.

Claims and Account Administrators – See the *Administrative Information* chapter of this SPD for identification of Claims and Account Administrators.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985.

Concurrent care claim – A claim approved by the Claims Administrator for an ongoing course of treatment over a period of time or for a specified number of treatments. There are two types of concurrent care claim review decisions:

- Where reconsideration of an approved claim results in a reduction or termination of the original period of time or number of treatments.
- Where an extension of the approved period of time or number of treatments is requested.

Coordination of Benefits (COB) – The Claims Administrator's consideration of the benefits payable by all plans covering the person for a certain service or supply in the determination of any benefit payable by the BNSF program.

Discretionary authority – The power or right to decide or act according to one's own judgment and enforce that decision or action.

Episode of care – Applies only to the SurgeryPlus benefit. An episode of care is limited to approved services rendered by SurgeryPlus , and hospital- or facility-related expenses for your specific diagnosis. The episode of care begins on the day you first receive services from the SurgeryPlus provider and ends when you are discharged from the hospital or facility to return home.

ERISA – Employee Retirement Income Security Act of 1974, as amended.

Improperly filed claim – Any request for benefits that is not made according to the claims procedures in this chapter.

Medical necessity, Medically necessary – A service or supply that is commonly and customarily recognized by physicians in a particular medical specialty as appropriate for the diagnosis or treatment of the illness or injury, as determined by the Claims Administrator.

Plan Administrator – Vice President and Chief Human Resources Officer, BNSF Railway Company, 2301 Lou Menk Drive, Fort Worth, TX 76131.

Post-service claim – A claim that involves only the payment or reimbursement of the cost for care that already has been provided. A post-service claim is any claim that is not a pre-service claim, an urgent care claim or a concurrent care claim.

Pre-service claim (pre-notification / pre-determination / advance claim review) – A claim for benefits that may require approval before incurring expenses for care.

Urgent care claim – Any claim for care where normal response times could seriously jeopardize the claimant's life, health or ability to regain maximum function; or would, in the opinion of a knowledgeable health care professional, subject the claimant to severe pain that cannot be adequately managed without the requested care. A knowledgeable health care professional can establish a claim as an urgent care claim. Otherwise, the Claims Administrator will make this determination. If the requested care already has been provided, the claim will be considered a post-service claim.

Defined Terms For:

- ***Life and AD&D Insurance Program***
- ***Business Travel Accident (BTA) Insurance Program***
- ***STD Benefit and LTD Insurance Programs***

About These Terms

The following definitions of certain words and phrases will help you understand the provisions to which the definitions apply.

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Benefits pay – For full-time employees (excluding BNSF Logistics), benefits pay is your base salary plus your target ICP for your salary band (not actual payout) as of Aug. 31 of the prior year. If you are a part-time employee (excluding BNSF Logistics), benefits pay is your base salary plus 50% of your target ICP for your salary band (not actual payout) as of the later of:

1. Aug. 31 of the prior year, or
2. The date you became part time.

For BNSF Logistics employees, benefits pay is your base salary.

Claim – Any request for a benefit. A communication regarding benefits that is not made according to these procedures will not be treated as a claim. Routine requests for information regarding your benefits under the Plan and other similar inquiries will not be considered a benefit claim that requires processing under ERISA. If you wish to make a claim for benefits under the Plan in accordance with your rights under ERISA, you must do so in writing to the appropriate Claims Administrator as described in this SPD.

Claims Administrator – See the *Administrative Information* chapter of this SPD for identification of Claims Administrators.

Claimant – An individual covered by the Life and AD&D Insurance, BTA Insurance, LTD Insurance or the STD Benefit Program. You become a claimant when you or a beneficiary makes a request for benefits.

Disabled, Totally disabled – ***Under the LTD Insurance Program*** – Means that, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment from a doctor on a continuing basis; and

1. During the first 24 months, due to your inability to perform the duties of your own occupation, you are unable to earn more than 80% of your pre-disability benefits pay at your own occupation or at a similar occupation for any employer in your local economy; or
2. After the first 24-month period, due to your inability to perform the duties of any gainful occupation for which you are reasonably qualified taking into account your training, education, experience and

pre-disability benefits pay, you are unable to earn more than 60% of your pre-disability benefits pay from any employer in your local economy.

Under the STD Benefit Program – Means you are unable to work at your regular job assignment due to accidental injury, sickness or pregnancy for five consecutive calendar days; and after the initial five-consecutive-calendar-day period, you continue to be unable to perform all of the material duties of your regular job assignment.

Discretionary authority – The power or right to decide or act according to one's own judgment and enforce that decision or action.

ERISA – Employee Retirement Income Security Act of 1974, as amended.

Plan Administrator – Vice President and Chief Human Resources Officer, BNSF Railway Company, 2301 Lou Menk Drive, Fort Worth, TX 76131.

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Defined Terms for Subrogation and Right of Recovery

About These Terms

The following definitions of certain words and phrases will help you understand the provisions to which the definitions apply.

Some definitions apply in a special way to specific benefits or provisions. So, if a term that is defined in another chapter of this SPD also appears as a defined term listed here, the definition in the other chapter will apply to that specific chapter rather than the definition below.

Claim – Any request for a benefit. A communication regarding benefits that is not made according to these procedures will not be treated as a claim. Routine requests for information regarding your benefits under the Plan and other similar inquiries will not be considered a benefit claim that requires processing under ERISA. If you wish to make a claim for benefits under the Plan in accordance with your rights under ERISA, you must do so in writing to the appropriate Claims Administrator as described in this SPD.

Claims Administrator – See the *Administrative Information* chapter of this SPD for identification of Claims Administrators.

Covered person – A covered person under this section includes anyone on whose behalf the BNSF Group Benefits Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any Plan participant or person entitled to receive any benefits from the Plan.

ERISA – Employee Retirement Income Security Act of 1974, as amended.

Fiduciary – A person to whom property or power is entrusted for the benefit of another.

Insurance coverage – Insurance coverage under this section refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, Workers' Compensation coverage, no-fault automobile insurance coverage or any first-party insurance coverage.

Lien – The legal claim of one person upon the property of another person to secure the payment of a debt or the satisfaction of an obligation.

Plan Administrator – Vice President and Chief Human Resources Officer, BNSF Railway Company, 2301 Lou Menk Drive, Fort Worth, TX 76131.

Responsible party – Responsible party under this section means any party actually, possibly or potentially responsible for making any payment to a covered person due to an injury, illness or condition. The term responsible party includes the liability insurer of that party or any insurance coverage.

Right of recovery – The BNSF Group Benefits Plan's right to recover amounts that it pays in benefits for illnesses or injuries caused by someone not covered under the Plan.

Subrogation, subrogated – Subrogation (or being subrogated to) means putting one person in the place of another. Under this section, it refers to the Claims Administrator taking your place if you are covered under the BNSF Group Benefits Plan and you have a right to recover your costs from someone else. This is done to recover amounts that the Plan paid for you but should have been paid by the person at fault. For example, say you are covered under the Plan and you are injured in an auto accident caused by someone else. The other person's auto insurance is obligated to pay some or all of your expenses for medical care. If the Plan pays your expenses, the Claims Administrator has the right to recover money paid by the Plan from the other insurer.