BNSF RAILWAY

MEDICAL PROGRAM FOR PRE-MEDICARE RETIREES

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CONTENTS

BNSF MEDICAL PROGRAM FOR PRE-MEDICARE RETIREES

The Big Picture

An Overview of the Medical Program Options

Effective January 1, 2014

MEDICAL PROGRAM OPTIONS IN BRIEF

	Option 1	Option 2
Deductible[1]	$1, 500 you only or $3,000 family.[2]	$3,000 you only or $6,000 family.[2]
Maximum HSA Contributions You May Make	• Up to $3,300 retiree only or $6,550 family. • If age 55 or older, you may make additional, tax-deductible "catch-up contributions" of up to $1,000/year.[3]	
Medical Coinsurance (BNSF / You)	Expenses other than prescription drugs and supplies: • In-network: 80% / 20%. • Out-of-network: 60% / 40%.	
Prescription Drug Benefit *See expanded summary.*	• For most prescription drugs: Benefits are paid after your covered medical and prescription drug expenses meet the deductible. You then pay a fixed copayment or coinsurance percentage. • Special benefit for specific preventive medications targeting certain risk factors: No deductible applies. You pay a fixed copayment or coinsurance percentage. • Certain preventive products: Covered at 100%. • Brand-name drugs: If you choose to use a brand-name drug when a generic is available, you will pay the cost difference (unless the brand-name is required by your doctor). The difference will not apply to your deductible or out-of-pocket maximum.	
Your Coinsurance Maximum	• In-network: $2,000 you only or $4,000 family. • Out-of-network: $4,000 you only or $8,000 family.	
Your Out-of-Pocket Maximum	• In-network: $3, 500 you only or $7,000 family.[4] • Out-of-network: $5,500 you only or $11,000 family.[4]	• In-network: $5,000 you only or $10,000 family.[4] • Out-of-network: $7,000 you only or $14,000 family.[4]

[1] *The deductible applies to all medical and prescription drug expenses, except preventive care services and specific preventive medications targeting certain risk factors.*

[2] *If you choose coverage for any dependents, you must meet the full family deductible before the Program begins paying benefits for anyone in the family. (The deductible does not apply to preventive care services and specific preventive medications targeting certain risk factors.)*

[3] *Your spouse age 55 or older may make "catch-up contributions" to his or her own separate HSA.*

[4] *If you choose coverage for any dependents, your portion of all covered expenses must reach the family out-of-pocket maximum before the Program begins paying 100 percent coinsurance. Eligible expenses for all enrolled members of the family are paid at 100 percent for the remainder of the calendar year.*

To Medical Program Table of Contents *To Defined Terms*

MEDICAL EXPENSES – WHAT'S COVERED UNDER THE MEDICAL PROGRAM FOR PRE-MEDICARE RETIREES, IN BRIEF

The Medical Program for Pre-Medicare Retirees offers broad coverage of health care expenses, including those listed below. The *Schedule of Benefits* shown later in this Medical Program chapter provides a detailed listing of the Program's coverage.

Please note that certain limitations, exclusions and penalties may apply to coverage of some of these expenses. For specific information, refer to the sections of this Medical Program chapter titled *Important Rules and Administrative Information in Brief* and *General Exclusions*.

- Physician expenses:
  - Doctor office services
  - Surgeon services
  - Anesthesiologist services
  - Radiologist services
  - Pathologist services
- Prescription drug expenses:
  - Retail pharmacy services
  - Mail-order pharmacy services
- Inpatient hospital expenses:
  - Semi-private room and board
  - Ancillary hospital services
  - Physician services
- Outpatient facility expenses:
  - Services and supplies
  - Laboratory and X-ray testing
  - Therapy
  - Surgery, including charges by a surgery center
  - Emergency room services
  - Urgent care center services
  - Physician services
- Convalescent or skilled nursing facility expenses:
  - Semi-private room and board
  - Services and supplies
- Home health care expenses
- Preventive care expenses:
  - Physician services
  - Laboratory testing
  - Immunizations

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

Previous view: Return to the 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.

- Skilled nursing or private-duty nursing care expenses
- Hospice care expenses
- Contraception expenses
- Infertility services expenses
- Outpatient short-term rehabilitation expenses
- Chiropractor care expenses
- Durable medical and surgical equipment expenses
- Complex imaging expenses
- Other medical expenses:
  - Diagnostic lab and radiology services
  - Radiation and other therapy
  - Professional ambulance service
  - Artificial limbs and eyes

HOW YOUR MEDICAL PROGRAM COVERAGE WORKS IN BRIEF

Financial Protection

Health care benefits at BNSF help shield you from the unexpected burden of major medical expenses. A good way to control your share of medical expenses is to take full advantage of the Medical Program's preventive care benefits, such as those for annual physical exams and preventive medications.

In addition, using in-network providers helps you control expenses, since your in-network coinsurance is significantly less than for out-of-network services. Also note that eligible out-of-network expenses are limited to the reasonable and customary amount set by the Claims Administrator. You are responsible for paying any charges over that amount.

Shared Cost

You and BNSF share in the cost of your coverage. The Medical Program for Pre-Medicare Retirees is self-insured by BNSF, meaning the company pays its share of costs from its general revenues. You pay your part through monthly billing or regular automatic deductions from your BNSF Retirement Plan pension.

Your cost depends on how much you use medical services, the deductible option you select, and the family members you include under your coverage. See *How Your Medical Program Coverage Works* in this chapter for more information.

Deductible, Coinsurance and Copayments

The covered medical expenses that you have paid on your own for doctor visits, prescription drugs and other expenses first must reach the annual deductible before the Medical Program begins paying benefits.[5]

Once you meet the deductible, the Medical Program begins paying a portion of your covered medical expenses and you pay a smaller portion. This is called coinsurance. Note that if your coverage includes any dependents, you must meet the full family deductible before coinsurance kicks in. This amount may be reached by one family member or a combination of family members' expenses.

A copayment (or copay) is a fixed amount that you pay for a service. Under the Medical Program, only generic prescription drugs have a copay.

Coinsurance Maximum and Out-of-Pocket Maximum

You must meet the full family deductible before the Program pays coinsurance benefits for any family member.

The Medical Program limits your overall financial risk for covered expenses. If you have met your deductible, and the amount of copays and coinsurance you have paid reaches the coinsurance maximum, you have also reached the annual out-of-pocket maximum. At that point, your Medical Program coverage begins paying 100 percent of your remaining eligible expenses (including prescriptions) for the rest of the calendar year. ***Note that if your coverage includes any dependents, you must meet your full family deductible, and your copays and coinsurance must reach the full family coinsurance maximum, before the Program begins paying expenses at 100 percent.***[6]

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[5] *Not subject to the deductible are: (1) Eligible preventive care expenses, which are covered at 100 percent, and (2) Specific preventive medications targeting certain risk factors, for which you pay only a fixed copay or coinsurance. Your share of covered expenses for specific preventive prescription drugs counts toward your annual deductible, annual coinsurance maximum and annual out-of-pocket maximums.*

[6] *If you cover any dependents, your portion of all covered expenses must reach the family out-of-pocket maximum before the Program begins paying 100 percent coinsurance. Eligible expenses for all enrolled members of the family are paid at 100 percent for the remainder of the calendar year.*

Health Savings Account (HSA) and Leftover Health Reimbursement Account (HRA) Balances

Your Medical Program coverage, which qualifies as a high-deductible health plan under Internal Revenue Service (IRS) rules, includes voluntary access to a Health Savings Account (HSA).[7] You may choose to make tax-deductible contributions to your HSA, up the annual limit set by the Internal Revenue Service (IRS), then reimburse yourself from the account for eligible out-of-pocket expenses, including your copays, your coinsurance and other expenses that count toward your deductible. The tax savings help reduce your cost for health care, and the HSA is yours to keep, even after your BNSF coverage for pre-Medicare retirees ends.

When you are enrolled in the Medical Program with an HSA, certain limits apply to your use of any balance remaining in a BNSF Health Reimbursement Account (HRA). (Certain participants accrued HRA balances under previous program provisions.) Under federal and Medical Program rules, that leftover HRA is a Limited Purpose HRA, which can be used only for reimbursement of eligible dental, orthodontia and vision care expenses.[8]

> ***HSA Unavailable to Certain Participants***
> Due to IRS rules, retirees enrolled in a government-sponsored health plan such as TRICARE or VA cannot participate in an HSA. If this applies to you, and you have a balance remaining in a BNSF HRA, you may continue to use that balance for eligible expenses as long as you are covered by a BNSF Medical Program.

For more information about the cash accounts, see the chapter of this Summary Plan Description (SDP) titled *Overview of Medical Options and Cash Accounts*. You may also call PayFlex at 800-284-4885.

Freedom to Use In-Network or Out-of-Network Providers

When you enroll, you may choose either the Aetna or the BlueCross BlueShield (BCBS) provider network for your in-network care. When you go to a physician (medical doctor), hospital or other health care provider, you have the freedom to choose either an in-network or out-of-network provider. An Aetna in-network provider (which Aetna calls a Preferred Provider) is a member of the Aetna Choice POS II (Open Access) network. A BCBS in-network provider (which BCBS calls a Participating PPO Provider) is a member of the BCBS PPO network. In-network providers have agreed to the network Claims Administrator's standards of care and to charge fees negotiated by the Claims Administrator. This usually results in lower overall costs for you.

For most types of out-of-network care you pay a greater coinsurance percentage. In addition, an out-of-network provider is not limited to the Claims Administrator's negotiated fee schedule. You will be responsible for paying the portion of any charge that exceeds the reasonable and customary limit.

You are free to see a specialist without a referral from an in-network doctor.

In-network Physician

You are not required to designate an in-network primary physician from your Aetna or BCBS network. However, it's to your advantage to choose an in-network doctor to provide your preventive and primary care. By getting to know you and your health profile, your primary physician is well positioned to see the "whole picture" of your health care needs and to coordinate appropriate treatment and medications. In addition, your in-network physician can assist you with referrals to in-network specialists.

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[7] *Unless you are also enrolled in TRICARE or Veterans Administration (VA) coverage. See* HSA Unavailable to Certain Participants *on this page.*

[8] *These limitations do not apply to HRA balances of participants who are also enrolled in a government-sponsored health plan such as TRICARE or VA. For those participants, the account is a General Purpose HRA.*

Preventive Care

Routine medical tests and immunizations are key to maintaining good health and preventing potential health problems. That's why the Medical Program offers periodic physical exams and certain preventive products at no cost to you. In addition, the Medical Program covers expenses for specific preventive medications targeting certain risk factors. See the *Preventive Care Services* section of this Medical Program chapter for details.

Prescription Drugs (Rx)

Coverage of prescription drugs is integrated into your Medical Program coverage. As a result, the prescription expenses you pay are credited to the deductible that applies to all other medical expenses. Once your share of expenses for all eligible medical services – including prescription drugs and supplies – reaches your deductible, benefits begin (see the following exception for specific preventive medications).

In-network coverage is provided through the Caremark network of retail pharmacies. In addition, maintenance prescription drugs are available through Caremark's mail-order service. Details are in the *Prescription Drugs* section, later in this Medical Program chapter.

Special Benefit for Specific Preventive Medications

The Medical Program provides special coverage of specific preventive medications targeting certain risk factors, such as listed drugs for asthma, diabetes, heart disease, control of cholesterol and blood pressure, osteoporosis, stroke prevention and tobacco cessation. You pay only a fixed copay or coinsurance percentage and no deductible applies. (See the *Schedule of Benefits* in this Medical Program chapter.) Amounts you pay for these specific preventive medications count toward your annual deductible, annual coinsurance maximum and annual out-of-pocket expense maximum.

Benefit Claims

One of the many advantages of using in-network providers is that the provider usually will file your claim for you automatically, saving you time and effort. You may have to file your own claims if you use an out-of-network provider.

Rules for Filing Claims and Appeals

The Medical Program has rules for the filing of claims, such as time limits and the information required. It also includes a process for you to appeal claims decisions. Details are in the chapter of this Summary Plan Description (SPD) titled *Claims Procedures – Medical and Vision Care Programs for Pre-Medicare Retirees*.

IMPORTANT RULES AND ADMINISTRATIVE INFORMATION IN BRIEF

Advance Confirmation of Coverage and Amount for Benefits Payable

- ***Pre-certification (by Aetna) or pre-notification (by BCBS) of coverage***
- ***Pre-authorization (by Aetna) or pre-determination (by BCBS) of expenses***

To be sure you will receive full benefits under the Medical Program for ***any hospital or facility admissions, as well as certain procedures, services and treatments, you must follow the Aetna pre-certification or BCBS pre-notification process before expenses occur.***

Your health care provider may assist you by requesting pre-certification (if you are in an Aetna option) or pre-notification (if you are in a BCBS option). However, ***it is always your responsibility to confirm*** that Aetna or BCBS has approved your pre-certification / pre-notification. If you are not certain that your provider has done this, call the Member Services number on your ID card to ask.

Also, you are strongly encouraged to ask your provider to request the separate ***pre-authorization of benefits payable from Aetna or pre-determination of benefits payable from BCBS*** for ***all hospital and facility admissions, as well as certain procedures, services and treatments*** so you can be certain of how benefits will be paid before you begin incurring expenses.

For details of these processes, see the section of this Medical Program chapter titled *Pre-certification / Pre-notification and Pre-authorization / Pre-determination of Expenses*.

Benefits Under Other Plans

Due to IRS "dual coverage" rules, when you participate in medical coverage that includes making contributions to an HSA (such as the BNSF Medical Program), you – the retiree – cannot simultaneously participate in another plan that pays for medical expenses, unless the other plan also has an HSA. For Medical Program claims and administrative purposes, *you are considered to be an HSA participant even if you do not set up an account* with the HSA Administrator.[9]

This means retirees who have any other medical coverage are not eligible for coverage under the Medical Program, unless the other plan also has an HSA. "Other medical coverage" includes your enrollment in your spouse's employer-sponsored medical coverage as well as in a spouse's Health Care Flexible Spending Account (HCFSA). The BNSF Medical Program will not coordinate its benefits for the retiree with the other plan's benefits unless the other plan includes an HSA or is TRICARE or Veterans Administration (VA) coverage.

However, your dependents can be covered by both the BNSF Medical Program and other medical coverage, and the Medical Program will coordinate benefits for dependents of retirees who are covered by other plans. For details, see *Coordination with Other Plans Except Medicare* in the chapter of this SPD titled *Claims Procedures – Medical and Vision Care Programs for Pre-Medicare Retirees*.

Expenses Owed by Other Parties

Occasionally, other parties are responsible for your medical expenses – for example, if you are injured in an auto accident and another driver is at fault. Your BNSF Medical 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 chapter of this SPD titled *Claims Procedures – Medical and Vision Care Programs for Pre-Medicare Retirees*.

[9] *This provision does not apply if the HSA is unavailable to you because of your enrollment in a government-sponsored health plan such as TRICARE or VA.*

When Coverage Begins

Coverage under the Medical Program as a retiree generally begins on the first of the month after your active employment ends if you enroll within 31 days. For specific information, refer to the chapter of this SPD titled *Who Is Eligible and How to Enroll in the Medical and Vision Care Programs for Pre-Medicare Retirees*.

When Coverage Ends

Coverage ends for a dependent when he or she is no longer eligible. Your coverage under this Medical Program for Pre-Medicare Retirees ends when you become eligible for Medicare or die. If a covered dependent loses coverage due to his or her loss of dependent eligibility, he or she may choose to continue coverage by paying the full cost. For more information, please see the chapters of this SPD titled *When Coverage Ends – Medical and Vision Care Programs for Pre-Medicare Retirees* and *Continuing Health Care Coverage Under COBRA – Medical and Vision Care Programs for Pre-Medicare Retirees*.

General and Administrative Information

This SPD contains detailed information, including your privacy rights, which may assist you in using your Medical Program coverage. For details, refer to the chapters of this SPD titled *General Information About Your Right to Benefits – BNSF Retirees* and *Administrative Information – Medical and Vision Care Programs for Pre-Medicare Retirees*.

Your ERISA Rights

A federal law, ERISA, gives you important rights that are described in the chapter of this SPD titled *Your Rights Under ERISA – Medical and Vision Care Programs for Pre-Medicare Retirees*.

Coverage Details

Medical Program Options

SCHEDULE OF BENEFITS

Note that the "family" rows are for coverage levels of "you + spouse," "you + child(ren)" and "you + family," and those rows apply to the entire family.

BENEFITS	Aetna or BCBS Option 1		Aetna or BCBS Option 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Medical Program Lifetime Maximum Benefit	Unlimited		Unlimited	
Deductible[10] *(per calendar year)*				
• **You only**	$1, 500		$3,000	
• **Family**	$3,000		$6,000	
Preventive Care Services *(when provided by physician; see preventive care prescription benefit below)*	100% (no deductible, no coinsurance)		100% (no deductible, no coinsurance)	
Coinsurance	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Coinsurance Maximum[11] *(per calendar year)*				
• **You only**	$2,000	$4,000	$2,000	$4,000
• **Family**	$4,000	$8,000	$4,000	$8,000
Out-of-Pocket Maximum[11] *(per calendar year)*				
• **You only**	$3,500	$5,500	$5,000	$7,000
• **Family**	$7,000	$11,000	$10,000	$14,000
Inpatient Hospital and Facility Admissions and Services[12]	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Procedures and Treatments[13]	80% after deductible	60% after deductible	80% after deductible	60% after deductible

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[10] *Deductible expenses count toward satisfying both the in-network and out-of-network deductibles simultaneously.*

[11] *Copays and coinsurance you pay for out-of-network services count toward both the in-network and out-of-network coinsurance maximum. Copays and coinsurance you pay for in-network services count only toward the in-network coinsurance maximum.*

[12] *Aetna pre-certification or BCBS pre-notification required.*

[13] *Aetna pre-certification or BCBS pre-notification required for certain outpatient procedures and treatments.*

BENEFITS	Aetna or BCBS Option 1		Aetna or BCBS Option 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Emergency Hospital, Physician and Ambulance	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Urgent Care Facility	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Physician Office Visit *(except routine prenatal care is covered at 100% in-network; no deductible)*	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Chiropractor Care *(limited to 60 visits per calendar year)*	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment (DME)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Occupational / Physical / Speech Therapy *(limited to 60 visits per therapy per calendar year)*	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Convalescent or Skilled Nursing Facility Care *(limited to 60 days per year)*[14]	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Skilled Nursing Care *(private duty nursing limited to 70 shifts/visits per year)*[15]	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Home Health Care *(limited to 40 visits per year)*[14]	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Infertility Treatment Services[16]	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Family Planning Expenses • Tubal ligation and associated ancillary services for females	100% (no deductible, no coinsurance)	60% after deductible	100% (no deductible, no coinsurance)	60% after deductible
• Other	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Other Covered Services[17]	80% after deductible	60% after deductible	80% after deductible	60% after deductible

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[14] *Aetna pre-certification or BCBS pre-notification required.*
[15] *Aetna pre-certification or BCBS pre-notification required for certain outpatient procedures and treatments.*
[16] *Coverage of infertility treatment services are limited as noted in the following sections of this Medical Program chapter: Infertility Treatment Expenses, Prescription Drug Benefits and Expenses That Are Not Covered.*
[17] *Aetna pre-certification or BCBS pre-notification may be required for certain expenses.*

Prescription Drugs **Benefits apply to BOTH Coverage Option 1 and Option 2**		
	In-Network (Caremark)	**Out-of-Network**
Specific Preventive Medications Targeting Certain Risk Factors *(retail and mail order)*	No deductible. You pay only copay or coinsurance amounts shown below.	No deductible. You pay amounts shown below.
Other Prescription Drugs ***Retail***	After you meet the annual deductible, you pay:	After you meet the annual deductible, you pay these amounts plus any difference between the actual out-of-network charge and the amount that would have been charged by an in-network pharmacy:
• **Generic** – Up to 34-day supply	$7.50 (or actual cost, if less)	$7.50 (or actual cost, if less)
– Up to 90-day supply if purchased at CVS pharmacies	$15 (or actual cost, if less)	N/A
• **Formulary brand** – Up to 34-day supply	25% (min. $25, max. $100)[18]	25% (min. $25, max. $100)[18]
– Up to 90-day supply if purchased at CVS pharmacies	25% (min. $50, max. $200)[18]	N/A
• **Non-formulary brand** – Up to 34-day supply	40% (min. $40, max. $125)[18]	40% (min. $40, max. $125)[18]
– Up to 90-day supply if purchased at CVS pharmacies	40% (min. $80, max. $250)[18]	N/A
Mail order *(up to 90-day supply)*	After you meet the annual deductible, you pay:	Not covered.
– Generic	$15.00 (or actual cost, if less)	
– Formulary brand	25% (min. $50, max. $200)[18]	
– Non-formulary brand	40% (min. $80, max. $250)[18]	

[18] *If you choose to use a brand-name drug when a generic is available, you will pay the cost difference (unless the brand-name is required by your doctor). The difference will not apply to your deductible or out-of-pocket maximum.*

HOW YOUR MEDICAL PROGRAM COVERAGE WORKS

Your Contributions for Coverage

The contributions required for each Medical Program coverage option are included with your annual enrollment or newly eligible enrollment materials. The amount of your contribution is determined by the coverage level (such as you only, you + spouse, etc.) and the option you select.

You make your contributions through monthly billing or regular automatic deductions from your BNSF Retirement Plan pension. BNSF regularly reviews the overall cost of medical benefit claims and may adjust the required retiree contributions each year.

Annual Deductibles

The annual deductible is the amount that you must pay each year before your coverage begins paying benefits. You may use money from an HSA to pay expenses that satisfy the deductible. (If you have a balance remaining in a General Purpose HRA because you are enrolled in a government-sponsored health care plan such as TRICARE or VA, you may use that account to pay expenses that satisfy your deductible.)

No deductible applies to certain preventive care services that are covered at 100 percent, or to expenses for specific preventive medications targeting certain risk factors.

Your deductible will differ depending on the medical option you select and whether you cover yourself only or yourself plus one or more eligible dependents (family coverage). The same deductible applies to both in-network expenses and out-of-network expenses. Any portion of an expense that exceeds the Claims Administrator's reasonable and customary limits does not count toward the deductible.

See deductible amounts in the *Schedule of Benefits* of this Medical Program chapter.

Family Deductible

When you cover one or more dependents, federal tax rules that apply to the Medical Program require you to ***satisfy the full family deductible before the Program can begin paying benefits for any family member***. That means your combined family expenses must reach $3,000 under Option 1 or $6,000 under Option 2 before Program benefits are payable for any family member.[19]

Copayment (Copay)

A copayment (or copay) is the fixed amount you pay for each generic prescription. The copayment amounts are shown in the *Prescription Drug Benefit* section of this Medical Program chapter.

[19] *Exception: Certain preventive care services and products and specific preventive medications targeting certain risk factors are covered with no upfront deductible.*

Coinsurance

Coinsurance is the share of expenses that you and the Program each pay after you meet your annual deductible. Coinsurance amounts are shown in the *Schedule of Benefits* in this Medical Program chapter. For example, if coinsurance is 80 percent/20 percent for a particular service, the Program pays 80 percent and you pay 20 percent of each covered charge, after you have met your deductible. Your share of coinsurance usually is higher for out-of-network care. In addition, charges by out-of-network providers are not limited to the Claims Administrator's negotiated fee schedule. You will have to pay the portion of any provider's charge that exceeds the reasonable and customary limit.

Annual Coinsurance Maximum

The annual coinsurance maximum is a limit on the amount of coinsurance (including copays for generic drugs) you could pay each calendar year. This maximum amount is shown in the *Schedule of Benefits* in this Medical Program chapter. There is a separate, higher annual coinsurance maximum for out-of-network expenses compared with in-network expenses. Any portion of an expense that exceeds the Claims Administrator's reasonable and customary limits does not count as coinsurance.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is a limit on the combined amount of deductible expenses and coinsurance (including copays for generic drugs) you could pay each calendar year. This maximum amount is shown in the *Schedule of Benefits* in this Medical Program chapter. There is a separate, higher annual out-of-pocket maximum for out-of-network expenses compared with in-network expenses. Once the share of expenses you have paid reaches your annual out-of-pocket maximum, the Program pays 100 percent of your eligible expenses for the remainder of the year.

Deductible and Out-of-Pocket Limit Exceptions

The following do not count toward the annual deductible or out-of-pocket maximums.

- Charges in excess of the reasonable and customary amount (applicable to out-of-network expenses only).
- Charges for services and supplies not covered under the Medical Program.
- Charges that exceed the applicable annual maximum for a covered expense.

Annual and Lifetime Maximums

There are no dollar limits on benefits the Medical Program will pay on an annual basis, or over a lifetime, other than those for infertility treatment. (See *Infertility Treatment Expenses* in this Medical Program chapter.) For certain services there are calendar year limits on the number of services or days of services.

Networks: Aetna Choice POS II (Open Access) and BCBS PPO

The Claims Administrator for the network option in which you enrolled has contracted with a broad range of health care providers, including hospitals, physicians, labs, etc., and brought them together into the:

- Aetna Choice POS II (Open Access) network, and
- BCBS PPO network.

These in-network providers have agreed to offer you quality health care at negotiated contract rates. Using the network saves money for both you and BNSF. While you are free to use any licensed provider, your cost usually will be lower if you use in-network providers.

Two Steps of Pre-approval Required for Admissions and Certain Services and Treatment

The Claims Administrator has two steps of approvals that need to be completed before you incur expenses for the services listed below. Both steps apply no matter whether you use in-network providers or out-of-network providers.

Step ❶: What's Covered – Called pre-certification by Aetna and pre-notification by BCBS. This ***required*** step determines if services are covered by the Medical Program, but it does not confirm whether certain limitations, requirements and exclusions might limit or deny benefits paid for those services.

> ***Your Responsibility***
> Your health care provider may assist you by requesting this advance certification of coverage *before* hospital and facility admissions or certain services, tests or treatment begin. However, ***it is always your responsibility to confirm*** that Aetna or BCBS has approved the coverage pre-certification / pre-notification of your admission, service or treatment. If you are not certain this has been completed, call the Member Services number on your ID card to ask.

Step ❷: Dollar Amount to Be Paid and Any Limitations that Apply – Called pre-authorization by Aetna and pre-determination by BCBS. This ***recommended*** step confirms the general dollar amount of benefits payable for your specific admission, test, care and/or treatment. Through this step, you'll find out if benefits for any covered services might be limited or denied due to certain requirements or exclusions that apply to those services.

> ***Your Responsibility***
> ***This step is always your responsibility***. Ask your provider to request pre-authorization by Aetna or pre-determination by BCBS. It is your responsibility to confirm the outcome.

These pre-approval processes apply to:

- Hospital admissions,
- Convalescent or skilled nursing facility admissions,
- Skilled nursing care,
- Hospice care,
- Home health care,
- Inpatient tests, procedures and treatment,
- Certain outpatient tests, procedures and treatment that are not considered routine office visits, and
- Hospital and treatment facility admissions and emergency treatment for alcohol and drug abuse and mental disorders.

For details of this two-step process, see the section of this Medical Program chapter titled *Pre-certification / Pre-notification and Pre-authorization / Pre-determination of Expenses.*

Retiree Cannot Have Dual Coverage

Due to IRS "dual coverage" rules, when you participate in medical coverage that includes making contributions to an HSA (such as the BNSF Medical Program for Pre-Medicare Retirees), you – the retiree – cannot simultaneously participate in another plan that pays for medical expenses, unless the other plan also has an HSA.[20]

This means retirees who have any other medical coverage are not eligible for coverage under the Medical Program, unless the other plan also has an HSA. "Other medical coverage" includes your enrollment in your spouse's employer-sponsored medical coverage as well as in a Health Care Flexible Spending Account (HCFSA). The BNSF Medical Program will not coordinate its benefits for the retiree with the other plan's benefits unless the other plan includes an HSA or is TRICARE or VA.

However, your dependents can be covered by both the BNSF Medical Program and other medical coverage, and the Medical Program will coordinate benefits for dependents of retirees who are covered by other plans. For details, see *Coordination with Other Plans Except Medicare* in the chapter of this SPD titled *Claims Procedures – Medical and Vision Care Programs for Pre-Medicare Retirees*.

HEALTH SAVINGS ACCOUNT (HSA)

You May Make Tax-advantaged Contributions to an HSA

Your Medical Program coverage automatically includes access to a Health Savings Account (HSA) to which you may choose to make tax-advantaged contributions. (If you are also enrolled in a government-sponsored health plan such as TRICARE or VA, your coverage cannot include an HSA due to the "dual coverage" restrictions noted in the previous section).

For Medical Program claims and administrative purposes, you are considered to be an HSA participant even if you do not have an account with the HSA Administrator.[21]

For more information about the HSA and balances left over in an HRA, see:

- *How Your Medical Program Coverage Works in Brief* earlier in this Medical Program chapter.
- The *Cash Accounts Overview* section of the chapter in this SPD titled *Overview of Medical Options and Cash Accounts for Pre-Medicare Retirees*.

[20] *For Medical Program claims and administrative purposes, you are considered to be an HSA participant even if you do not set up an account with the HSA Administrator. This provision does not apply if the HSA is unavailable to you because of your enrollment in a government-sponsored health plan such as TRICARE or VA.*

[21] *HSA is not available to participants enrolled in a government-sponsored health plan such as TRICARE or VA.*

COMPREHENSIVE MEDICAL COVERAGE – COVERED EXPENSES

In-network Physician

You are encouraged (but not required) to select an in-network primary physician from the network in which you enrolled:

- Aetna Choice POS II (Open Access) network, or
- BCBS PPO network.

Your in-network primary physician will provide preventive, basic and routine care, and will refer you to in-network specialists and facilities when medically necessary. Note that a referral to a specialist is not required, but is recommended, to ensure consistent use of network providers.

Medically Necessary

Although a specific service or supply may be listed as a covered expense, it will not be covered unless it is medically necessary for the prevention, diagnosis or treatment of an illness or injury.

Inpatient Hospital Expenses

Charges for hospital room and board, and other hospital services and supplies, are covered when you are confined as a full-time inpatient.

In-network Care

- If a private room is used, the daily room and board charge will be covered if:
  - Your in-network provider requests the private room, and
  - The request is approved by the Claims Administrator.
- If the above requirements are not met, any part of the daily room and board charge that exceeds the semi-private rate is not covered.

Out-of-network Care

Expenses are covered up to the amount the Claims Administrator considers to be reasonable and customary.

Limitation
No benefit is paid for any out-of-network charge for daily room and board in a private room over the semi-private rate.

Outpatient Hospital Expenses

Hospital services and supplies also are covered when you are not confined as a full-time inpatient, as shown below.

Outpatient Surgery

Outpatient surgical services are covered to the extent shown below. This includes services:

- From a surgery center, the outpatient department of a hospital, or a physician's or dentist's office.
- By a physician.
- On behalf of a salaried staff physician by the outpatient department of a hospital.

- For outpatient services and supplies furnished in connection with a surgical procedure performed in a surgery center, or in a hospital, or in a physician's or dentist's office. The procedure must meet these tests:
  - It is not expected to result in extensive blood loss, require major or prolonged invasion of a body cavity, or involve any major blood vessels; and
  - It can safely and adequately be performed in a surgery center, in a hospital or in an office-based surgical facility of a physician or dentist; and
  - It is not normally performed in the office of a physician or dentist.

Outpatient Services and Supplies

Coverage includes:

- Services and supplies furnished by the surgery center or hospital or office of a physician or dentist on the day of the procedure.
- Services of the operating physician for performing the procedure and for:
  - Related pre- and post-operative care, and
  - Administering an anesthetic.
- Services of any other physician for related post-operative care and for administering an anesthetic. This does not include a local anesthetic.

Limitations

No benefit is paid for:

- The services of a physician who renders technical assistance to the operating physician.
- Outpatient charges while you are confined as a full-time inpatient in a hospital.
- Facility charges for office-based surgery.

Convalescent or Skilled Nursing Facility Expenses

The following services and supplies are covered if furnished while you are confined in a convalescent or skilled nursing facility to recover from a disease or injury:

- Room and board. This includes services related to room occupancy (for example, general nursing care). Not included are daily room and board in a private room if the charge exceeds the semi-private rate.
- Use of special treatment rooms.
- X-ray and lab work.
- Restorative physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a convalescent facility. This does not include private or special nursing, or physician's services.
- Medical supplies.

Limitations

- Benefits are paid for up to 60 days during any one calendar year.
- Benefits are not paid for convalescent facility treatment of:
  - Drug addiction.
  - Chronic brain syndrome.
  - Alcoholism.
  - Senility.
  - Mental retardation.
  - Any other mental disorder.

Home Health Care Expenses

Home health care services are covered if:

- The charge is made by a home health care agency,
- The care is given under a home health care plan, and
- The care is provided in your home.

Coverage includes charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aide services for patient care.
- Restorative physical, occupational or speech therapy.
- The following, to the extent they would have been covered under the Medical Program if you had been confined in a hospital or convalescent facility:
  - Medical supplies,
  - Drugs and medicines prescribed by a physician, and
  - Lab services provided by or for a home health care agency.

Limitations

- Up to 40 home health care visits are covered during a calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to four hours by a home health aide is one visit.
- These home health care services are not covered:
  - Services or supplies that are not a part of the home health care plan.
  - Services provided by someone who usually lives with you or who is a member of your family or your spouse's family.
  - Services of a social worker.
  - Transportation.
  - Services that are considered custodial care.

- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.

Preventive Care Services

Preventive care means routine health care that includes screenings, checkups and patient counseling to prevent illnesses, disease or other health problems, as determined by the Claims Administrator. Women's health services such as prenatal doctor's office visits, support and counseling, and certain contraceptives also are covered as preventive care services.

Preventive services typically are covered only when conducted and billed as part of your annual physical exam, periodic well-woman exam or periodic well-child checkup. Preventive services for women may be performed in one visit, or in several. Regardless of your age, the Medical Program will cover screenings, preventive immunizations and covered counseling that are recommended by your doctor due to your individual risk factors.

The Medical Program's preventive care benefits are intended to comply with the requirements of the Affordable Care Act of 2010. For more information, go to www.healthcare.gov/what-are-my-preventive-care-benefits/.

Routine Physical Exam Expenses

The Medical Program covers an annual routine physical exam (preventive care services) at 100 percent of eligible expenses and with no deductible.[22] A routine physical exam is a medical examination given by a physician for a reason other than to diagnose or treat a suspected or identified injury or illness.

Additional Preventive Health Services

In addition to other services described in this Preventive Care Services section, these services are covered at 100 percent of eligible expenses and with no deductible:

- Screenings and counseling services for:
  - Preventing or reducing the use of alcohol and controlled substances.
  - Sexually transmitted diseases and HIV infection.
  - Weight reduction due to obesity.
- Women's health services including:
  - Well-woman visits, including Pap smears.
  - Gestational diabetes screening.
  - Human Papillomavirus (HPV) DNA testing.
  - FDA-approved contraception methods and contraceptive counseling. (Certain contraception methods may be subject to costs, for example in cases of obtaining a brand-name drug when a generic drug is available or if not prescribed for preventive purposes.)
  - Prenatal care office visits.
  - Domestic violence screening and counseling.

[22] *Note that if you combine a preventive care office visit with non-preventive services, only 50 percent of the eligible non-preventive services will be considered. That amount will be subject to your annual deductible and coinsurance.*

Immunizations

Routine childhood immunizations are covered at 100 percent and with no deductible, as are certain periodic adult re-immunization and immunizations recommended by your doctor due to your personal risk factors.

It is important to talk with your doctor about any immunizations or screenings that you or a dependent may need based on your personal risk factors such as personal and family history, and potential exposure to diseases.

Preventive Products

In addition, certain preventive pharmaceutical products are covered at 100 percent with no deductible, as noted in the *Prescription Drug Benefit* section.

Specific Preventive Medications Targeting Specific Risk Factors

See the *Prescription Drug Benefit* section of this Medical Program chapter for information about special no-deductible coverage of specific preventive medications that are prescribed to target certain health risk factors.

Tobacco Use Cessation

The Medical Program encourages quitting the use of tobacco products by covering tobacco-cessation prescription medications, including those covered at 100 percent or with only a copay or coinsurance with no upfront deductible.

Preventive Care for Children

In addition to the services described above and those in compliance with the Affordable Care Act of 2010, the Medical Program covers routine examinations and childhood immunizations at appropriate ages and frequency as determined by the Claims Administrator and as recommended by the child's doctor.

Coverage of exams includes:

- Physician charges for routine examination;
- X-rays, laboratory, and other screenings and tests done in connection with the exam;
- Counseling of the patient (or child's parents/guardians);
- Guidance to teens and preteens on issues such as tobacco use, injury prevention, nutrition, physical activity and sexual health; and
- Immunizations for infectious disease and testing for tuberculosis. However, immunizations for travel or work are not covered under the preventive care benefit.

Age for Well-Child Checkups
• 7 exams from birth through age 12 months.
• 3 exams in 13th through 24th month.
• 3 exams in 25th through 36th month.
• 1 exam annually thereafter.

Requirements of Exams for All Children

For a dependent child, the physician's exam must include at least:

- A review and written record of the child's complete medical history,
- A check of all body systems, and
- A review and discussion of the exam results with the child or with the parent or guardian.

Preventive Care Limitations – All Participants

Benefits will ***not*** be paid as preventive care for:

- Services covered to any extent under any other part of this Medical Program or other group plan offered or sponsored by BNSF.
- Services for diagnosis or treatment of a suspected or identified injury or disease.
- Exams given while you are confined in a hospital or other place for medical care.
- Services not given by, or under the direction of, a physician.
- Medicines, drugs, appliances, equipment or supplies, except specific preventive medications targeting certain risk factors and certain preventive pharmaceutical products covered at 100 percent under the Program. See the *Prescription Drug Benefit* section of this Medical Program chapter for details.
- Psychiatric, psychological, personality or emotional testing or exams.
- Exams in any way related to employment.
- Premarital exams.
- Dental, vision and hearing exams, except when included as part of routine exams summarized in *Preventive Care for Children*.
- A physician's office visit related to immunization or testing for tuberculosis. (Note that immunization and *testing* for tuberculosis are covered as an office visit. Testing is covered as preventive care if it is part of a *regular physical exam*.)
- Expenses that exceed the reasonable and customary charge for routine preventive care services received from out-of-network providers, including office visits, lab and facility charges.

Keep Preventive Exams Separate from Other Treatment

It is important not to combine your periodic well-adult or well-child checkup with visits to a doctor for other health issues. ***Any office visit that results in a treatment during the visit does not qualify as a preventive exam.*** For example, if you go to the doctor for a preventive exam while you have a sore throat, and the doctor diagnoses and treats a bronchial infection, your visit is considered as treatment of an illness and not a preventive exam.

Skilled Nursing Care Expenses

Coverage includes skilled nursing services from an R.N. or L.P.N. or a nursing agency. Skilled nursing services means private duty nursing by an R.N. or L.P.N. if skilled nursing care is required and visiting nursing care is not adequate.

Limitations

Benefits for skilled nursing services during a calendar year are limited to 70 shifts/visits. Each visit of up to eight hours is one shift.

Benefits are not paid for the following skilled nursing services:

- Any nursing care that does not require the education, training and technical skills of an R.N. or L.P.N., such as transportation, meal preparation, charting of vital signs and companionship activities.
- Any private duty nursing care given while you are an inpatient in a hospital or other health care facility.
- Care provided to help you in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting.
- Any service provided solely to administer oral medicines, except where applicable law requires that these medicines be administered by an R.N. or L.P.N.
- Care provided solely for skilled observation. However, skilled observation of up to one four-hour period per day for up to 10 consecutive days after any of the following occurs is not excluded:
  - A change in patient medication,
  - The need for treatment of an emergency condition by a physician,
  - The onset of symptoms indicating the likely need for these services,
  - Surgery, or
  - Release from inpatient confinement.

Aside from the above, benefits are not paid for other charges made by an R.N. or L.P.N. or a nursing agency.

Hospice Care Expenses

The following charges are covered for hospice care when given as a part of a hospice care program:

Facility Expenses

Inpatient Care

Room and board, and other services and supplies, are covered while you receive full-time inpatient care at a hospice facility, hospital or convalescent facility for the below items. Not covered are daily room and board charges for a private room to the extent they exceed the semi-private rate.

- Pain control, or
- Other acute and chronic symptom management.

Outpatient Care
Coverage includes:

- Services and supplies furnished to you by a hospice facility, hospital or convalescent facility while you are not confined as a full-time inpatient.
- Charges by a hospice care agency for:
  - Part-time or intermittent nursing care by an R.N. or L.P.N. for up to eight hours per day.
  - Medical social services under the direction of a physician. These include:
    - Assessment of your social, emotional and medical needs, and the home and family situation,
    - Identification of the community resources available to you, and
    - Assisting you to obtain the resources needed to meet your assessed needs.
  - Psychological and dietary counseling.
  - Consultation or case management services by a physician.
  - Physical and occupational therapy.
  - Part-time or intermittent home health aide services, primarily to care for you, for up to eight hours per day.
  - Medical supplies.
  - Drugs and medicines prescribed by a physician.
- Outpatient care from the following providers, but only if the provider is not an employee of a hospice care agency, and the agency retains responsibility for your care:
  - A physician for consultant or case management services.
  - A physical or occupational therapist.
  - A home health care agency for:
    - Physical and occupational therapy,
    - Part-time or intermittent home health aide services, primarily to care for you, for up to eight hours per day,
    - Medical supplies,
    - Drugs and medicines prescribed by a physician, and
    - Psychological and dietary counseling.

Limitations

Not covered are:

- Bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.

- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services that are not solely related to your care, such as sitter or companion services either for you or other members of the family, transportation, housecleaning and maintenance of the house.
- Respite care. This is care furnished when your family or usual caretaker cannot, or will not, attend to your needs.

Family Planning Expenses

Coverage includes services by a physician and/or hospital for voluntary sterilization by vasectomy, or by tubal ligation including associated ancillary services.

Limitation

Reversal of a sterilization procedure is not covered.

Contraception Expenses

Coverage includes:

- Contraceptive drugs and devices approved by the FDA that by law require a physician's prescription. See *Prescription Drug Benefit* and *Preventive Products Covered at 100%*.
- Related outpatient contraceptive services such as:
  - Consultations,
  - Exams,
  - Procedures, and
  - Other medical services and supplies.

Infertility Treatment Expenses

Coverage includes diagnosis and treatment of a covered female for the underlying medical condition for infertility (the inability to conceive a child after one year of unprotected sexual intercourse, or the inability to sustain a successful pregnancy). In addition, benefits for the following are covered up to $2,500, but only when pre-approved by the Claims Administrator. See the *Pre-certification / Pre-notification and Pre-authorization / Pre-determination of Expenses* section of this SPD for the pre-approval process.

- In vitro fertilization.
- Gamete intrafallopian tube transfer and zygote intrafallopian tube transfer (only if less costly procedures have not been successful and limited to four completed oocyte retrievals and two more oocyte retrievals after a live birth).
- Uterine embryo lavage.
- Artificial insemination.
- Low tubal ovum transfer.

Limitations

Benefits for the treatment of infertility and all related services and supplies except outpatient prescription drugs are subject to a lifetime maximum of $2,500 per covered person. Coverage of prescription medications for treatment of infertility is

limited to a separate benefit of $2,500 per covered person per lifetime. (See *Covered Prescription Drugs*.)

Not covered are:

- Childbirth services rendered to a surrogate mother.
- Cryopreservation and storage of sperm, eggs or embryos, except for procedures using a cryo-preserved substance.
- Non-medical costs of an egg or sperm donor.

Outpatient Short-Term Rehabilitation Expenses

Coverage includes short-term rehabilitation services by a physician or a licensed or certified physical, occupational or speech therapist for treatment of acute conditions. A short-term rehabilitation service means therapy that is expected to result in the restoration of a body function (including the restoration of previous speech function), which has been lost or impaired due to:

- Injury,
- Disease, or
- Congenital defect.

The following services are covered if:

- You are not confined as an inpatient in a hospital or other facility for medical care, and
- The therapy includes:
  - Physical therapy.
  - Occupational therapy.
  - Speech therapy.

Limitations

Benefits for short-term rehabilitation services are limited to 60 visits per therapy, per year.

Not covered are:

- Any services that are covered to any extent under any other plan sponsored by BNSF.
- Services not performed by a physician or under his or her direct supervision.
- Services rendered by a physical, occupational or speech therapist who resides in your home or who is a part of your family or your spouse's family.
- Services for the treatment of delays in speech or other developmental delays, unless resulting from:
  - Disease,
  - Injury, or
  - Congenital defect that can be corrected through surgery, such as cleft lip/palate.

- Services for the treatment of diagnoses that are considered developmental and/or chronic, including Pervasive Developmental Disorders such as autism, Down's syndrome and cerebral palsy.
- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired.
- Services that also would be eligible under the Medical Program's Chiropractor Care benefit, whether or not benefits for the maximum number of Chiropractor Care visits have been paid.
- Services that are not considered restorative.

In addition, no service is covered unless it follows a specific treatment plan that details the treatment to be given and its frequency and duration.

Chiropractor Care Expenses

Coverage includes treatment of spinal subluxation or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Limitations

Benefits for Chiropractor Care visits are limited to 60 visits in a calendar year. However, this maximum does not apply to services:

- While you are a full-time inpatient in a hospital.
- For treatment of scoliosis.
- For fracture care.
- For surgery, including pre- and post-surgical care given or ordered by the operating physician.

Durable Medical and Surgical Equipment (DME) Expenses

Coverage includes:

- Rental of durable medical and surgical equipment.
- Initial purchase of durable medical and surgical equipment and accessories needed to operate it only if the Claims Administrator is shown that:
  - Long-term use is planned, and
  - The equipment cannot be rented, or it is likely to cost less to buy it than to rent it.
- Repair or replacement of purchased durable medical and surgical equipment and accessories. Replacement is covered only if the Claims Administrator is shown that:
  - It is needed due to a change in your physical condition, or
  - It is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.
- Charges for oxygen.

Limitations

Not included are:

- More than one item of equipment for the same or similar purpose.
- Equipment that is:
  - Normally of use to persons who do not have a disease or injury,
  - For use in altering air quality or temperature, or
  - For exercise or training.

Complex Imaging Expenses

Complex Imaging Services are covered when provided on an outpatient basis in a:

- Physician's office,
- Hospital outpatient department or emergency room, or
- Licensed radiological facility.

Only Complex Imaging Services determined to be medically necessary by the Claims Administrator are covered. These may include:

- CAT scans,
- Magnetic resonance imaging (MRIs), and
- Positron emission tomography (PET) scans.

Other Medical Expenses

Coverage also includes:

- Physician services unless otherwise excluded.
- Diagnostic lab work and X-rays.
- X-rays, radium and radioactive isotope therapy.
- Anesthetics and oxygen.
- Acupuncture services provided by a physician if the service is performed as a form of anesthesia in connection with a covered surgical procedure.
- Professional ambulance service to transport you from the place where you are injured or stricken by disease to the closest hospital where adequate treatment can be given.
- Artificial limbs and eyes.
- Walk-in clinic visits for unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations administered within the scope of the clinic's license.
- Bariatric surgeries, if determined to be medically necessary, based on the clinical guidelines of the Claims Administrator, on an inpatient or outpatient basis by a hospital or a physician for the surgical treatment of morbid obesity. *You must contact the Claims Administrator in advance of this procedure to ensure that you have met all requirements necessary for this procedure to be covered.*

Limitations

The Medical Program does not cover:

- Eyeglasses.
- Vision aids.
- Hearing aids.
- Communication aids.
- Orthopedic shoes, foot orthotics or other devices to support the feet, unless necessary to prevent complications of diabetes, based on the clinical guidelines of the Claims Administrator.

Transplant Expenses

The Medical Program covers in-network and out-of-network expenses for many types of human organ, stem cell, bone marrow and tissue transplants under its provisions for physician, in-patient hospital and other related expenses described elsewhere in this Medical Program SPD.

Special Coverage Through Transplant Networks

For specifically listed human organ and tissue transplants, in-network coverage is provided exclusively through the Claims Administrators' transplant networks. Any services that you receive outside of your Claims Administrator's transplant network program for listed transplants are considered out-of-network.

Your care provider must follow the pre-approval processes described below to determine if a proposed transplant is covered, and if so, what benefits will be payable.

Specific Transplants

The following human organ or tissue transplants are covered under the Claims Administrators' transplant networks:

Aetna Institutes of Excellence	BCBS Blue Distinction Centers
• Bone marrow/stem cell • Combination heart/lung • Heart • Intestine • Kidney • Liver • Lung • Pancreas • Simultaneous pancreas/kidney	• Bone marrow/stem cell • Combination heart/lung • Heart • Liver • Lung • Pancreas • Simultaneous pancreas/kidney

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

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

- If you are a recipient and the donor has no medical coverage from any source, Medical Program benefits will apply to the donor for transplant purposes only.
- If you are the donor and no coverage is available to you from any other source, you will be covered under the Medical Program. No benefits will be provided for the recipient under the Program.

Transplant coverage begins at the point of evaluation for a transplant and ends either 180 days from the date of the transplant, or on the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later. Only U.S. or Canadian transportation of a donor organ is covered.

No benefits are provided for transportation of a donor or recipient by an ambulance, or for travel time and related expenses of a medical provider.

Aetna Institutes of Excellence™ and BCBS Blue Distinction Centers Transplant Networks

The Aetna Institutes of Excellence and BCBS Blue Distinction Centers transplant networks are the Claims Administrators' provider networks for specific transplants and transplant-related services including initial evaluation and follow-up care. Hospitals that have exhibited successful clinical outcomes, met quality of care standards and agreed to acceptable contractual terms have been selected to participate in the networks for one or more specific transplants.

For coverage of transplant-related services to be considered in-network, including initial evaluation, donor expenses, transplant and follow-up care, you must use a transplant facility and physician that have been specifically contracted by the Claims Administrator for your type of transplant under the Institutes of Excellence (if you are enrolled in Aetna coverage) or a Blue Distinction Center (if you are enrolled in BCBS coverage).

Pre-approval Required

Charges made for or in connection with all organ or tissue transplant services require pre-approval.

- The first step of the ***two-step pre-approval process*** is called pre-certification by Aetna and pre-notification by BCBS. Your care provider may assist with handling the first pre-approval step at the time of your evaluation. However, ***it is always your responsibility to confirm*** that Aetna or BCBS has approved the coverage of your transplant through the pre-certification / pre-notification process.
- Prior to incurring expenses, ***you are responsible*** for making sure your provider has completed the ***second pre-approval step***, called pre-authorization by Aetna and pre-determination by BCBS.

Your Responsibility

It is your responsibility to make sure your doctor or other provider receives the necessary pre-approvals by Aetna or BCBS before you incur transplant-related expenses.

For details of this two-step process, see the section of this Medical Program chapter titled *Pre-certification / Pre-notification and Pre-authorization / Pre-determination of Expenses*.

Any facility or physician that is not specified as an Aetna Institutes of Excellence (if you are enrolled in Aetna coverage) or BCBS Blue Distinction Centers (if you are enrolled in BCBS coverage) transplant network care provider is considered out-of-network for transplant-related services, even if the facility or physician is considered in-network for other types of services.

A listing of the Aetna Institutes of Excellence facilities is available through DocFind, at www.aetna.com. BCBS Blue Distinction Centers facilities are listed at www.bcbsil.com. You also may call your network's Claims Administrator at the number on your Medical Program ID card for additional information.

Additional Covered Expenses When You Use the Transplant Network

Your network's transplant program coordinates solid organ and bone marrow transplants and other specialized care for the types of transplants listed under Special Coverage Through Transplant Networks. When the patient's care is directed to a medical facility more than 100 miles from the patient's home, the transplant program will pay a benefit for travel and lodging expenses, as follows:

Travel Expenses

Covered travel expenses include:

- The patient's transportation between his or her home and the medical facility to receive services related to an approved procedure or treatment, and
- A companion's expenses for transportation when traveling to and from the patient's home and the medical facility for the patient to receive approved services.

Lodging Expenses

- The patient's expenses are covered for lodging away from home while traveling between his or her home and the medical facility to receive services related to an approved procedure or treatment.
- A companion's expenses for lodging away from home are also covered:
  - While traveling with the patient between the patient's home and the medical facility for the patient to receive approved services; or
  - When the companion's presence is required to enable the patient to receive services from the medical facility on an inpatient or outpatient basis.

Limitations
The maximum benefit for lodging expenses is $50 per person per night.

To determine travel and/or lodging expenses, "home" means the origination point from which a patient travels to begin treatment at the medical facility, or to which he or she travels after discharge. This could be the patient's residence, or a hospital or other temporary residence where the patient was either staying before traveling to the medical facility or will be staying after leaving the medical center.

For any one procedure or treatment type:

- The maximum combined travel and lodging benefit is $10,000 per episode of care.
- Expenses are eligible for reimbursement from the day you become an approved patient under either the Aetna Institutes of Excellence or BCBS Blue Distinction Center transplant network until whichever of the following occurs first:
  - One year after the day the procedure is performed; or
  - The date the patient stops receiving any services from the medical facility in connection with the procedure.

Travel and lodging benefits will not be paid for any charges that are covered by any other part of this Medical Program or any other plan. Expenses may be covered for only one companion who travels with the patient.

Emergency Room Treatment Expenses

Hospital emergency room services are covered if:

- Treatment is received while you are not a full-time inpatient, and
- The treatment is emergency care.

Out-of-Network Services
Note that out-of-network providers do not have a contract with the Claims Administrator and may not accept payment of your cost share (your deductible and coinsurance) as payment in full. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Send the bill to the Claims Administrator at the address shown on the back of your member ID card. Make sure your member ID number is on the bill. The Claims Administrator will resolve any payment dispute with the provider over that amount.

Limitation
Expenses for non-emergency treatment in an emergency room are covered as *Outpatient Hospital Expenses*.

Urgent Care Treatment Expenses

Services of a hospital or urgent care provider to evaluate and treat an urgent condition are covered, including:

- Use of emergency room facilities when in-network urgent care facilities are not in your service area and you cannot reasonably wait to visit your physician.
- Use of urgent care facilities.
- Physicians' services.
- Nursing staff services.
- Radiologists' and pathologists' services.

Please contact your primary care physician (PCP) after receiving treatment of an urgent condition. If you visit an urgent care provider for a non-urgent condition, the Program will not cover your expenses.

When traveling to an urgent care provider for treatment of an urgent condition is not feasible, treatment by any licensed provider may be covered as in-network care. If a claim for treatment of an urgent condition is paid at the out-of-network level, and you believe that it should have been paid at the in-network level, please call the Claims Administrator.

Limitations

Services provided by an urgent care provider for a non-urgent condition are not covered.

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

- Routine or preventive care (including immunizations).
- Follow-up care.
- Physical therapy.
- Elective surgical procedures.
- Any lab and radiologic exams that are not related to the treatment of the urgent condition.

Walk-in Clinic Expenses

Coverage includes services of walk-in clinics for:

- Unscheduled, non-emergency illnesses and injuries; and
- Administration of certain immunizations.

Treatment of Alcoholism, Drug Abuse or Mental Disorders

Inpatient Treatment

Coverage includes full-time inpatient care in either a hospital or treatment facility:

Hospital

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

Treatment Facility

- Room and board at the semi-private room rate and other necessary services and supplies for:
  - Certain expenses for the effective treatment of alcoholism or drug abuse.
  - Treatment of mental disorders.

Partial Confinement Treatment

Benefits are paid for covered services given through a partial confinement treatment program by either a hospital or residential treatment facility, including those for the effective treatment of alcoholism or drug abuse or for the treatment of mental disorders.

Outpatient Treatment

Benefits are paid for covered services in settings other than full-time inpatient care in either a hospital or treatment facility, including those for the treatment of alcoholism or drug abuse or for the treatment of mental disorders.

Residential Treatment Facility

Benefits are paid for covered services in settings other than full-time inpatient care or a partial confinement treatment program in either a hospital or residential treatment facility, including those for residential crisis services.

Mouth, Jaws and Teeth

Coverage includes services and supplies provided by a physician, dentist or hospital for:

- Non-surgical treatment of infections or diseases of the mouth, jaws, jaw joints and supporting tissues including bones, muscles and nerves.
- Surgical treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, including bones, muscles and nerves, needed to:
  - Treat a fracture, dislocation or wound.
  - Cut out cysts, tumors or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is covered only when *not* done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Hospital services and supplies during a stay required because of your covered treatment or condition.
- Dental work, surgery and orthodontic treatment needed *due to accidental injury* to remove, repair, replace, restore or reposition:
  - Natural teeth that have been damaged, lost or removed, or
  - Other body tissues of the mouth that have been fractured or cut.

These teeth must have been:

- Free from decay,
- In good repair, and
- Firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the calendar year of the accident or the following year.

If crowns (caps), dentures (false teeth), bridgework or in-mouth appliances are installed as the result of an accidental injury, the following are covered:

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

Limitations

Except when needed as the result of a covered injury, Medical Program coverage does not include:

- In-mouth appliances, crowns, bridgework, dentures, tooth restorations, implants or any related fitting or adjustment services, whether or not the purpose of those services or supplies is to relieve pain.
- Root canal therapy.
- Routine tooth removal (not needing the cutting of bone).
- Treatment to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing.
- Treatment to repair, replace or restore fillings, crowns, dentures or bridgework.
- Non-surgical periodontal treatment.
- Dental cleaning, in-mouth scaling, planing or scraping.
- Myofunctional therapy, which is muscle training therapy, or training to correct or control harmful habits.

Prescription Drug Benefit

Prescription drugs are covered if they are dispensed by a pharmacy and are medically necessary for the prevention or treatment of an illness or condition. The tables in this Medical Program chapter show the deductible and copay or coinsurance that apply to covered prescription expenses. No deductible applies to specific preventive medications targeting certain risk factors; for most, you pay only a fixed copay or coinsurance percentage. However, several preventive pharmaceutical products are covered at 100 percent with no deductible. If you choose to use a brand-name drug when a generic is available, you will pay the cost difference (unless the brand-name is required by your doctor). The difference will not apply to your deductible or out-of-pocket maximum.

Primary/Preferred Drug List (Formulary)

A Primary/Preferred Drug List ("formulary") is part of your prescription drug benefit program. The list contains preferred prescription medications that are proven to be effective but generally are lower in cost than other available drugs. To see which prescription drugs are included in the Primary/Preferred Drug List and which pricing category applies to any drug, you may go to the Caremark site at www.caremark.com or call Caremark's toll free number at 800-378-7559.

Prescription Drug Benefit Levels

Prescription drugs and certain products and supplies are covered in three ways under the Medical Program, when prescribed by a physician:

❶	❷	❸
Most prescription medications and supplies: • Subject to deductible. • You pay a fixed copay or coinsurance percentage once your combined medical and prescription drug expenses reach the deductible. • You will pay the cost difference if you choose to use a brand-name drug when a generic is available (unless the brand-name is required by your doctor).	***Specific preventive medications and supplies targeting certain risk factors***: • Not subject to deductible. • You pay fixed copay or coinsurance percentage.	***Certain preventive products***: • Covered at 100 percent. • No deductible, copays or coinsurance.

❶ Prescription Medications and Supplies

Retail Pharmacy

Except as noted for specific preventive medications and certain products (see ❷ and ❸ on the following pages), your purchases of prescription drugs and supplies are subject to your Medical Program deductible. Once you meet your deductible, the Program covers your in-network or out-of-network pharmacy purchases of up to a 34-day supply (or up to a 90-day supply if purchased at CVS pharmacies) of a prescription drug with a fixed copay or coinsurance paid by you. If your share of overall covered expenses reaches the annual out-of-pocket maximum, your eligible prescription drug expenses will be paid at 100 percent for the rest of the calendar year.

The total covered charge for any prescription drug purchase is determined by the pharmacy and Caremark, the prescription drug Claims Administrator.

If you use an out-of-network retail pharmacy for any prescription purchase, you initially will pay 100 percent of the prescription price. Then you may submit a paper claim form, along with the original prescription receipt(s), to Caremark for reimbursement of covered expenses. You will pay the difference between the cost charged by the out-of-network pharmacy and the discounted amount that would have been charged by an in-network pharmacy. These additional out-of-network charges do not apply toward the deductible or out-of-pocket maximum.

If you choose to use a brand-name drug when a generic is available, you will pay the cost difference (unless the brand-name is required by your doctor). The difference will not apply to your deductible or out-of-pocket maximum.

The time limit to file a paper claim is 365 days from the prescription fill date.

To see which prescription drugs are included in the Primary/Preferred Drug List and which pricing category applies to any drug, you may go to Caremark's website at www.caremark.com or call Caremark toll free at 800-378-7559.

In-network drug prices include discounts negotiated by the Claims Administrator, which hold down the expenses you pay.

The Claims Administrator pays the benefit amount to the in-network pharmacy on your behalf.

In-network Retail Pharmacy Purchases[23]	
Prescription Drug Type	**Your Cost (after you meet the deductible):** *(Deductible does not apply to specific preventive medications and products – see ❷ and ❸ on the following pages.)*
Generic	• Up to 34-day supply: $7.50 or actual cost, if less. • Up to 90-day supply if purchased at CVS pharmacies: $15 or actual cost, if less.
Primary/Preferred (Formulary) Brand	• Up to 34-day supply: 25% but not less than $25. Your cost limited to $100 max.[24] • Up to 90-day supply if purchased at CVS pharmacies: 25% but not less than $50. Your cost limited to $200 max.[24]
Non-Primary/Preferred (Non-Formulary) Brand	• Up to 34-day supply: 40% but not less than $40. Your cost limited to $125 max.[24] • Up to 90-day supply if purchased at CVS pharmacies: 40% but not less than $80. Your cost limited to $250 max.[24]

[23] *For out-of-network retail purchases, you also pay the difference between the cost charged by the out-of-network pharmacy and the amount that would have been charged by an in-network pharmacy.*

[24] *If you choose to use a brand-name drug when a generic is available, you will pay the cost difference (unless the brand-name is required by your doctor). The difference does not apply to your deductible, coinsurance maximum or out-of-pocket maximum.*

In-network Mail Order[25]
Caremark's mail-order program allows you to order up to a 90-day supply of maintenance or long-term medication for direct delivery to your home. (Quantities for certain preventive products differ as noted at ❸ on the following page.) In addition to the convenience, purchasing a multi-month supply by mail order will likely cost less than purchasing smaller quantities at a retail pharmacy.

Once you meet your Medical Program deductible, your in-network mail-order purchases of prescription drugs are covered at the copayment or coinsurance rates in the following table.

In-network Mail-Order Purchases[25]	
Prescription Drug Type	**Your Cost (after you meet the deductible), up to 90-day Supply:** *(Deductible does not apply to specific preventive medications and products – see ❷ and ❸ as follows.)*
Generic	$15 or actual cost, if less.
Primary/Preferred (Formulary) Brand	25% but not less than $50. Your cost limited to $200 max.[26]
Non-Primary/Preferred (Non-Formulary) Brand	40% but not less than $80. Your cost limited to $250 max.[26]

For questions about mail-order prescriptions, refer to www.caremark.com or call Caremark at 800-378-7559.

❷ Specific Preventive Medications and Supplies Targeting Certain Risk Factors

To encourage you to manage certain controllable health conditions, the Medical Program offers special coverage of specific preventive medications and supplies targeting certain risk factors. ***No deductible applies, and you pay a fixed copay or coinsurance percentage*** as shown in the retail pharmacy and mail-order tables that follow. In addition, ***your share of covered expenses for preventive prescription drugs counts toward your annual deductible, coinsurance maximum and out-of-pocket maximum.***

List of Specific Preventive Medications Targeting Certain Risk Factors
Prescription medications and supplies eligible for the special no-deductible benefit are listed by Caremark and include medications and certain supplies for:

[25] *Out-of-network mail-order pharmacies are not covered.*
[26] *If you choose to use a brand-name drug when a generic is available, you will pay the cost difference (unless the brand-name is required by your doctor). The difference does not apply to your deductible, coinsurance maximum or out-of-pocket maximum.*

- Asthma.
- Heart disease.
- Diabetes.
- High cholesterol and high blood pressure control.
- Osteoporosis.
- Stroke prevention.

For the current list of specific preventive medications targeting certain risk factors, go to myBNSF.com or www.bnsf.com/retirees/exempt-retirees/plan-details/

In addition, certain preventive products are covered at 100 percent as noted in ❸ as follows.

❸ Preventive Products Covered at 100%

When prescribed by a physician, the following products are covered at 100 percent, with no upfront deductible when purchased from either an in-network or out-of-network retail pharmacy or via mail order. This list is determined in accordance with federal rules applying to preventive care coverage and may change periodically based on recommendations from the federal Agency for Healthcare Research and Quality (AHRQ).

Covered at 100%, No Deductible	
Medication / Product	**When Prescribed for:**
Aspirin (generic)	Participants age 45 or older (limit 100 units per fill).
Contraceptives (generic and single-source brand) • Oral contraceptives • Injectables • Intrauterine devices • Vaginal rings • Subdermal rods • Transdermal patch • Diaphragm and cervical cap • Emergency contraception	Covered participants.
Fluoride supplements (generic and brand)	Participants age 1 year or younger (quantity as prescribed).
Folic acid (generic)	Women age 55 or younger (limit 100 units per fill).
Iron supplements (generic and brand)	Participants age 1 year or younger (quantity as prescribed).
Tobacco cessation • Nicotine replacement products including patches, gum, lozenges (generic) • Zyban or Chantix (generic) or Wellbutrin for smoking cessation	Limit 168-day supply per year. Limit 168-day supply per year.

Covered Prescription Drugs

- A prescription legend drug for which a written prescription is required.
- Tobacco cessation aids specified by the Claims Administrator for up to two 12-week regimens per year.
- Oral or injectable insulin dispensed only upon the written prescription of a physician.
- Insulin needles and syringes.
- A compound medication of which at least one ingredient is a prescription legend drug.
- Topical acne products (certain restrictions apply for individuals age 35 and over).
- Any other drug that, under the applicable state law, may be dispensed only upon the written prescription of a physician.
- FDA-approved contraceptive methods.
- Contraceptive devices, including implantable contraceptive devices.
- Prenatal vitamins, upon written prescription.
- An injectable drug, excluding injectable infertility drugs, for which a prescription is required, including needles and syringes.
- Oral infertility drugs up to the $2,500 lifetime maximum for outpatient prescriptions related to infertility treatment.
- Glucose test strips.
- Growth hormones and anabolic steroids (available only through Caremark's Specialty Pharmacy Program).
- A drug prescribed for a particular use for which it has not been approved by the Food and Drug Administration (FDA) only if it meets the following criteria:
  - The drug is recognized for the specific use in any one of the following established references: the United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluation, the American Hospital Formulary Service, or any peer-reviewed national professional medical journal,
  - The drug has been otherwise approved by the FDA, granted an NDC number and is available at retail pharmacies, and
  - The drug has not been contraindicated by the FDA for the use prescribed.

Pre-approval May Be Required

As new drugs become available, existing drugs are prescribed for new purposes, protocols change for prescribing a drug and other reasons, coverage of some medications require pre-approval from Caremark. This process involves a review to determine whether the Program covers the medication based on medical necessity. To request approval, you, your doctor or your pharmacist may begin the review process by calling Caremark.

Prescription Drug Limitations

No benefits are payable under the Medical Program for the following expenses:

- Non-legend drugs, other than those specified above under Covered Prescription Drugs.
- To the extent that payment is unlawful where the person resides when expenses are incurred.
- Charges that the person is not legally required to pay.
- Charges that would not have been made if the person was not covered under the Medical Program.
- Experimental drugs or drugs labeled "Caution – limited by federal law to investigational use."
- Drugs that are not considered essential for the necessary care and treatment of an injury or sickness, as determined by the prescription drug benefit Claims Administrator.
- Drugs obtained from an out-of-network mail-order pharmacy.
- Any prescription filled in excess of the quantity specified by the physician or dispensed more than one year from the date of the physician's order.
- More than a 34-day supply when dispensed in any one prescription order through a retail pharmacy.
- More than a 90-day supply when dispensed in any one prescription order through a participating mail-order pharmacy.
- Indications not approved by the Food and Drug Administration except as indicated above.
- To the extent that the person is covered under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law (any auto insurance adjustment option chosen under such part will be taken into account).
- Immunization agents, biological sera, blood or blood plasma.
- Therapeutic devices or appliances, including support garments and other non-medicinal substances, excluding insulin syringes.
- Drugs used for cosmetic purposes.
- Administration of any drug.
- Medication that is taken or administered – in whole or in part – at the place where it is dispensed, or while a person is a patient in an institution that operates – or allows to be operated on its premises – a facility for dispensing pharmaceuticals.
- Prescriptions that an eligible person is entitled to receive without charge from any Workers' Compensation or similar law or any public program other than Medicaid.
- Nutritional or dietary supplements, anti-obesity drugs or anorexiants.

- Vitamins, excluding prenatal vitamins, upon written prescription.
- Oral infertility drugs in excess of the $2,500 lifetime maximum.
- Injectable fertility drugs.

PRE-CERTIFICATION / PRE-NOTIFICATION AND PRE-AUTHORIZATION / PRE-DETERMINATION OF EXPENSES

Two Separate Processes for Pre-approval of All Admissions and Certain Services and Treatment

The Claims Administrator has two steps of approvals that need to be completed before you incur expenses for the services listed in this section. Both steps apply no matter whether you use in-network providers or out-of-network providers.

Note that Aetna and BCBS use different words to name the same claim processes:

- Aetna uses ❶ "pre-certification" and ❷ "pre-authorization" for its two separate processes.
- BCBS uses ❶ "pre-notification" and ❷ "pre-determination" for its corresponding two separate processes.

Through these two processes, you and your provider can find out in advance:

❶ **What's Covered** – This step determines if services are covered by the Medical Program, but it does not confirm whether certain limitations, requirements and exclusions might limit or deny benefits paid for those services.

Your Responsibility

- Your health care provider may assist you by requesting this advance certification of coverage *before* hospital and facility admissions or certain services, tests or treatment begin. However, ***it is always your responsibility to confirm*** that Aetna or BCBS has approved the coverage pre-certification / pre-notification of your admission, service or treatment.
- The Claims Administrator normally responds within 15 days of receiving the pre-certification / pre-notification request for routine (non-urgent or non-emergency) care.[27]

How to Verify Pre-certification / Pre-notification

The Claims Administrator mails a notice to the doctor or hospital and the covered person (you or your dependent) when the pre-certification (by Aetna) or pre-notification (by BCBS) process has been completed for an admission or service. If you are not certain this process has been completed or know of its outcome, call the Member Services number on your ID card to ask.

[27] *For the claims process, your responsibilities and those of the Claims Administrator, including circumstances when additional time can be taken for making pre-certification / pre-determination decisions, see the* Filing a Claim *section of the SPD chapter titled* Claims Procedures – Medical and Vision Care Programs for Pre-Medicare Retirees.

❷ **Dollar Amount to Be Paid and Any Limitations that Apply** – This step confirms in writing the general dollar amount of benefits payable for your specific admission, test, care and/or treatment. Through this step, you'll find out if benefits for any covered services might be limited or denied due to certain requirements or exclusions that apply to those services.

Your Responsibility
This step is always your responsibility. Ask your provider to request pre-authorization by Aetna or pre-determination by BCBS. It is your responsibility to confirm the outcome.

How to Verify Pre-authorization / Pre-determination
The Claims Administrator provides your doctor or hospital with an authorization whenever an admission or service has been pre-authorized (by Aetna) or pre-determined (by BCBS). If you are not certain this process has been completed or know of its outcome, call the Member Services number on your ID card to ask.

Example
If you are scheduled for an outpatient surgery, you might be told that (Step ❶) pre-certification by Aetna or pre-notification by BCBS is not necessary. *It is your responsibility to confirm whether pre-certification or pre-notification is necessary and the outcome as determined by Aetna or BCBS.*

In addition, by having your doctor's office request (Step ❷) ***pre-authorization by Aetna or pre-determination by BCBS***, you will learn if your specific surgery procedures will be covered under the Medical Program ***and*** the general level of benefits payable.

It is possible that benefits are not payable because of Program limitations, exclusions or requirements. ***Requesting*** (Step ❷) ***pre-authorization by Aetna or pre-determination by BCBS always is a good idea.***

Hospital and Facility Admissions

You must obtain pre-certification by Aetna or pre-notification by BCBS of an admission whether in-network or out-of-network, ***before*** you are admitted to any:

- Hospital;
- Treatment facility for alcoholism, drug abuse or mental disorder; or
- Convalescent or skilled nursing facility.

Requesting Pre-certification by Aetna or Pre-notification by BCBS for Hospital and Facility Admissions

- If your admission is a non-urgent admission, it is ***your responsibility*** to make sure your provider obtains pre-certification by Aetna or pre-notification by BCBS from the Claims Administrator at least 14 days before admission.
- If your admission is an emergency admission or an urgent admission, it is ***your responsibility*** to make sure your doctor, or the hospital or facility, obtains the Claims Administrator's confirmation of pre-certification by Aetna or pre-notification by BCBS as follows:
  - Before the start of an urgent admission; or

- Not later than 48 hours following an emergency admission, or as soon as reasonably possible thereafter. (For an emergency admission on a Friday or Saturday, the 48-hour requirement will be extended to 72 hours.)

If, in the opinion of your doctor, it is necessary for you to be confined for a longer time than already approved by the Claims Administrator, then you, your doctor or the facility or hospital may request that additional days be approved. This must be done no later than the last day already approved. It is ***your responsibility*** to make sure the request is made and that you have received confirmation that your admission, treatment or service is covered.

The Claims Administrator will promptly send written notice of the number of days approved to the hospital or facility. A copy will be sent to you and your doctor.

If you choose to remain in a hospital, alcoholism, drug abuse or mental disorder treatment facility, convalescent facility, or skilled nursing facility after the date approved by the Claims Administrator, you are responsible for payment to the hospital or facility for all expenses incurred after the end of the approved days.

Inpatient and Outpatient Services, Skilled Nursing Care, Hospice Care and Home Health Care

You must obtain pre-certification by Aetna or pre-notification by BCBS ***before*** you incur expenses for the following services whether in-network or out-of-network:

- All non-emergency inpatient services that are provided in a hospital, convalescent facility or skilled nursing facility; and
- All skilled nursing care, hospice care and home health care.

It is your responsibility to make sure that your provider obtains pre-certification / pre-notification and that you have received confirmation that your admission, treatment or service is covered.

GENERAL EXCLUSIONS

Expenses that Are Not Covered

Coverage does not include:

- Services and supplies not necessary, as determined by the Claims Administrator, for the diagnosis, care or treatment of the disease or injury involved. This applies even if the services and supplies 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 that are, as determined by the Claims Administrator, experimental or investigational. A drug, device, procedure or treatment will be determined to be experimental or investigational if:
  - There is insufficient data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;

- FDA-required approval has not been granted for marketing;
- In the case of a drug, it has not been granted an NDC number and/or is not available in retail pharmacies;
- A recognized national medical or dental society or regulatory agency has determined, in writing, that the service or supply is experimental, investigational or for research purposes; or
- It is stated to be experimental, investigational or for research purposes by:
  - The 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.

  However, this exclusion will not apply to services or supplies (other than drugs) received in connection with a disease, if the Claims Administrator determines that the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the Claims Administrator will take into account the results of a review by a panel of independent medical professionals who are selected by the Claims Administrator and who treat the type of disease involved.

- Services, treatment, education testing or training related to learning disabilities or developmental delays, or charges related to those services.
- Care furnished mainly to provide surroundings free from exposure that can worsen your disease or injury.
- Care for any injury or disease resulting from, or in the course of, any employment for wage or profit.
- The following types of treatment: primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training, carbon dioxide therapy or charges related to those services.
- Treatment of those in the mental health care field who receive treatment as a part of their training in that field.
- Services of a resident physician or intern rendered in that capacity.
- Amounts charged only because there is health coverage.
- Amounts you are not legally obligated to pay.
- Custodial care, as determined by the Claims Administrator.
- Services and supplies:
  - For active duty military personnel, or for any injury or illness that is a direct result of current or past military service.
  - Furnished, paid for or for which benefits are provided or required under any law of a government. (This exclusion will not apply to “no fault” auto

insurance if it is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section titled *Coordination with Other Plans Except Medicare* in the *Claims Procedures – Medical and Vision Care Programs for Pre-Medicare Retirees* chapter of this SPD. In addition, this exclusion will not apply to a plan established by a government for its own employees or their dependents, or Medicaid.)

- Any eye surgery mainly to correct refractive errors, or related charges.
- Education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Therapy, supplies or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Drugs or supplies used for the treatment of erectile dysfunction (except up to eight doses annually if purchased at retail or 24 doses by mail order), impotence or sexual dysfunction or inadequacy. This exclusion applies whether or not the drug is delivered in oral, injectable or topical forms.
- Performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for these drugs or supplies is specifically listed as covered.
- Sex change surgery or any treatment of gender identity disorders, or related charges.
- Routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services, supplies or products, except to the extent that these exams, immunizations, services, supplies or products are specifically listed under the *Preventive Care Services* section of this Medical Program chapter.
- Marriage, family, child, career, social adjustment, pastoral or financial counseling, or related charges.
- Acupuncture therapy, except acupuncture performed by a physician as a form of anesthesia in connection with surgery that is covered under this Medical Program coverage.
- Speech therapy or related charges. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words and form sentences) as the result of a disease or injury.
- Weight control services including surgical procedures, medical treatments; weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications, food or food supplements, exercise programs, exercise or other equipment, and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions. Certain adult nutritional counseling programs and surgical procedures may be covered subject to meeting the Claim Administrator's selection criteria. For more information, call the Claims Administrator for Aetna at 800-826-2386 or for BCBS at 888-399-5945.

- Plastic surgery, reconstructive surgery, cosmetic surgery or other services and supplies that improve, alter or enhance appearance (facings on molar crowns and pontics will always be excluded as cosmetic), whether or not for psychological or emotional reasons, except to the extent needed to:
  - Improve the function of a part of the body that:
    - Is not a tooth or structure that supports the teeth, and
    - Is malformed:
      - As a result of a severe birth defect, including cleft lip, webbed fingers or toes, or
      - As a direct result of disease or surgery performed to treat a disease or injury, including reconstructive surgery following a mastectomy.
  - Repair an injury. Surgery must be performed in the calendar year of the accident that caused the injury or in the next calendar year.
- Amounts to the extent they are not reasonable charges, as determined by the Claims Administrator.
- Reversal of sterilization procedures and certain infertility services not specifically listed as Covered Medical Expenses.
- Services or supplies that, in the opinion of the Claims Administrator, are associated with injuries, illnesses or conditions suffered due to the acts or omissions of a third party and are subject to the Subrogation and Right of Recovery provisions as stated in the chapter of this SPD titled *Claims Procedures – Medical and Vision Care Programs for Pre-Medicare Retirees*.
- Services or supplies furnished by an in-network provider in excess of the provider's negotiated charge for that service or supply.

If any law contradicts a listed exclusion, the exclusion will not apply.

Excluded charges will not be used when determining the amount of any deductible, coinsurance or out-of-pocket maximum benefits.

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

OTHER INFORMATION

Newborns' and Mothers' Health Protection Act of 1996

Group health plans may not under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the birth. In any case, under federal law the Medical Program may not require that the attending physician or the expectant mother obtain authorization from the Claims Administrator for prescribing a length of stay not in excess of 48 hours (or 96 hours, where applicable). Your Claims Administrator must follow these rules.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires that all group health plans that provide medical and surgical benefits for a mastectomy also must provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and coverage for any complications in all stages of mastectomy, including lymphedemas.

The act requires that coverage be provided in a manner that is consistent with other benefits provided by the Medical Program. The coverage may be subject to annual deductibles and/or to copayments.

The act prohibits any group health plan from:

- Denying a participant or a beneficiary eligibility to enroll or renew coverage in order to avoid the requirements of the act.
- Penalizing, reducing or limiting reimbursement to the attending provider (e.g. the attending physician, clinic or hospital) to induce the provider to give care that is inconsistent with the act.
- Providing monetary or other incentives to an attending provider to induce the provider to give care that is inconsistent with the act.

BNSF's Privacy Practices

Participants in the Burlington Northern Santa Fe Group Benefits Plan (the "Plan") have certain rights under the Health Insurance Portability and Accountability Act (HIPAA). These rights and the Plan's legal duties with respect to protected health information (PHI), including how the Plan may use and disclose PHI, are explained in the Plan's Privacy Practices Notice.

Retirees may view or print a copy of the Privacy Practices Notice from the Internet at www.bnsf.com/retirees/exempt-retirees/pdf/PrivacyPracticeNotice.pdf. In addition, any participant may request a copy by calling the Employee Service Center at 800-234-1283, option 6.

You may also contact the Plan's Privacy Official 800-234-1283 for more information on the Plan's privacy policies or your rights under HIPAA.

Medical Program Provisions

Expenses Covered Only While Coverage is in Effect

The BNSF Medical 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.

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.

WHOM TO CALL ABOUT YOUR BENEFITS

For questions about eligibility for coverage or enrollment in the Medical Program, call the BNSF Benefits Center at 877-451-2363.

For questions about the Medical Program options, covered expenses or claims, call Aetna at 800-826-2386 or BCBS at 888-399-5945.

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 section of this Medical Program chapter also appears as a defined term, the definition in the other section will apply to that specific section rather than the definition below.

Previous view: Return to the 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.

Blue Distinction Centers – The BCBS Solid Organ and Bone Marrow Transplant Program coordinates care and provides access to covered transplant treatment through the national Blue Distinction Centers network for those who have enrolled in the BCBS provider network. Hospitals that have met extensive criteria for quality and cost-effectiveness have been selected by BCBS to participate as Blue Distinction Centers facilities for solid organ transplants and bone marrow transplants. These facilities have been contracted on a transplant-specific basis and are considered participating only for the transplant type listed in the Blue Distinction Centers network directory.

Body mass index (BMI) – A practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

> Example: A person who is five feet, six inches tall is 1.68 meters tall. The square of 1.68 meters is 2.82. If this person weighs 180 pounds (81.7 kilograms), their Body Mass Index is 29. (81.7 kilograms divided by 2.82 = 29)

Brand-name drug – A prescription drug that is protected by trademark registration.

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, as amended. For more information on your COBRA rights, see the chapter of this SPD titled *Continuing Health Care Coverage Under COBRA – Medical and Vision Care Programs for Pre-Medicare Retirees*.

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

Companion – A person whose presence as a companion or caregiver is necessary to enable a transplant patient under the Aetna Institutes of Excellence and BCBS Blue Distinction Centers transplant networks to:

- Receive services in connection with an Aetna Institutes of Excellence and BCBS Blue Distinction Centers procedure or treatment on an inpatient or outpatient basis, or
- Travel to and from the facility where treatment is given.

Convalescent facility (also called a Skilled Nursing Facility) – An institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for recuperating from disease or injury:
  - Professional nursing care by an R.N., or by an L.P.N. directed by a full-time R.N., and
  - Physical restoration services to help patients meet a goal of self-care in daily living activities.

- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Charges for its services.

"Copay" or copayment – The fixed dollar amount you pay for purchases of generic prescriptions.

Custodial care – Services and supplies furnished to help you in the activities of daily life, whether or not you are disabled. This includes room and board and other institutional care. Services and supplies are considered to be custodial care, regardless of who recommends, prescribes or performs them.

Deductible – The amount of eligible expenses you must pay each year before the Program begins to pay benefits.

Dentist – A legally qualified dentist as well as a physician who is licensed to do the dental work performed.

Detoxification – Treating the aftereffects of a specific episode of alcoholism or drug abuse.

Directory – A listing of in-network [Aetna Choice POS II (Open Access) Network or BCBS PPO Network] providers in the service area included under the Medical Program. A current list of network providers is available through the Provider Lookup tool on the BNSF Benefits Center website at www.BNSF.mercerhrs.com. You may also access Aetna's online provider directory, DocFind, at www.aetna.com, or the BCBS online provider directory at www.bcbsil.com.

Durable medical and surgical equipment – Equipment and the accessories needed to operate the equipment that are:

- Made to withstand prolonged use,
- Made for and mainly used in the treatment of a disease or injury,
- Suited for use in the home,
- Not normally of use to persons who do not have a disease or injury,
- Not for use in altering air quality or temperature, and
- Not for exercise or training.

Excluded is equipment such as: whirlpools, portable whirlpool pumps, sauna baths, massage devices, over-bed tables, elevators, communication aids, vision aids, telephone alert systems and items deemed experimental or investigational.

Effective treatment of alcoholism or drug abuse – A program of alcoholism or drug abuse therapy that is prescribed and supervised by a physician and either:

- Has a follow-up therapy program directed by a physician on at least a monthly basis, or
- Includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

Excluded are:

- Detoxification.
- Maintenance care. This means providing an environment free of alcohol or drugs.

Emergency admission – An event when a physician admits you to a hospital or treatment facility immediately after the sudden and unexpected onset of a change in your physical or mental condition:

- Which requires confinement immediately as a full-time inpatient, and
- For which if immediate inpatient care was not given could, as determined by the Claims Administrator, reasonably be expected to result in:
  - Placing your health in serious jeopardy,
  - Serious impairment to bodily function,
  - Serious dysfunction of a body part or organ, or
  - In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency care – Treatment given in a hospital's emergency room to evaluate and treat medical conditions of a recent onset and severity, including but not limited to severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the condition, illness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy,
- Serious impairment to bodily function,
- Serious dysfunction of a body part or organ, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency condition – A recent and severe medical condition, including but not limited to severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the condition, illness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy,
- Serious impairment to bodily function,
- Serious dysfunction of a body part or organ, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

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

Health Savings Account (HSA) Administrator – HSAs offered in connection with BNSF Medical Program coverage are administered by UMB Bank.

Home health care agency – An agency that:

- Mainly provides skilled nursing and other therapeutic services,
- Is associated with a professional group that makes policy (this group must have at least one physician and one R.N.),
- Has full-time supervision by a physician or an R.N.,

- Keeps complete medical records on each person,
- Has a full-time administrator, and
- Meets licensing standards.

Home health care plan – A plan that provides for care and treatment of a disease or injury. The care and treatment must be:

- Prescribed in writing by the attending physician, and
- An alternative to confinement in a hospital or convalescent facility.

Hospice care – Care given to a terminally ill person by or under arrangements with a hospice care agency as part of a hospice care program.

Hospice care agency – An agency or organization that:

- Has hospice care available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it operates.
- Provides:
  - Skilled nursing services,
  - Medical social services, and
  - Psychological and dietary counseling.
- Provides or arranges for other services including:
  - Services of a physician,
  - Physical and occupational therapy,
  - Part-time home health aide services that mainly consist of caring for terminally ill persons, and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel that include at least:
  - One physician,
  - One R.N., and
  - One licensed or certified social worker employed by the agency.
- Establishes policies governing the provision of hospice care.
- Assesses the patient's medical and social needs, and develops a hospice care program to meet those needs.
- Provides an ongoing quality assurance program, including reviews by physicians, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice care program – A written plan of hospice care that:

- Is established and reviewed periodically by:
  - An attending physician, and
  - Appropriate personnel of a hospice care agency.
- Is designed to provide:
  - Palliative and supportive care to terminally ill persons, and
  - Supportive care to their families.
- Includes:
  - An assessment of the patient's medical and social needs, and
  - A description of the care to be given to meet those needs.

Hospice facility – A facility or distinct part of the facility that:

- Mainly provides inpatient hospice care to terminally ill persons,
- Charges for its services,
- Meets any licensing or certification standards set forth by the appropriate jurisdiction,
- Keeps a medical record on each patient,
- Provides an ongoing quality assurance program, including reviews by physicians other than those who own or direct the facility,
- Is run by a staff of physicians, with at least one physician on call at all times,
- Provides 24-hour-a-day nursing services under the direction of an R.N., and
- Has a full-time administrator.

Hospital – A place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment and care of injured and ill persons,
- Is supervised by a staff of physicians,
- Provides 24-hour-a-day R.N. service,
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics or a nursing home, and
- Charges for its services.

In-network care or provider – See Preferred Care Provider (Aetna) or Participating Provider (BCBS).

Jaw joint disorder –

- 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.

L.P.N. – A licensed practical nurse.

Mail-order pharmacy – An establishment where prescription drugs are legally dispensed by mail and in larger quantities than are typically dispensed at a retail pharmacy.

Maximum –

- **Annual maximum benefit** – The greatest amount of benefits or services the Program will pay for a person in a calendar year.
- **Coinsurance maximum** – The greatest dollar amount you would have to pay in coinsurance and copayments in a calendar year.
- **Out-of-pocket maximum** – The greatest amount of deductible and coinsurance/copayment expenses (combined) a person will pay in a calendar year.

Mental disorder – A disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes, but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

Coverage of mental disorders includes alcoholism and drug abuse only if the type of treatment does not apply under other alcoholism and drug abuse provisions of the Program.

Morbid obesity – A Body Mass Index that:

- Exceeds 40 kilograms (about 88 pounds) per meter (about 3.28 feet) squared of height; or
- Equals or exceeds 35 kilograms (about 77 pounds) per meter (about 3.28 feet) squared of height with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

National Medical Excellence (NME) Patient – A person who has enrolled in the Aetna provider network and who:

- Requires any of the procedures or treatments for which the charges are covered under the NME Program,
- Is approved by the Claims Administrator as an NME Patient, and
- Agrees to have the procedure or treatment performed in a hospital designated by the Claims Administrator as the most appropriate facility.

National Medical Excellence (NME) Program – Aetna's NME Program coordinates care and provides access to covered transplant treatment through the national Institutes of Excellence™ network for those who have enrolled in an Aetna network option. Hospitals that have met extensive criteria for quality and cost-effectiveness have been selected by Aetna to participate as Institutes of Excellence transplant facilities for solid organ transplants and bone marrow transplants. These facilities have been contracted on a transplant-specific basis and are considered participating only for the transplant type listed in the Institutes of Excellence network directory.

Necessary – A service or supply is necessary if the Claims Administrator determines that it is appropriate for the diagnosis, care or treatment of the illness or injury involved. To be appropriate, the service or supply must:

- Be care or treatment that, as it relates both to the illness or injury involved and to your overall health condition, is:
  - As likely to produce a significant positive outcome as any alternative service or supply, and
  - No more likely to produce a negative outcome than any alternative service or supply;
- Or be a diagnostic procedure indicated by your health status that, as it relates both to the illness or injury involved and to your overall health condition, is:
  - As likely to result in information that could affect the course of treatment as any alternative service or supply, and
  - No more likely to produce a negative outcome than any alternative service or supply;
- And be no more costly for diagnosis, care and treatment (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply meeting the above tests.

In determining if a service or supply is appropriate under the circumstances, the Claims Administrator will take into consideration:

- Information provided on your health status,
- Reports in peer-reviewed medical literature,
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data,
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment,
- The opinion of health professionals in the generally recognized health specialty involved, and
- Any other relevant information brought to the Claims Administrator's attention.

In no event will the following services or supplies be considered necessary:

- Those that do not require the technical skills of a medical, mental health or dental professional.
- Those furnished mainly for your personal comfort or convenience or that of any caregiver, family member, health care provider or health care facility.
- Those furnished solely because you are an inpatient on any day on which your illness or injury could safely and adequately be diagnosed or treated while not confined.
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated charge – The maximum amount an in-network provider has agreed to accept for any service or supply for the purpose of determining benefits under this Medical Program coverage.

Non-participating provider – A health care provider that has not contracted to furnish services or supplies for a negotiated charge under the BCBS provider network.

Non-preferred care (out-of-network care) – A health care service or supply furnished by a health care provider that does not participate in the Aetna provider network.

Non-preferred care provider (out-of-network provider) – A health care provider that has not contracted to furnish services or supplies for a negotiated charge under the Aetna provider network.

Orthodontic treatment – Any medical or dental service or supply furnished to prevent, diagnose or correct a misalignment of teeth or the bite or the jaws or jaw-joint relationship, whether or not for the purpose of relieving pain.

Not considered orthodontic treatment is:

- The installation of a space maintainer, or
- A surgical procedure to correct malocclusion.

Out-of-network care – See Non-Preferred Care or Non-Preferred Care Provider.

Participating provider – A health care provider that has contracted with the BCBS network to furnish services or supplies for a negotiated charge.

Pharmacy – An establishment where prescription drugs are legally dispensed.

Physician – A legally qualified physician.

Pre-authorization – See related section of this chapter.

Pre-certification – See related section of this chapter.

Pre-determination – See related section of this chapter.

Pre-notification – See related section of this chapter.

Preferred care (in-network care) – A health care service or supply furnished by:

- Any in-network provider,
- Any health care provider for an emergency condition when travel to an in-network (Aetna Preferred Care) provider is not feasible, if approved by the Claims Administrator, and
- An out-of-network (Non-Preferred) Urgent Care Provider when travel to an in-network (Preferred) Urgent Care Provider for treatment is not feasible, and if approved by the Claims Administrator.

Preferred Care also is care that is recommended and approved by the Claims Administrator.

Preferred care provider (in-network provider) – A health care provider that has contracted with the Claims Administrator to furnish services or supplies for a negotiated charge. In-network providers are listed in each network directory.

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

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

Prescription drugs (or medications) – Any of the following:

- A drug, biological, compounded prescription or contraceptive device that, by federal law, may be dispensed only by prescription and that is required to be labeled "Caution: Federal law prohibits dispensing without a prescription."
- An injectable contraceptive drug prescribed to be administered by a paid health care professional.

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid health care professional. Covered injectable drugs include insulin.
- Disposable needles and syringes that are purchased to administer a covered injectable prescription drug.
- Disposable diabetic supplies.

Prescription legend drug – A drug that can be dispensed to the public only with an order (prescription) from a properly authorized person (physician, physician assistant or nurse practitioner). The Food and Drug Administration designates if a medication will be considered legend.

Primary care physician (PCP) – An in-network provider listed as a General Practice, Family Practice or Internal Medicine physician in the network directory.

Psychiatric physician – A physician who:

- Specializes in psychiatry, or
- Has the training or experience to do the required evaluation and treatment of mental illness.

R.N. – A registered nurse.

Reasonable charge (also "reasonable and customary charge" or "recognized charge") – The lowest of:

- The provider's usual charge for furnishing the service or supply,
- The charge the Claims Administrator 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, or
- The charge the Claims Administrator determines to be the prevailing charge level made for the service or supply in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is unusual, not often provided in the area or provided by only a small number of providers in the area, the Claims Administrator may take into account factors such as:

- The complexity,
- The degree of skill needed,
- The specialty of the provider,
- The range of services or supplies provided by the facility, and
- The prevailing charge in other areas.

Only that part of a charge which is reasonable is covered.

In some circumstances, the Claims Administrator may have an agreement with a provider (either directly or indirectly through a third party) that sets the charge that the Claims Administrator considers reasonable for a service or supply. In these instances, regardless of the methodology described above, the reasonable charge is established in that agreement.

If a provider does not have a written agreement with the Claims Administrator, the reasonable charge will be the lower of the provider's billed charge or the Claims Administrator's reasonable charge for non-contracting providers.

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

Semi-private rate – The charge for room and board that an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, the Claims Administrator will determine the semi-private rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Service area – The geographic area, as determined by the Claims Administrator, in which in-network providers for this Medical Program coverage are located.

Specialist – A physician who:

- Practices in any generally accepted medical or surgical sub-specialty, and
- Is providing other than routine medical care.

Surgery center – A freestanding ambulatory surgical facility that:

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

Terminally ill – A medical prognosis of six months or less to live.

Treatment facility (for alcoholism or drug abuse) – An institution that:

- Mainly provides a program for diagnosis, evaluation and effective treatment of alcoholism or drug abuse;
- Charges for its services;
- Meets licensing standards;
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a physician; and
- Provides, on the premises, 24 hours a day:
  - Detoxification services needed with its effective treatment program,
  - Infirmary-level medical services. Also, it provides, or arranges for, any other medical services that may be required,
  - Supervision by a staff of physicians, and
  - Skilled nursing care by licensed nurses who are directed by a full-time R.N.

Treatment facility (for mental disorder) – An institution that:

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

Urgent admission – An admission to a hospital due to:

- The onset of or change in a disease,
- The diagnosis of a disease, or
- An injury caused by an accident.

This disease or injury, while not requiring an emergency admission, must be severe enough to require confinement as an inpatient in a hospital within two weeks from the date the need for the confinement becomes apparent.

Urgent care provider/facility –

- A freestanding medical facility that:
  - Provides unscheduled medical services to treat an urgent condition if your physician is not reasonably available,
  - Routinely provides ongoing unscheduled medical services for more than eight consecutive hours,
  - Charges for its services,
  - Is licensed and certified as required by any state or federal law or regulation,
  - Keeps a medical record on each patient,
  - Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility,
  - Is run by a staff of physicians. At least one physician must be on call at all times, and
  - Has a full-time administrator who is a licensed physician.
- A physician's office, but only one that has contracted with the Claims Administrator to provide urgent care; and is, with the Claims Administrator's consent, included in the network directory as an in-network (preferred) Urgent Care Provider.

An Urgent Care Provider is not the emergency room or outpatient department of a hospital.

Urgent condition – A sudden illness, injury or condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health,
- Includes a condition that would subject you to severe pain that could not be adequately managed without urgent care or treatment,
- Does not require the level of care provided in the emergency room of a hospital, and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

Walk-in clinic – A health care facility, typically staffed by nurse practitioners and/or physician assistants with a physician on call during all hours of operation, that provides limited primary care services.