BNSF RAILWAY

DENTAL PROGRAM

CONTENTS

BNSF DENTAL PROGRAM

The Big Picture

An Overview of the Dental PPO and DMO Options

Effective Jan. 1, 2021

DENTAL BENEFITS ENCOURAGE PREVENTIVE CARE AND ASSIST WITH TREATMENT EXPENSES

It's a fact: Good oral hygiene and preventive dental care keep your teeth and gums healthy and contribute to your overall physical wellness. Periodic preventive care visits help reduce the possibility of costly and potentially painful dental procedures down the road.

Your BNSF dental coverage is set up to encourage you and your covered family members to see your dentist regularly, even if you don't have any current dental problems. In-network preventive and diagnostic procedures (check-ups, cleanings, X-rays) are covered at no cost to you. In addition, benefits paid by the program for preventive care do not count toward the annual maximum benefit.

It's also well known that your dental health affects other aspects of your overall well-being. Most everyone knows how hard it is to live with a toothache. And certain dental infections can even damage the heart and lead to other serious health issues. To support effective and timely treatment if major dental services are needed, BNSF's dental benefits help with the cost.

With a choice of two coverage options in many geographic areas, you have the flexibility to choose how broad your selection of dental providers will be, how you want to pay your share of costs when you have treatment and the price of coverage.

DENTAL OPTIONS IN BRIEF

	Aetna Dental PPO (In-Network and Out-of-Network)	Aetna Dental DMO (In-Network Only)
Dental Program Lifetime Maximum Benefit	None (except orthodontia; see below)	None (except orthodontia; see below)
Network	Freedom to choose in-network or out-of-network dental care providers	In-network dental care providers only[1]
Annual Maximum Benefit	$1,500 per person (excluding expenses for preventive and diagnostic services and orthodontia)	None
Annual Deductible	$50 per person / $150 family maximum	None
Benefits	**Coinsurance (plan / you)** • Preventive and diagnostic care: 100% / 0% (no deductible) • Basic services: 80% / 20% • Major services: 50% / 50% • Orthodontia: 50% / 50%	**You pay $0 or a fixed-dollar copayment for each service** • You pay nothing for many covered services • You pay a fixed-dollar copayment for most other services • Coverage varies by state
Orthodontia	• Covers eligible children for treatment that begins before age 19 • Separate $1,500 lifetime benefit maximum per covered person	• Covers adults and eligible children • You pay fixed-dollar copayments • One full course of treatment for each covered person's lifetime

[1] Dental *DMO coverage varies by state. In some states, certain out-of-network services are covered as noted in the group plan booklet and schedule of benefits for various states.*

HOW DENTAL COVERAGE WORKS IN BRIEF

Financial Protection

Dental care benefits at BNSF help you with the cost of your dental health expenses. By paying the entire cost of certain preventive and diagnostic dental care, the Dental Program encourages you to maintain proper dental health. While the Dental Program also assists with the cost of basic and major dental work, you may be able to control your expenses by visiting your dentist for regular check-ups and cleanings.

Shared Cost

You and BNSF share in the cost of your coverage. You pay your part with pre-tax dollars through regular automatic payroll deductions. Your cost depends on the Dental Program option you select and which family members you choose to cover.

Deductible, Coinsurance and Copayments

Preventive and Diagnostic Services

Regular check-ups, cleanings and diagnostic work are key to maintaining good dental health and to preventing problems later. That's why both the Dental PPO and DMO options pay the entire cost of periodic in-network preventive and diagnostic services with no deductible on your part. Benefits paid by the program for these services do not count toward the annual maximum benefit under the Dental PPO.

Basic, Major and Orthodontia Services

Under the Dental PPO, other services are subject to the deductible. That means before the PPO begins paying benefits, the covered expenses that you have paid on your own must first reach the annual deductible. Once you meet the deductible, the PPO begins paying a portion of your covered dental expenses and you pay a portion. This is called coinsurance. No copayments are required under the Dental PPO.

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.

The DMO option includes a schedule of fixed copayments for all basic, major and orthodontia services. Coverage and benefit amounts may vary by state, so refer to the separate Dental DMO group plan booklets and summaries of benefits for more coverage details, including a complete list of benefit amounts for each type of service.

Annual and Lifetime Maximum Benefits

The annual maximum benefit under the Dental PPO is $1,500 per person, excluding preventive and diagnostic services and orthodontia benefits. The lifetime maximum orthodontia benefit is $1,500 per child.

The Dental DMO does not limit the total dollar amount of annual or lifetime benefits. The DMO option limits benefits for each type of service to a specific amount or course of treatment as listed in the separate group plan booklets and summaries of benefits.

Using Your Company-Funded Cash Account and Health Care Flexible Spending Account

If you participate in BNSF's Medical Program, each year you receive a cash contribution to

your Health Savings Account (HSA).[2] In addition, each year you may enroll in a tax- advantaged Health Care Flexible Spending Account (HCFSA). You may use funds from the accounts to pay your out-of-pocket dental expenses, including expenses that count toward your deductible and coinsurance, or your copayments.

Dental Providers

Dental PPO

You may use any licensed dentist you wish under the Dental PPO. Benefits are the same under the Dental PPO regardless of whether you use an in-network or out-of-network provider. However, your share of the cost of services is likely to be less if you use Dental PPO in-network providers. In-network providers have agreed to charge fees negotiated by Aetna and to abide by Aetna's standards of care.

Out-of-network providers may charge more than the reasonable and customary limit, since they are not limited to Aetna's negotiated fee schedule. ***You will be responsible for paying 100% of any portion of charges that exceeds the reasonable and customary limit.***

In most cases, your in-network provider will file your claims directly with the Claims Administrator, saving you time and effort. You may have to file your own claims if you use an out-of-network provider.

Dental DMO

Under the Dental DMO, you must select a Primary Care Dentist (PCD) who provides or coordinates all your dental care.[3] If you require care by a specialty dentist, you must receive a referral from your PCD.[3] ***The Dental DMO is available only in certain locations.***

The DMO is owned and operated by the Claims Administrator, Aetna, independent of BNSF.

The DMO plan is insured, meaning BNSF has arranged to purchase insured coverage on your behalf from the DMO. The DMO, not BNSF, determines the benefits the DMO option offers, and the DMO decides which expenses will be paid. BNSF's role is limited to managing the eligibility of employees and dependents who can participate in program options.

If you choose the DMO, generally only care by DMO providers is covered, and typically there are no claim forms for you to file.[4]

Network Directories

For a list of in-network dentists and other dental service providers, go to Aetna's online provider directory, DocFind, at aetna.com.

- For the Dental PPO, select the network called PPO/PDN with PPO II Network.
- For the Dental PPO, select the network called Dental Maintenance Organization (DMO).

You may also access the Provider Lookup tool on the BNSF Benefits Center website at digital.alight.com/BNSF.

Filing Claims and Claim Appeals

The Dental PPO and DMO options include rules for filing claims, such as time limits and the information required. They also include a process for you to appeal claims decisions. Details are in the *Claims Procedures* section of this SPD for the Dental PPO and in the DMO booklet for the DMO.

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[2] *Or Health Reimbursement Account (HRA), if applicable.*

[3] *In some states, you may select your network orthodontist without referral from a PCD. See the group plan booklet and schedule of benefits for your state.*

[4] *In some states, certain out-of-network services are covered as noted in the group plan booklet and schedule of benefits for various states.*

EXPENSES COVERED UNDER THE DENTAL OPTIONS IN BRIEF

The Dental Program options offer broad coverage of dental care expenses, including those listed below. The *Schedule of Benefits* shown later in this chapter provides a detailed listing of the Dental PPO coverage. For the benefit provided for each type of expense under the Dental DMO, see the *schedule of benefits or group plan booklet* for your state.

Please note that certain limitations and exclusions apply. For specific information, refer to the sections of this chapter titled *Important Rules and Administrative Information* and *Expenses Not Covered*.

- Preventive and diagnostic services:
  - Oral exams.
  - X-rays.
  - Cleanings.
  - Fluoride application for children.
  - Sealant application for children.
  - Space maintainers.
- Basic restorative services:
  - Visits and exams.
  - X-rays and pathology services.
  - Oral surgery.
  - Periodontics.
  - Endodontics.
  - Basic restorations.
  - Anesthesia and sedation.
- Major restorative services:
  - Major restorations.
  - Prosthodontics.
- Orthodontia services.

IMPORTANT RULES AND ADMINISTRATIVE INFORMATION IN BRIEF

Advance Claim Review of Certain Procedures and Treatments (Pre-determination)

To be sure you receive full benefits under the Dental Program, you and your dentist should authorize, in advance, certain procedures and treatments with the Claims Administrator. This is called Advance Claim Review or Pre-determination. Details of this process are provided in the *Advance Claim Review* section of this Dental Program chapter.

Benefits Under Other Plans

If you or a covered dependent is eligible for dental benefits under another plan, such as your spouse's plan, the Dental Program coordinates its benefits with the other plan's benefits so that duplicate benefits are not paid. See *Coordination with Other Plans Except Medicare* in the *Claims Procedures* chapter of this SPD for details.

Expenses Owed by Other Parties

Occasionally, other parties are responsible for your dental expenses – for example, if you are injured in an auto accident. The Dental Program has the right to recover amounts that others are obligated to pay. The related provisions are described under *Subrogation and Right of Recovery* in the *Claims Procedures* chapter of this SPD.

When Coverage Begins

Coverage under the Dental Program may begin at different times, based on various factors, including the timing of your request for coverage and the individuals to be insured. Refer to the chapter of this SPD titled *Who Is Eligible and How to Enroll* for specific information.

Leaves of Absence

If you take certain leaves of absence, such as a military leave or a leave under the Family and Medical Leave Act (FMLA), you may be able to continue program coverage for a period of time by paying the required cost. You can find details in the *Continuation of Coverage During Leaves* section of the *When Coverage Ends* chapter of this SPD.

When Coverage Ends

Coverage usually ends for a dependent when he or she is no longer eligible and for you when your salaried employment with BNSF ends. If you or a covered dependent loses coverage under these circumstances or because of any other event eligible under COBRA, you may choose to continue coverage by paying the full cost. Please see the *When Coverage Ends* chapter of this SPD for more information.

General and Administrative Information

This SPD contains detailed information, including your privacy rights, which may assist you in using the program. For details, refer to the chapters of this SPD titled *General Information About Your Rights to Benefits* and *Administrative Information*.

Your ERISA Rights

A federal law, ERISA, gives you important rights under the program. Those rights are described in the *Your Rights Under ERISA* chapter of this SPD.

Separate DMO Booklet and Schedule of Benefits

The remainder of this SPD describes *only* the Dental PPO option. Details of the DMO option and its schedule of benefits for each state are contained in separate booklets provided by the DMO.

Coverage Details

Dental PPO Option

SCHEDULE OF BENEFITS

BENEFITS	In-network and Out-of-network[5]
Lifetime Maximum Benefit • All expenses except orthodontia	No lifetime maximum
• Orthodontia services	$1,500 per person
Dental PPO Annual Maximum Benefit *(per calendar year)* • All expenses except preventive and diagnostic care and orthodontia	$1,500 per person
• Preventive and diagnostic care, and orthodontia services	No annual maximum
Deductible *(per calendar year)*	$50 per person / $150 family maximum
Coinsurance *(Plan / you)* • Preventive and diagnostic care	100% / 0% (no deductible)
• Basic restorative care	80% / 20% after deductible
• Major restorative care	50% / 50% after deductible
• Orthodontia (for children whose treatment begins before age 19)	50% / 50% after deductible

HOW COVERAGE WORKS

Your Contributions for Coverage

The contributions required for each Dental Program option are shown on the BNSF Benefits Center website during annual enrollment or during your enrollment period as a newly eligible participant. Your per-pay-period contribution reflects the coverage level you choose:

- You only,
- You + spouse,
- You + child(ren), or
- You + family.

[5] *Benefits are the same regardless of whether you use an in-network or out-of-network provider. However, your share of the cost of services is likely to be less if you use in-network providers. In-network providers have agreed to charge fees negotiated by Aetna and to abide by Aetna's standards of care. Out-of-network providers may charge more than the reasonable and customary limit since they are not limited to Aetna's negotiated fee schedule. You will be responsible for paying 100% of any portion of out-of-network charges that exceeds the reasonable and customary limit.*

You make your contributions through regular automatic payroll deductions from pre-tax pay, which saves you taxes and reduces your net cost. From time to time, BNSF reviews its costs for providing benefit coverage options and may adjust employee contributions each year.

Annual Deductibles

The annual deductible is the amount that you must pay first each year before the Dental PPO begins paying benefits for basic or major restorative services, or for orthodontia services. You may use money from your Health Savings Account (HSA), Health Reimbursement Account (HRA) or a Health Care Flexible Spending Account (HCFSA) for costs that count toward satisfying the deductible.

There is an individual deductible amount per person and a family maximum deductible amount for the whole family (if you choose coverage for more than just yourself). When the covered family members as a group meet the family deductible during a calendar year, no further deductibles are due from any family members for the rest of that calendar year.

See deductible amounts in the *Schedule of Benefits*.

The following charges do not count toward the annual deductible:

- Charges in excess of the reasonable and customary limit.
- Charges for services and supplies not covered by the Dental PPO.
- Charges that exceed the applicable annual maximum or orthodontia lifetime maximum.

Coinsurance

Coinsurance is the share of expenses that you and the Dental PPO each pay after you meet the annual deductible. Coinsurance amounts are found in the *Schedule of Benefits*. For example, if coinsurance is 80% / 20% for a particular service, the plan pays 80% and you pay 20% of each expense, after you have met your deductible. You have to pay the portion of any out-of-network provider's charge that exceeds the reasonable and customary limit or any amounts in excess of the annual or lifetime maximums.

Lifetime and Annual Maximums

The Dental PPO does not have an overall lifetime maximum benefit. However, orthodontia benefits do have a lifetime maximum benefit of $1,500.

The Dental PPO has an annual maximum benefit for all services (except those for preventive and diagnostic care, and orthodontia services) of $1,500 per person.

Dental PPO Network

Aetna, the Dental PPO's Claims Administrator, has contracted with a broad range of dental care providers and brought them together into the Aetna Dental PPO network. Aetna refers to these providers as Preferred Providers or in-network providers. These providers have agreed to provide you high-quality dental care at discounted contract rates, which saves money for both you and BNSF.

While you are free to use any licensed provider, your cost usually is lower if you use in-network providers. In-network providers have agreed to accept the Aetna fee allowance as payment in full. ***Out-of-network care providers may charge more than the reasonable and customary limit since they are not limited to Aetna's negotiated fee schedule. You are required to pay 100% of any portion the out-of-network provider charges that exceeds the reasonable and customary limit.***

Advance Claim Review (Pre-determination)

You or your dentist should ask the Claims Administrator for an Advance Claim Review (sometimes called Pre-determination) of a course of treatment with expected charges of more than $350, including those for diagnostic X-rays. The review should take place ***before*** dental work has started. If there is a major change in the planned treatment after work begins, you or your dentist should send a revised treatment plan to the Claims Administrator.

During an Advance Claim Review, the Claims Administrator reviews the proposed course of treatment, taking into consideration the *Alternate Benefit Provision* (see below) and estimates the benefits the Dental PPO will pay.

A treatment plan (which may be called a course of treatment) is a planned program of one or more services to treat a dental condition. The dental condition must be diagnosed by your dentist as a result of an oral exam. The treatment can be given by one or more dentists. The course of treatment starts on the date a dentist first provides you services to correct or treat the dental problem.

The benefits payable by the Dental PPO may be a lower amount if an Advance Claim Review is not performed, or if requested information is not provided. Benefits are reduced by the amount of covered expenses the Claims Administrator cannot verify.

Advance Claim Review

Whether you use an in-network or out-of-network dentist, it is your responsibility to confirm that your dentist has completed an Advance Claim Review (Pre-determination) with the Claims Administrator, Aetna, when required. This assures that you receive the highest benefits available. In most cases, in-network dentists request an Advance Claim Review automatically, but ***it is ultimately your responsibility to be sure this occurs***. The Advance Claim Review will tell you and your dentist what services will be covered by the Dental PPO and what benefits will be paid.

Alternate Benefit Provision

Benefit When Multiple Treatments Are Suitable

When more than one dental service could provide suitable treatment based on common dental standards, the Claims Administrator determines which dental services are covered by the Dental PPO. Benefits are provided for treatment that meets accepted dental standards for adequate and appropriate care, but this may differ from the services your dentist proposes. You and your dentist are free to apply the benefit paid by the Dental PPO toward the cost of your choice of treatment. However, you are responsible for expenses that are not covered. Expenses that exceed the covered expenses when a standard alternate treatment is available do not count toward the Dental PPO deductible.

Claims Administrator Review and Verification

The Claims Administrator has the right to require an oral exam, at no cost to you, as proof the course of treatment was completed. You also are required to authorize your dentist to supply information, including X-rays, on your course of treatment.

COMPREHENSIVE DENTAL COVERAGE – COVERED EXPENSES

Dental PPO Providers

If you choose to use a Dental PPO in-network provider, you probably will pay less for dental services compared to using out-of-network providers. Dental PPO in-network providers bill their services at negotiated network rates. You are responsible for paying any required deductible and coinsurance.

To find in-network providers, go to aetna.com and click Find a Doctor. Choose Dental Providers in the Provider Category. In the Plan drop-down box, select PPO/PDN with PPO II Network. The directory is also available at digital.alight.com/BNSF. You may also contact Aetna Member Services at 877-238-6200 to ask about in-network providers.

If you choose to use an out-of-network provider, the Dental PPO pays benefits based on the reasonable and customary cost of the dental service. A charge is considered reasonable and customary if the Claims Administrator determines it does not exceed the normal charge made by most out-of-network dental providers in the geographic region. If you use an out-of-network provider, you will be required to pay 100% of any portion of charges that exceeds the reasonable and customary limit.

Definition of Covered Dental Treatment

The Dental PPO pays benefits for covered expenses incurred when the dental treatment or service is:

- Necessary,
- Customarily used nationwide,
- Appropriate and meets broadly accepted national standards of dental practice, and
- Performed or started while the patient is covered under the Dental PPO.

A dental treatment or service is started when the actual treatment or service begins, except for:

- Fixed bridgework and full or partial dentures – starts when the first impressions are taken and/or abutment teeth are fully prepared;
- A crown, inlay or onlay – starts on the first date of preparation of the tooth involved; and
- Root canal therapy – starts when the pulp chamber of the tooth is opened.

Preventive and Diagnostic Care Services

Expenses for the following preventive care and diagnostic services by a Dental PPO in-network dentist are covered at 100% with no deductible. Charges by an out-of-network dentist are covered at 100% of the charge, up to the reasonable and customary limit, with no deductible.

- Clinical oral examination – limited to twice per calendar year.
- X-rays (complete series) including panoramic film – limited to once in any three calendar years.
- Bitewing X-rays – limited to twice per calendar year.
- Vertical bitewing X-rays – limited to one set every three calendar years.

- Panoramic (Panorex) X-ray – limited to once every three calendar years.
- Periapical X-rays – limited to 13 per calendar year.
- Prophylaxis (cleaning) – limited to twice per calendar year.
- Topical application of fluoride (excluding prophylaxis) – limited to persons younger than age 18; one application per calendar year.
- Topical application of sealant, per tooth, on permanent molars only – limited to persons younger than age 18; one treatment per tooth in any three calendar years.
- Space maintainers, fixed or removable, unilateral or bilateral – limited to non-orthodontic treatment including all adjustments within six months after installation.

Basic Restorative Care Services

Expenses for the following basic restorative care services by a Dental PPO in-network dentist are covered at 80% after you meet your deductible. Charges by an out-of-network dentist are covered at 80% of charges, up to the reasonable and customary limit, after you meet your deductible.

Visits and Exams

- Office visit.
- Emergency treatment, per visit.

X-Ray and Pathology

- Intra-oral occlusal view, maxillary or mandibular.
- Upper or lower jaw, extra-oral.
- Biopsy and histopathologic examination of oral tissue.

Oral Surgery

- Extractions, uncomplicated, and surgical removal of erupted tooth/root tip.
- Impacted teeth: removal of tooth (soft tissue).
- Impacted teeth: removal of tooth (partially or completely bony).
- Odontogenic cysts and neoplasms incision and drainage of abscess; removal of odontogenic cyst or tumor.
- Other surgical procedures:
  - Alveoplasty – per quadrant.
  - Sialolithotomy: removal of salivary calculus.
  - Closure of salivary fistula.
  - Excision of hyperplastic tissue.
  - Removal of exostosis.
  - Transplantation of tooth or tooth bud.
  - Closure of oral fistula of maxillary sinus.

- Sequestrectomy.
- Crown exposure to aid eruption.
- Removal of foreign body from soft tissue.
- Frenectomy.
- Suture of soft tissue injury.
- General anesthesia and intravenous sedation – only when provided in conjunction with a covered surgical procedure.

Periodontics

- Emergency treatment (periodontal abscess, acute periodontitis, etc.).
- Occlusal adjustment (other than with an appliance or by restoration).
- Subgingival curettage or root planing and scaling, per quadrant, limited to four separate quadrants every two years.
- Gingivectomy (including post-surgical visits) per quadrant, limited to one per quadrant every three years.
- Gingivectomy, treatment per tooth (fewer than three teeth), limited to one per site, every three years.
- Gingival flap procedure, including root planing, per quadrant, limited to one per quadrant, every three years.
- Periodontal maintenance procedures, limited to two per year following history of periodontal therapy.
- Full-mouth debridement (removal of unhealthy tissue), limited to once per lifetime.
- Crown lengthening.
- Osseous surgery (including post-surgical visits), per quadrant, limited to one per quadrant, every three years.
- Localized delivery of antimicrobial agents.

Endodontics

- Pulp capping.
- Pulpotomy.
- Apexification / recalcification.
- Apicoectomy.
- Root canal therapy, including necessary X-rays (anterior, bicuspid and molars).

Restorative Dentistry

Excludes inlays, crowns (other than prefabricated stainless steel or resin crowns) and bridges. Multiple restorations in one surface are considered as a single restoration.

- Amalgam restorations – primary teeth.
- Amalgam restorations – permanent teeth.
- Resin restorations – anterior teeth.
- Sedative fillings.
- Pins – pin retention, per tooth, in addition to amalgam or resin restoration.
- Crowns (when tooth cannot be restored with a filling material), limited to prefabricated stainless steel or prefabricated resin crown (excluding temporary crowns).
- Recementation – inlay, crown and bridge.
- Repairs – crowns and bridges.

Major Restorative Care Services

Expenses for the following major restorative care services by a Dental PPO in-network dentist are covered at 50% after you meet your deductible. Charges by an out-of-network dentist are covered at 50% of the charge, up to the reasonable and customary limit, after you meet your deductible.

Restorative

Cast or processed restorations and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.

- Inlays / onlays – metallic or porcelain/ceramic.
  - Inlay – one or more surfaces.
  - Onlay – two or more surfaces.
- Inlays / onlays – resin.
  - Inlay – one or more surfaces.
  - Onlay – two or more surfaces.
- Labial veneers.
  - Laminate – chairside.
  - Resin laminate – laboratory.
  - Porcelain laminate – laboratory.
- Crowns (including crown build-ups).
  - Resin; resin with noble metal; resin with base metal.
  - Porcelain; porcelain with noble metal; porcelain with base metal.
  - Base metal (full cast); noble metal (full cast).

- Metallic (3/4 cast).
- Post and core.

Prosthodontics

- Bridge abutments.
- Pontics.
  - Both base and noble metal (full cast).
  - Porcelain with either base or noble metal.
  - Resin with either base or noble metal.
- Removable bridge (unilateral). One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics.
- Dentures and partials. (Expenses for dentures and partial dentures include relines, rebases and adjustments within six months after installation. Expenses for relines and rebases include adjustments within six months after installation. Specialized techniques and characterizations are not covered.)
  - Complete upper and lower denture.
  - Partial upper or lower resin base.
  - Partial upper or lower cast metal base with resin saddles.
  - Stress breakers.
  - Interim partial denture (stayplate), anterior only.
  - Office reline.
  - Laboratory reline.
  - Special tissue conditioning, per denture.
  - Rebase, per denture.
  - Adjustment to denture more than six months after installation.
- Full and partial denture repairs, including broken dentures (no teeth involved); repair cast framework; replacing missing or broken teeth, each tooth.
- Adding teeth to existing partial denture – each tooth; each clasp.
- Implants.
- Occlusal guard (for bruxism only), limited to one every three years.

Limitation – Replacement Rule

The replacement of, addition to or modification of existing dentures, crowns, casts or processed restorations, or removable or fixed bridgework is covered only if:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. You must have been covered by the Dental PPO or DMO when the extraction took place.

- The existing denture, cast, or processed restoration or bridge cannot be made serviceable and was installed at least five years prior to the replacement.
- The existing denture is an immediate temporary one to replace one or more natural teeth extracted while you are covered under the Dental PPO or DMO, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

Orthodontia

Expenses for the following orthodontia services for eligible children by a Dental PPO in-network dentist are covered at 50% after you meet your deductible. Charges by an out-of-network dentist are covered at 50% of the charge, up to the reasonable and customary limit, after you meet your deductible. To be covered, orthodontic treatment must begin before the child reaches age 19.

- Comprehensive orthodontic treatment.
- Interceptive orthodontic treatment.
- Limited orthodontic treatment.
- Post-treatment stabilization.
- Removable inhibiting appliance to correct thumbsucking.
- Fixed or cemented inhibiting appliance to correct thumbsucking.

GENERAL EXCLUSIONS

Expenses that Are Not Covered

The following are not covered under the Dental PPO:

- Any dental services and supplies that are covered in whole or in part under any other program in the BNSF Group Benefits Plan.
- Services and supplies to diagnose or treat a disease or injury resulting from, or in the course of, any employment for wage or profit, except for salaried employees injured while performing duties for BNSF.
- Replacement of lost, missing or stolen appliances, and replacement of appliances that have been damaged due to abuse, misuse or neglect.
- Dentures, crowns, inlays, onlays, bridgework or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion or to correct attrition, abrasion or erosion.
- Services intended for treatment of any jaw joint disorder. *Note that treatment of jaw joint disorders may be included under your medical coverage.* (A jaw joint disorder is a temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint; a myofacial pain dysfunction (MPD); or any similar disorder in the relationship between the jaw joint and the related muscles and nerves.)
- Orthodontic treatment, except as specifically provided.
- General anesthesia and intravenous sedation, unless done in conjunction with a necessary covered service.

- Treatment by someone other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
- A crown, cast or processed restoration unless:
  - It is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
  - The tooth is an abutment to a covered partial denture or fixed bridge.
- Pontics, crowns, cast or processed restorations made with high noble metals[6], except as specifically provided.
- Surgical removal of impacted wisdom teeth only for orthodontic reasons, except as specifically provided.
- Services needed solely in connection with services not covered under the Dental PPO.
- Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.
- Services and supplies that are not necessary, as determined by the Claims Administrator, for the diagnosis, care or treatment of the disease or injury involved. This applies even if they are prescribed, recommended or approved by your attending physician or dentist.
- Care, treatment, services or supplies that are not prescribed, recommended or approved by your attending physician or dentist.
- Services or supplies for, or in connection with, treatment that is determined to be experimental or investigational by the Claims Administrator. A drug, device, procedure or treatment is determined to be experimental or investigational if:
  - There is insufficient outcome data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
  - Required approval for marketing has not been granted by the FDA;
  - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
  - If any of the following state that a procedure or service is experimental, investigational or for research purposes:
    - Written protocol or protocols used by the treating facility;
    - The protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment; or
    - The written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment.

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[6] *High noble metal means an alloy that contains more than 60% gold, palladium and/or platinum (with at least 40% gold).*

- Services of a resident physician or intern rendered in the capacity of a resident physician or intern.
- Charges that are made only because there is dental coverage.
- Charges that you are not legally obligated to pay.
- To the extent allowed by the law of the applicable jurisdiction, charges for services and supplies furnished, paid for or for which benefits are provided or required:
  - By reason of past or present service in the armed forces of a government.
  - Under any law of a government. (This exclusion does not apply to no-fault auto insurance if it is required by law, is provided on other than a group basis and is included in the definition of Other Plan in the *Coordination with Other Plans Except Medicare* section of the *Claims Procedures* chapter of this SPD. In addition, this exclusion does not apply to a plan established by a government entity for its own employees or their dependents or to Medicaid.)
- Routine dental exams or other preventive services and supplies, except to the extent coverage for those exams, services or supplies is specifically provided under the Dental PPO.
- Acupuncture therapy, except acupuncture performed by a physician as a form of anesthesia in connection with surgery that is covered under the Dental PPO.
- A service or supply furnished by an in-network provider in excess of that provider's negotiated charge for the service or supply. This exclusion does not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the Dental PPO are paid.
- Plastic surgery, reconstructive surgery, cosmetic surgery or other services and supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to repair an injury. Facings on molar crowns and pontics are considered cosmetic, so they are excluded from coverage.
- Charges to the extent that they are not recognized charges as determined by the Claims Administrator.
- Any other services noted as not covered.

Any exclusion above does not apply to the extent that coverage of the expenses is required under any law.

Excluded expenses are not used in determining benefits payable by the Dental PPO.

The jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they are not paid.

OTHER INFORMATION

Expenses Covered Only While Coverage Is in Effect

The Dental Program will pay benefits only for eligible expenses incurred while your coverage is in effect. No benefits are payable for expenses incurred before coverage has begun or after coverage has ended. This applies even if the expenses were incurred as a result of an accident, injury or disease which occurred, began or existed while coverage was in effect. An expense for a service or supply is incurred on the date the service or supply is furnished. See the *Comprehensive Dental Coverage – Covered Expenses* section for limited exceptions to this provision.

Charge for Multiple Services

When a single charge is made for a series of services, each service will bear a proportional share of the total expense. The amount of that share will be determined by the Claims Administrator and only that amount will be considered incurred on the date of the service.

Limit of Claims Administrator's Responsibility

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

WHO TO CALL ABOUT YOUR BENEFITS

For questions about eligibility for coverage or enrollment in the Dental Program, 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.

For questions about covered expenses or claims under the Dental PPO or DMO options, call Aetna Member Services at 877-238-6200.

DEFINED TERMS

About These Terms

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

Some definitions apply in a special way to specific benefits. 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.

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.

Advance Claim Review – Also called pre-determination. See related section of this chapter.

Alternate benefit provision – See related section of this chapter.

Annual maximum benefit – The greatest amount of benefits (exclusive of orthodontia benefits) the program will pay for a person in a calendar year. See related section of this chapter for amounts.

Basic restorative services – See related section of this chapter.

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

Coinsurance – Percentage of the eligible expenses that you and the Dental Program each pay after the deductible (if any) is met.

Copayment – The set dollar amount you pay each time you receive a specific service.

Covered dental treatment – See related section of this chapter.

Deductible – The amount of eligible expenses you must pay each year before the Dental Program begins to pay benefits. See related section of this chapter.

Endodontics – The branch of dentistry dealing with the cause, diagnosis, prevention and treatment of diseases of the dental pulp, usually by removal of the nerve and other tissue of the pulp cavity, and its replacement with suitable filling material; pulp canal therapy; root canal therapy.

Jaw joint disorder – A jaw joint disorder is a temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint; a myofacial pain dysfunction (MPD); or any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Lifetime maximum benefit – The greatest amount of benefits the program will pay for a person in a lifetime. See related section of this chapter for amounts.

Major restorative services – See related section of this chapter.

Orthodontia – Braces and related services for straightening teeth. See related section of this chapter.

Periodontics – The branch of dentistry that deals with diseases of the supporting and investing structures of the teeth including the gums.

Pre-determination – See Advance Claim Review.

Preventive and diagnostic services – See related section of this chapter.

Prosthodontics – The branch of dentistry that deals with the restoration and maintenance of oral function by the replacement of missing teeth and other oral structures by artificial devices.

Reasonable and customary limit – The normal charge made by most out-of-network dental providers in your geographic region, as determined by Aetna's recognized charge as explained below.

Recognized Charge

Only that part of a charge that is less than or equal to the recognized charge is covered. The recognized charge for a service or supply is the lowest of:

- The provider's usual charge for furnishing it;
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded; or the provider charge data from the Optum Insight, Inc. Prevailing Healthcare Charges System (PHCS) at the 80th percentile of PHCS data. This PHCS data is generally updated at least every six months.
- The charge Aetna determines to be the usual charge level made for it in the geographic area where it is furnished.

In determining the recognized charge for a service or supply that is:

- Unusual,
- Not often provided in the geographic area, or
- Provided by only a small number of providers in the geographic area,

Aetna may take into account factors, such as the:

- Complexity,
- Degree of skill needed,
- Type of specialty of the provider,
- Range of services or supplies provided by a facility, and
- Recognized charge in other geographic areas.

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

Replacement rule – See related section of this chapter.