BURLINGTON NORTHERN SANTA FE MEDICAL PROGRAM

Aetna Select EPO
And
Aetna Build Your Own Program Options
Summary Plan Description

Effective January 1, 2006

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BNSF Medical Program

The BNSF Medical Program offers you protection against the financial burden an illness or injury can create. You can choose the Medical Program option and coverage level that best meet your coverage needs.

Medical Program options from which you can choose include:

- The Aetna Select EPO where available;
- The Blue Cross Blue Shield Preferred Provider Organization (BCBS PPO) Base;
- The Build Your Own Option (BYO) with Blue Cross Blue Shield or Aetna
- Aetna High Deductible Health Program (Aetna HDHP); or
- A Health Maintenance Organization (HMO) where available.

The Aetna EPO and BYO medical options feature a Health Reimbursement Account (HRA). This BNSF-funded account is yours to use for qualified medical expenses during the year that aren't paid by the plan (for example, deductibles or copays for office visits or prescriptions). Any unused balance remaining at year-end can be carried forward to the next year. More details can be found beginning on page 37.

You may also elect to opt out of the BNSF Medical Program, which is an election to waive Medical Program coverage for yourself and any dependents.

This Summary Plan Description is for BNSF Employees who chose the Aetna Select EPO or one of the Aetna BYO Options only. These benefits are not insured with Aetna but will be paid from BNSF's general funds. Aetna will provide certain administrative services under the Plan as outlined in the Administrative Services Agreement between Aetna and BNSF.

Coverage level options from which you can choose include:

• Employee only;

• Employee plus spouse;

• Employee plus child(ren) only; and

• Employee plus family, which includes coverage for you, your dependent children and your spouse.

The Company shares the cost of coverage. Your contribution will be paid on a before-tax basis through the BNSF Internal Revenue Code Section 125 cafeteria plan.

This Summary Plan Description (SPD) covers benefits available under the Aetna Select EPO and Aetna BYO options only. There is a separate SPD for employees electing other coverage options. HMO coverage and benefit information is provided in separate HMO booklets. Whatever coverage you choose, you have special rights under ERISA as described in the section of this SPD titled "Your Rights Under ERISA."

This SPD does not include retiree medical benefits. Retiree benefits are explained in a separate Retiree Medical SPD.

If you have questions regarding your benefits, call Aetna Member Services at 1-800-826-2386 from 8:00 a.m. to 6:00 p.m. Central Standard Time. You can also access the Aetna website at **www.aetna.com.**

Eligibility and Enrollment

Your Eligibility for Coverage

You are eligible to enroll in the Medical Program if you are a regularly assigned, salaried employee of BNSF or a Participating Affiliated Company. Employees covered under a collective bargaining agreement that does not provide for participation in the Medical Program are not eligible to enroll. Medical coverage is not available to other employees or service providers, such as leased employees or independent contractors, unless otherwise specified in the Medical Program document.

Dependent Eligibility

Family members you may cover as eligible dependents under the Medical Program include:

• Your legal spouse, unless you are legally separated or divorced.

• Your unmarried children under age 19 (or under age 23 if the child is a full-time student at an accredited institution) and dependent primarily on you for financial support. Eligible children must live with you in a parent-child relationship and include:

– your unmarried natural children;

– your stepchildren, legally adopted children, children placed for adoption, or children placed under the full legal guardianship of you or your spouse; and

– children related to you by blood or marriage, including grandchildren who live with you in a parent child relationship (for grandchildren, a parent-child relationship does not exist if the child's natural parent lives in the same home).

• A child who is the subject of a Qualified Medical Child Support Order (QMCSO) issued under ERISA Section 609, as determined by BNSF. You may request copies of the BNSF QMCSO policies and procedures free of charge through the Benefits Department in Fort Worth or you may contact Your Benefits Resources (YBR).

Your children are considered to depend primarily on you for financial support if you provide more than 50% of their support and they are eligible to be claimed as dependents on your federal income tax return. Coverage ends on the first to occur of the following:

• the end of the month in which a child who is not a full-time student turns 19;

• the date that the child over 19 graduates or ceases to be a full-time student;

• the end of the month in which a child who is a full-time student reaches age 23;

• the child's marriage; or

• the date the child ceases to be a dependent for income tax purposes.

To be considered a full-time student at an accredited institution, your child must be registered as a full-time student in a high school, college, university, trade school, professional school, school in a foreign country or remedial education facility. The Benefits Administrator, Your Benefits Resources (YBR), will require proof of whether a child qualifies as a full-time student.

Eligible enrolled children who are mentally or physically disabled may retain coverage beyond age 19 (or age 23, if they are full-time students when they become disabled) if their disability occurred before reaching the Medical Program's maximum age. To be eligible for continued coverage, the child must be unmarried, legally

reside with you, must be incapable of self-sustaining employment and must be primarily dependent on you for financial support. To continue coverage for a disabled child, you must contact Aetna with proof of the disability within 60 days of the date the child turns age 19 (or age 23 if the child is a full-time student) and as requested from time to time thereafter as determined by Aetna.

First Enrollment

If you are a newly hired employee you must enroll within 31 days of your first day of employment. Your coverage will begin on the first day of employment provided you enroll on time. For newly eligible employees (e.g., employees promoted from union to salaried exempt positions), the effective date of coverage is the first day of the month following 30 days' classification as a regularly assigned salaried employee. An exception applies to newly promoted salaried exempt employees whose promotion date is February 1. This group of employees will be covered effective March 1, provided the employee chooses a Medical Program option and enrolls on time.

If you do not enroll within 31 days of your effective date, you will be automatically enrolled in the Blue Cross and Blue Shield Base PPO Base Program option with "employee only" coverage.

Annual Enrollment

Each year you have the opportunity to change your coverage option election during Annual Enrollment. If you do not wish to change the Medical Program option you chose in the prior year, the prior option will automatically renew, if the option is available and you continue to be eligible for coverage. If a Program option is no longer available, and you fail to make a new election, your coverage level will remain the same and you and your dependents will be automatically enrolled in the Blue Cross and Blue Shield Base Program.

If you opted out of Medical Program coverage you must show a Family Status Event or otherwise qualify for HIPAA Special Enrollment in order to enroll in the Program before the next Annual Enrollment. In that case you must enroll through the YBR web site or by phone with YBR within 31 days of the Family Status Event or the Special Enrollment event, except as noted under "Effective Date of Revised Coverage" for newly eligible dependent enrollment.

Electing the Opt-Out Option

If you choose to opt out of Medical Program coverage, you want to consider having other group or individual medical coverage in place to cover yourself and your dependents at the time you opt out. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows you to carry over credit from coverage under another medical plan (whether the coverage is individual coverage or group coverage) and to apply it to a new group medical plan's pre-existing condition exclusion period. Under HIPAA, if you have a break in coverage that is greater than 62 days, you may not be able to carry over credit for any prior medical coverage to any new medical coverage.

Although this Medical Program does not have a pre-existing condition exclusion period, you should still familiarize yourself with HIPAA's coverage credit carryover rules. You may want to purchase medical coverage that does have a pre-existing exclusion period at some future date.

Changing Your Election During the Year

You must enroll within 31 days after the date you first become eligible for coverage, or by the deadline set by your Employer for each Annual Enrollment. Your enrollment elections will remain in place for the calendar year in which you enroll. You are allowed to make a change *only* if you experience a change in family or employment status as described below. Otherwise, you must wait until the next Annual Enrollment period to make a change.

Family Status Event

Eligible changes in family or employment status include:

• Your marriage, legal separation, divorce or annulment;

• The birth, placement for adoption or adoption of a child;

• The death of a dependent (including your spouse);

• The termination or commencement of your spouse's employment, a change in hours worked, or an unpaid leave of absence taken by you or your spouse resulting in a change in eligibility for medical coverage;

• a dependent satisfies or ceases to satisfy eligibility requirements;

• a change in residence or worksite, but only if it results in the need to change health care networks as determined by YBR;

• A significant change in your spouse's group medical coverage, as determined by the Program Administrator; or

• Service of a Qualified Medical Child Support Order (QMCSO) issued under ERISA Section 609, as approved by the Program Administrator.

You must request enrollment or a change in enrollment within 31 days of your Family Status Event. If you experience one of the qualifying family status change events noted above, any changes to your benefit selections will be based on the type of event you experience. You can make only those changes that directly relate to the event and are consistent with the event.

HIPAA Special Enrollment Rules

If you opted out of Medical Program coverage for yourself or an eligible dependent during Annual Enrollment, you may enter the Medical Program or add eligible dependents, on a special enrollment date if you enroll through YBR **within 31 days** of the occurrence of one of the following events:

• If you become married, even though you may have waived coverage initially, you and your spouse may take advantage of special enrollment.

• If you are married and chose Employee only coverage, and you subsequently acquire a new dependent (whether through birth, placement for adoption or adoption), you may elect special enrollment for your spouse and child, or for the child only.

• If you opted out of Medical Program coverage because you were covered under another employer's group medical plan and you lose coverage under that plan for a reason other than failing to pay premiums or misrepresentation (for example, a Family Status Event), you may elect special enrollment for you and any eligible dependents. You are not required to take COBRA continuation under another plan to elect special enrollment under this Medical Program.

• If you opted out of Medical Program coverage (or you opted not to enroll your dependents) because COBRA continuation was in effect on your eligibility date, you (or your dependents) must exhaust the COBRA continuation period before special enrollment can be elected under the Medical Program. This means you (or your dependents) must continue COBRA coverage for the entire COBRA period. Failure to pay a COBRA premium does not result in the exhaustion of COBRA.

Neither you nor an eligible dependent is required to elect COBRA continuation under another employer's plan in order to become eligible for special enrollment. However, once you or your dependent elects COBRA continuation, if you also opted out of coverage under this Medical Program, the entire COBRA continuation period must be completed before you can enroll in this Program.

• If you either opted out of the Medical Program or chose Employee only coverage and YBR receives a valid Qualified Medical Child Support Order under ERISA Section 609, the child will be enrolled under the Program's Special Enrollment rules. If you are not enrolled, you and the child will be enrolled in Employee plus child coverage, and you will be required to pay the applicable cost of coverage. You may request a copy of the BNSF policies and procedures for QMCSOs from the Benefits Department or YBR.

A HIPAA special enrollment is also allowed if (1) your other group medical plan terminates, or (2) the employer sponsoring the other group medical plan ceases to make employer contributions. However, you must give notice and actually enroll in the BNSF Medical Program within 31 days of the occurrence of a special enrollment event described in (1) or (2). If you fail to do so, you must wait until the next Annual Enrollment for the Medical Program, unless you have a subsequent Family Status Event and give notice within 31 days of the subsequent change.

Special Enrollment under the HIPAA rules can occur at any time during the calendar year.

Giving Notice of a Family Status Event

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

Effective Date of Revised Coverage

Generally, all changes due to Family Status Events and HIPAA Special Enrollment Rules must be made within 31 days of the event. In those cases, the effective date of the new coverage will be the date of the event. However, there are some *limited* exceptions to the 31-day rule as indicated below:

- If your request is to add a newly eligible dependent, and the request is made after 31 days of the Family Status Event, the new dependent's coverage will be effective on the date of the request; or

- If the request is to add a newly eligible dependent, and you already have "family coverage", the new dependent's coverage will be retroactive to the date of eligibility.

If the above exceptions do not apply, and your request is more than 31 days after the event, you must wait until the next Annual Enrollment period to make the change. Therefore, it is always best to request the change as soon as possible.

Benefit Changes Due to Relocation or Closing of an HMO

If you originally elected HMO coverage and later relocate outside the HMO service area, you can change your Medical Program election within 31 days after the date of your relocation. You may not change your coverage level election until the next Annual Enrollment unless you have a Family Status Event.

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

If you do not request a change within 31 days of one of these events, you will have to wait until Annual Enrollment to become covered under the Medical Program.

Cost of Coverage

When you elect a Medical Program coverage option, you will be advised of the cost of coverage. From time to time, BNSF reviews the cost of the various Medical Program options. You will be notified of any changes in the cost of coverage for the Medical Program option you have elected before the change goes into effect.

Your Health Benefits

This Program will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

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

Your Primary Care Physician

Consult your Primary Care Physician whenever you have questions about your health. He or she provides basic and routine care, and can refer you to specialists and facilities in the network, when medically necessary.

Primary and Preventive Care

Your selected Primary Care Physician can provide preventive care and treat you for illnesses and injuries. Coverage for out-of-network care is limited to emergency situations. Refer to the “Schedule of Benefits” for details.

Schedule of Benefits – Aetna Select EPO

LIFETIME MEDICAL PROGRAM LIFETIME MAXIMUM	Unlimited
Deductible (per calendar year)* (Individual/Family)	$500 / $1,000
Program Coinsurance	100% after deductible
Coinsurance limit (Out-of-pocket Maximum)*	Not Applicable
Inpatient Hospital Services (pre-certification required; $500 penalty if pre-certification not received)	100% after deductible
Outpatient Surgery & Diagnostic Tests (pre-certification required on certain procedures and treatments [see page 27]; $200 penalty if pre-certification not received)	100% after deductible
Outpatient Emergency (Hospital & Physician - - Initial treatment of accidental injuries or sudden and unexpected medical conditions with severe life threatening symptoms. Non-emergency use of emergency room is not covered.)	$50 copayment (waived if admitted)
Physician Office Visit	Primary Care Physician: $15 Copay Specialist: $25 Copay
Well Child & Adult Routine Care	100% (no deductible and no coinsurance)
Chiropractor (limited to 60 visits per calendar year)	80% after deductible
Durable Medical Equipment (DME)	80% after deductible
Occupational / Physical / Speech Therapy (limited to 60 visits per therapy per calendar year)	80% after deductible
Other Covered Services	80% after deductible
Prescription Drugs (Retail) **See page 54 for prescription drug coverage details**	Generic $10 copay Formulary $25 copay Non-Formulary $40 copay
Prescription Drugs (Mail Order) **See page 54 for prescription drug coverage details**	Generic $20 copay Formulary $50 copay Non-Formulary $80 copay
Inpatient Mental Health Services	100% after deductible (limited to 60 days per calendar year)
Outpatient Mental Health Services	100% after deductible
Inpatient Chemical Dependency	100% after deductible (limited to 60 days per calendar year)
Outpatient Chemical Dependency	100% after deductible
Medical Management /Aetna Healthline: • Notification required before all elective inpatient admissions. Emergency and U admission notification required within 48 hours of admittance. $500 penalty applied if pre-certification not received. **Notification required before certain outpatient procedures and treatments as outlined on page 27. $200 penalty applied if pre-certification not received**	

*Penalties for not requesting pre-authorization and charges in excess of reasonable and customary for out-of-network providers are not credited toward the deductible or out-of-pocket maximum.

AETNA Build Your Own Options
Level of Coverage

AETNA BYO Option 1	In Network	AETNA BYO Option 2	In Network
Deductible (Individual/Family)	$500 / $1,000	**Deductible** (Individual/Family)	$500 / $1,000
Coinsurance	85%	**Coinsurance**	85%
Out-of-pocket Maximum (Individual/Family)	$2,000 / $4,000	**Out-of-pocket Maximum** (Individual/Family)	$2,000 / $4,000
Prescription Coverage	Copay	**Prescription Coverage**	Coinsurance

AETNA BYO Option 3	In Network	AETNA BYO Option 4	In Network
Deductible (Individual/Family)	$500 / $1,000	**Deductible** (Individual/Family)	$500 / $1,000
Coinsurance	70%	**Coinsurance**	70%
Out-of-pocket Maximum (Individual/Family)	$3,000 / $6,000	**Out-of-pocket Maximum** (Individual/Family)	$3,000 / $6,000
Prescription Coverage	Copay	**Prescription Coverage**	Coinsurance

AETNA BYO Option 5	In Network	AETNA BYO Option 6	In Network
Deductible (Individual/Family)	$1,000 / $2,000	**Deductible** (Individual/Family)	$1,000 / $2,000
Coinsurance	85%	**Coinsurance**	85%
Out-of-pocket Maximum (Individual/Family)	$2,000 / $4,000	**Out-of-pocket Maximum** (Individual/Family)	$2,000 / $4,000
Prescription Coverage	Copay	**Prescription Coverage**	Coinsurance

Continued

AETNA BYO Option 7	In Network	AETNA BYO Option 8	In Network
Deductible (Individual/Family)	$1,000 / $2,000	**Deductible** (Individual/Family)	$1,000 / $2,000
Coinsurance	70%	**Coinsurance**	70%
Out-of-pocket Maximum (Individual/Family)	$3,000 / $6,000	**Out-of-pocket Maximum** (Individual/Family)	$3,000 / $6,000
Prescription Coverage	Copay	**Prescription Coverage**	Coinsurance

AETNA BYO Option 9	In Network	AETNA BYO Option 10	In Network
Deductible (Individual/Family)	$1,500 / $3,000	**Deductible** (Individual/Family)	$1,500 / $3,000
Coinsurance	85%	**Coinsurance**	85%
Out-of-pocket Maximum (Individual/Family)	$2,000 / $4,000	**Out-of-pocket Maximum** (Individual/Family)	$2,000 / $4,000
Prescription Coverage	Copay	**prescription Coverage**	Coinsurance

AETNA BYO Option 11	In Network	AETNA BYO Option 12	In Network
Deductible (Individual/Family)	$1,500 / $3,000	**Deductible** (Individual/Family)	$1,500 / $3,000
Coinsurance	70%	**Coinsurance**	70%
Out-of-pocket Maximum (Individual/Family)	$3,000 / $6,000	**Out-of-pocket Maximum** (Individual/Family)	$3,000 / $6,000
Prescription Coverage	Copay	**Prescription Coverage**	Coinsurance

Special Comprehensive Medical Coverage

Although a specific service may be listed as a covered expense, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of an illness or condition. The Schedule of Benefits outlines the Payment Percentages that apply to the Covered Medical Expenses described below. There are exclusions, deductibles and stated maximum benefit amounts. Covered Medical Expenses include expenses for certain **hospital** and other medical services and supplies and must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses.

Hospital Expenses

Inpatient Hospital Expenses
Charges made by a **hospital** for giving **board and room** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.
For **Preferred Care**:

- If a private room is used, the daily **board and room** charge will be covered if:
  the person's **Preferred Care Provider** requests the private room; and
  the request is approved by Aetna.
- If the above procedures are not met, any part of the daily **board and room** charge which is more than the **semiprivate rate** is not covered.

Outpatient Hospital Expenses
Charges made by a **hospital** for **hospital** services and supplies which are given to a person who is not confined as a full-time inpatient.

Outpatient Surgical Expenses

Covered Medical Expenses include charges for outpatient surgical expenses to the extent shown below.
Covered Medical Expenses include charges made:

- in its own behalf by:
  a **surgery center**;
  the outpatient department of a **hospital**; or
  an office based surgical facility of a **physician** or a **dentist**.
- 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 the center or in a hospital. 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.
- It can safely and adequately be performed only in a **surgical center** or in a **hospital** o r
  in an office based surgical facility of a **physician** or a **dentist**.
- It is not normally performed in the office of a **physician** or a **dentist**.

Outpatient Services and Supplies
These are:

- Services and supplies furnished by the **surgery center** or by a **hospital** on the day of the procedure.
- Services of the operating **physician** for performing the procedure and for:
  related pre and postoperative care; and
  the administering of an anesthetic.

- Services of any other **physician** for related postoperative care and for the administering of an anesthetic. This does not include a local anesthetic.

Limitations:
No benefit is paid for charges incurred:
- For the services of a **physician** who renders technical assistance to the operating **physician**.
- While the person is confined as a full-time inpatient in a **hospital**.

Convalescent Facility Expenses

Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury.

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a private room over the **semiprivate rate**.
- Use of special treatment rooms.
- X-ray and lab work.
- 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.

Benefits will be paid for no more than 60 days, the Convalescent Days Maximum, during any one calendar year.

Limitations to Convalescent Facility Expenses
This section does not cover charges made for treatment of:
- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

Home Health Care Expenses

Home health care expenses are covered if:
- the charge is made by a **home health care agency**; and
- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home.

Home health care expenses are 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.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Program if the person 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**.

There is a maximum of 40 visits covered in a plan year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Limitations To Home Health Care Expenses
This section does not cover charges made for:
- Services or supplies that are not a part of the **home health care plan**.
- Services of a person who usually lives with you or who is a member of your or your wife's or husband's family.
- Services of a social worker.
- Transportation.

Routine Physical Exam Expenses

The charges for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included are:
- X-rays, laboratory and other tests including a Pap Smear given in connection with the exam; and
- materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For a dependent child:
- To qualify as a covered physical exam, the **physician's** exam must include at least:
- a review and written record of the patient's complete medical history;
- a check of all body systems; and
- a review and discussion of the exam results with the patient or with the parent or guardian.

For all exams given to your child under age 7, Covered Medical Expenses will not include charges for:
- More than 7 exams in the first year of the child's life.
- More than 2 exams in the second year of the child's life; or
- More than one exam per year during the next 5 years of the child's life.

For all exams given to your child age 7 up to age 18, Covered Medical Expenses will not include charges for more than one exam every 12 months in a row.

For all exams given to your child age 18 and over, Covered Medical Expenses will not include charges for more than one exam in 24 months in a row.

For you and your spouse:

For all exams given to you or your spouse, Covered Medical Expenses will not include charges for more than:

one exam in 24 months in a row for a person under age 65; and
one exam in 12 months in a row for a person age 65 and over;

Also included as Covered Medical Expenses are charges made by a physician for one annual routine gynecological exam. Included as part of the exam is a routine Pap smear.

Not covered are charges for:
- services which are covered to any extent under any other part of this Program or any other group plan sponsored by BNSF;
- services which are for diagnosis or treatment of a suspected or identified injury or disease;
- exams given while the person is confined in a **hospital** or other place for medical care;
- services not given by a **physician** or under his or her direction;
- medicines, drugs, appliances, equipment or supplies;
- psychiatric, psychological, personality or emotional testing or exams;
- exams in any way related to employment;
- premarital exams;

- vision, hearing or dental exams;
- a **physician's** office visit in connection with immunization or testing for tuberculosis.

Skilled Nursing Care Expenses

The charges made by a **R.N.** or **L.P.N.** or a nursing agency for "skilled nursing services" are included as Covered Medical Expenses. No other charges made by a **R.N.** or **L.P.N.** or a nursing agency are covered. As used here, "skilled nursing services" means these services:

- Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by a **R. N.** or **L.P.N.** if the person's condition requires skilled nursing care and visiting nursing care is not adequate.

Benefits will not be paid during a plan year for private duty nursing for any shifts in excess of the60 day Private Duty Nursing Care Maximum Shifts or a maximum of $10,000. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Not included as "skilled nursing services" is:

- that part or all of any nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs and companionship activities; or
- any private duty nursing care, given while the person is an inpatient in a **hospital** or other health care facility; or
- care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
- care provided solely for skilled observation except as follows:
  for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:
  change in patient medication;

  need for treatment of an **emergency condition** by a **physician**, or the onset of symptoms indicating the likely need for such services;

  surgery; or

  release from inpatient confinement; or

- any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a **R.N.** or **L.P.N.**

Hospice Care Expenses

Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

Facility Expenses

The charges made in its own behalf by a:

- **hospice facility**;
- **hospital**; or
- **convalescent facility**;

which are for:

Inpatient Care

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:
  pain control; and
  other acute and chronic symptom management.

- Not included is any charge for daily board and room in a private room over the Private Room Limit. Also not included is the charge for any day of confinement in excess of the Maximum Number of Days for all confinements for **Hospice Care**.

Outpatient Care
- Services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses For Outpatient Care
Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours in any one day.
- Medical social services under the direction of a **physician**. These include:
  assessment of the person's:
  social, emotional, and medical needs; and
  the home and family situation;
  identification of the community resources which are available to the person; and
  assisting the person to obtain those resources needed to meet the person's 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 for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a **physician**.

Charges made by the providers below for Outpatient Care, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- 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 for up to 8 hours in any one day; these consist mainly of caring for the person;

  medical supplies;

  drugs and medicines prescribed by a **physician**; and

  psychological and dietary counseling.

Not included are charges made:
- For bereavement counseling.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Contraception Expenses

Covered Medical Expenses include:

- charges incurred for contraceptive drugs that by law need a physician's prescription; and that have been approved by the FDA.
- related outpatient contraceptive services such as:
  - consultations;
  - exams;
  - procedures; and
  - other medical services and supplies.

Not covered are:

- charges for services which are covered to any extent under any other part of this Program or any other group plan sponsored by your Employer; and
- charges incurred for contraceptive services while confined as an inpatient.

Infertility Services Expenses

The following infertility services expenses are not Covered Medical Expenses and are not payable by the Program:

- Ovulation induction with ovulatory stimulant drugs;
- Artificial insemination.
- Purchase of donor sperm or storage of sperm.
- Care of donor egg retrievals or transfers.
- Cryopreservation or storage of cryopreserved embryos.
- Gestational carrier programs.
- Home ovulation prediction kits.
- In vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and intracytoplasmic sperm injection.
- Frozen embryo transfers, including thawing.
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Care associated with a donor IVF program, including fertilization and culture.
- Injectable infertility medications.

Even though not incurred for treatment of a disease or injury, Covered Medical Expenses will include expenses incurred by a covered female for the diagnosis and treatment of the underlying medical condition for infertility. Contact member services for additional information on covered expenses.

Outpatient Short-Term Rehabilitation Expense Coverage

The charges made by:

- a **physician**; or
- a licensed or certified physical, occupational or speech therapist;

for the following services for treatment of acute conditions are Covered Medical Expenses.

Short-term rehabilitation is therapy which is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to:

- an injury;
- a disease; or
- congenital defect.

Short-term rehabilitation services consist of:

- physical therapy;
- occupational therapy,

- speech therapy; or
- spinal manipulation,

furnished to a person who is not confined as an inpatient in a **hospital** or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

Not covered are charges for:
- Services which are covered to any extent under any other part of this Program.
- Any services which are covered expenses in whole or in part under any other group plan sponsored by BNSF.
- Services received while the person is confined in a **hospital** or other facility for medical care.
- 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 the person's home or who is a part of the family of either the person or the person's spouse.
- Services rendered for the treatment of delays in speech development, unless resulting from:
  - disease;
  - injury; or
  - congenital defect.
- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired to function without that ability.
- Treatment for which a benefit is or would be provided under the Spinal Manipulation Expenses section, whether or not benefits for the maximum number of visits under that section have been paid.

Also, not covered are any services unless they are provided in accordance with a specific treatment plan which:
- details the treatment to be rendered and the frequency and duration of the treatment.
- provides for ongoing reviews and is renewed only if therapy is still necessary.

Spinal Manipulation Expenses

Covered Medical Expenses include charges for treatment of spinal subluxation or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the Spinal Manipulation maximum visits will be payable in any one calendar year.

The maximum does not apply to expenses incurred:
- while the person is a full-time inpatient in a **hospital**;
- for treatment of scoliosis;
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating physician.

Durable Medical And Surgical Equipment Expenses

Covered Expenses

Covered Medical Expenses are the following:
- The rental of **durable medical and surgical equipment**.
- The initial purchase of **durable medical and surgical equipment** and accessories needed to operate it only if Aetna 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.
- The repair or replacement of purchased **durable medical and surgical equipment** and accessories. Replacement will be covered only if Aetna is shown that:
  - it is needed due to a change in the person's 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
Covered Medical Expenses do not include:
- 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 Services

Covered Medical Expenses include charges for Complex Imaging Services received by a covered person on an outpatient basis when performed in:
- a physician's office
- a Hospital outpatient department or emergency room; or
- a licensed radiological facility

Complex Imaging Services include:
- C.A.T. Scans;
- Magnetic Resonance Imaging (MRIs);
- Positron Emmision Tomography (PET Scans); and
- any other outpatient diagnostic imaging service costing over $ 500.

Deductibles, copayments, coinsurance and other cost sharing features; maximum benefit amounts; and exclusions apply.

Other Medical Expenses

These include:
- Charges made by a **physician**.
- Charges for the following:
  – Drugs and medicines which by law need a **physician's** prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.
  – Diagnostic lab work and X-rays.
  – X-rays, radium, and radioactive isotope therapy.
  – Anesthetics and oxygen.
  – Rental of **durable medical and surgical equipment**. In lieu of rental, the following may be covered:
    The initial purchase of such equipment if Aetna is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.

    Repair of purchased equipment.

    Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.
- Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given.
- Charges for orthopedic shoes, foot orthotics, or other devices to support the feet.
- Artificial limbs and eyes. Not included are charges for:
  eyeglasses;
  vision aids;
  hearing aids;
  communication aids; and
  orthopedic shoes, foot orthotics, or other devices to support the feet, unless **necessary** to prevent complications of diabetes.

National Medical Excellence Program ® (NME)

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Program will pay a benefit for Travel and Lodging Expenses, but only to the extent described below. The maximum Lodging expense is $50.00 per person per night and the Travel and Lodging Maximum is $10,000 per type of procedure.

Travel Expenses

These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

Lodging Expenses

These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

Travel and Lodging Benefit Maximum

For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:
  one year after the day the procedure is performed; and
  the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Benefits paid for Travel Expenses and Lodging Expenses do not count against any person's Maximum Benefit.

Limitations

Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Program.

Travel Expenses do not include expenses incurred by more than one **Companion** who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one **Companion** per night.

Family Planning

The charges made by:

- a **physician**; or
- a **hospital**;

for the following even though they are not incurred in connection with the diagnosis or treatment of a disease or injury, are Covered Medical Expenses.

Benefits will be payable for:

- a vasectomy for voluntary sterilization; and
- a tubal ligation for voluntary sterilization.
-

Not covered are charges for the reversal of a sterilization procedure.

Emergency Room Treatment

Emergency Care

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is **emergency care**;

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Payment Percentage.

Non-Emergency Care

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is not **emergency care**;

no benefits will be payable.

Treatment by an Urgent Care Provider

*You should not seek medical care or treatment from an **Urgent Care Provider** if your illness; injury; or condition; is an **emergency condition**. Please go directly to the emergency room of a **hospital** or call 911 (or the local equivalent) for ambulance and medical assistance.*

Urgent Care

This Program pays for the charges made by an **Urgent Care Provider** to evaluate and treat an urgent condition.

When travel to an Urgent Care Provider for treatment of an urgent condition is not feasible, such treatment may be paid at the Preferred level of benefits

Non-Urgent Care

No coverage is provided for covered medical expenses for charges made by an Urgent Care Provider to treat a non-urgent condition.

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

- routine or preventive care (this includes immunizations);
- follow-up care;
- physical therapy;
- elective surgical procedures; and
- any lab and radiologic exams which are not related to the treatment of the urgent condition.

Certification For Hospital Admissions

This certification section applies to Out-of-network admissions other than those for the treatment of alcoholism, drug abuse, or **mental disorders**. A separate section below applies to such admissions.

If:

- a person becomes confined in a **hospital** as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by:
  your **Primary Care Physician**; or a **Preferred Care Provider**;

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

- As to Hospital Expenses incurred during the confinement:
  If certification has been requested and denied:

  No benefits will be paid for Hospital Expenses incurred for board and room.
  Benefits for all other Hospital Expenses will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:
  No benefits will be paid for Hospital Expenses incurred for board and room.

  As to all other Hospital Expenses:
  Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.
  Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:
  Hospital Expenses incurred for board and room, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.
  Benefits for all other Hospital Expenses will be payable at the Payment Percentage.
- As to other Covered Medical Expenses:
  Benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Program; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not **necessary** will not be applied.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency admission** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card.
This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission**; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. (In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.)

If, in the opinion of the person's **physician**, it is necessary for the person to be confined for a longer time than already certified, you, the **physician** or the **hospital** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital**. A copy will be sent to you and to the **physician**.

Certification for Convalescent Facility Admissions, Home Health Care, Hospice Care, and Skilled Nursing Care (This applies to Out-of-Network only)

If a person incurs Covered Medical Expenses:

- while confined in a **convalescent facility** or a **hospice facility**; or
- for a service or a supply for home health care or **hospice care** while not confined as an inpatient or skilled nursing care; and

it has not been certified that:

- such confinement or any day of it is **necessary**; or
- such other services or supplies (either specifically or as a part of a planned program of care) are **necessary**, and
- the confinement or service or supply has not been ordered or prescribed by:
  your **h Physician**; or
  a **Preferred Care Provider**;

such Covered Medical expenses will be paid only as follows:

- As to Convalescent Facility Expenses and Hospice Care Facility Expenses incurred while confined in a **convalescent facility** or a **hospice facility**:

  If certification has been requested and denied:
  No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.
  Benefits for all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:
  No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

  As to all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement:
  Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for all other such expenses will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:
  Convalescent Facility Expenses or Hospice Care Facility Expenses, incurred during the confinement, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

  Benefits for all other such expenses, incurred during the confinement, will be paid at the Payment Percentage.

  As to all other Covered Medical Expenses incurred during the confinement, benefits will be paid at the Payment Percentage.

- As to Covered Medical Expenses incurred for services or supplies either as stated or as a part of a planned program of care for home health care, **hospice care** while not confined as an inpatient, or skilled nursing care:

  If certification for a service or supply has been requested and denied or if certification has not been requested and the service or supply is not **necessary**, no benefits will be paid for the denied or unnecessary service or supply.

If certification has not been requested for a service or supply and the service or supply is **necessary**, benefits for the **necessary** service or supply will be paid as follows:

Expenses incurred for the service or supply, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other Covered Medical Expenses incurred for the service or supply will be paid at the Payment Percentage.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Program; except that:

- To the extent that a day of confinement has been certified, the exclusion of services and supplies because they are not **necessary** will not apply to:
  Convalescent Facility Expenses for room and board; or

  Hospice Care Facility Expenses for room and board.

- To the extent that such service or supply has been certified for home health care, **hospice care**, or skilled nursing care, the exclusion of services or supplies because they are not **necessary** will not apply to such service or supply.

To get certification you must call the number shown on your ID card. Such certification must be obtained before an expense is incurred.

If a person's **physician** believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you must call to certify more days of confinement or services or supplies. Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.

If:
- services and supplies for **hospice care** provided to a person have been certified; and
- the person later requires confinement in a **hospital** for pain control or acute symptom management;

any other certification requirement in this Program will be waived for any such day of confinement in a **hospital** .

Certification For Certain Procedures and Treatments

Certification of the necessity of certain Out-of-Network procedures and treatments is required:
before the procedure is performed; or
before the treatment starts; unless

such procedure or treatment has been ordered and prescribed by:

- your **Primary Care Physician**; or
- a **Preferred Care Provider**.

When any of the procedures or treatments shown below are to be performed on an inpatient or outpatient basis, Covered Medical Expenses incurred in connection with the performance of the procedure or treatment will be payable as follows:

- If the procedure or treatment is not **necessary**:
  No benefits will be payable whether or not certification has been requested.
- If certification has been requested and the procedure or treatment is **necessary**:

Benefits will be payable at the Payment Percentage.

- If certification has not been requested and the procedure or treatment is **necessary**:
  Expenses incurred in connection with its performance, up to the Excluded Amount, will not be considered to be Covered Medical Expenses.

  Benefits for Covered Medical Expenses in excess of the Excluded Amount will be payable at the Payment Percentage.

List of Procedures and Treatments

The following procedures or treatments require certification before the procedure or treatment is performed. Even though the procedures or treatments are most often done on an outpatient basis, certification is required whether the procedure or treatment will be performed:

- on an inpatient basis; or
- on an outpatient basis.
  Allergy Immunotherapy
  Bunionectomy
  Carpal Tunnel Surgery
  Colonoscopy
  Computerized Axial Tomography
  (CAT Scan)-Spine
  Coronary Angiography
  Dilation/Curettage
  Hemorrhoidectomy
  Knee Arthroscopy
  Laparoscopy (pelvic)
  Magnetic Resonance Imaging (MRI)-Knee
  Magnetic Resonance Imaging (MRI)-Spine
  Septorhinoplasty
  Tympanostomy Tube
  Upper GI Endoscopy

You or the provider performing the procedure or treatment, must call the number shown on your ID card to request certification.

If the procedure or treatment is performed due to an **emergency condition**, the call must be made:

- before the procedure or treatment is performed; or
- not later than 48 hours after the procedure or treatment is performed; unless the call cannot be made within that time. In that case, the call must be made as soon as it is reasonably possible. In the event the procedure or treatment is performed on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.

If the procedure or treatment is performed for any condition other than an **emergency condition**, the call must be made at least 14 days before the date the procedure is to be performed or the treatment is to start. If it is not possible to make the call during the specified time, it must be made as soon as reasonably possible before the date the procedure or treatment is to be performed.

Written notice of the certification decision will be sent promptly to you and the provider performing the procedure or treatment. This decision will be valid for 60 days from the date you receive the notice. If the procedure or treatment is to be performed after this 60 day period, certification must again be requested, as described above.

Certification For Hospital and Treatment Facility Admissions for Alcoholism, Drug Abuse, or Mental Disorders

If, in connection with the treatment of alcoholism, drug abuse, or a **mental disorder**, a person incurs Covered Medical Expenses while confined in a **hospital** or **treatment facility**; and it has not been certified that such confinement (or any day of such confinement) is **necessary**; and

- the confinement has not been ordered and prescribed by:
  the BHCC; or

  a **Preferred Care Provider** upon referral by the BHCC:

Covered Medical Expenses incurred on any day not certified during the confinement will be paid only as follows:

With respect to expenses for **hospital** and **treatment facility** board and room:

If certification has been requested and denied, or if certification has not been requested and the confinement (or any day of it) is not **necessary**, no benefits will be paid.

If certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

With respect to all other **hospital** and **treatment facility** expenses:

If certification has been requested and denied, or if certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

If certification has not been requested and the confinement is not **necessary**, no benefits will be paid.

Whether or not a day of confinement is certified, no benefits will be payable for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Program; except that, if certification has been given for any day of confinement, the exclusions of services and supplies because they are not **necessary** will not be applied to **hospital** and **treatment facility** board and room.

To get the days certified, you must call the number shown on your ID card. Such certification must be obtained before confinement as a full-time inpatient, or in the case of an **emergency admission**, within 48 hours after the start of a confinement as a fulltime inpatient or as soon as reasonably possible.

If the person's **physician** believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified. This must be done no later than on the last day that has already been certified.

Treatment of Alcoholism, Drug Abuse, or Mental Disorders

Certain expenses for the treatment shown below are Covered Medical Expenses.

Inpatient Treatment
If a person is a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Hospital
Expenses for the following are covered:
- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- **Effective treatment of alcoholism or drug abuse**.
- Treatment of **mental disorders**.

Treatment Facility
Certain expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered. The expenses covered are those for:

- Board and room. Not covered is any **charge** for daily **board and room** in a private room over the **semiprivate rate**.
- Other **necessary** services and supplies.

Calendar Year Maximum Benefit
A Special Inpatient Calendar Year Maximum Days applies to the **hospital** and **treatment facility** expenses described above.

Outpatient Treatment
If a person is not a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;
-

then the coverage is as shown below.

Expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered.

For such treatment given by a **hospital**, **treatment facility** or **physician**, benefits will not be payable for more than the Special Outpatient Calendar Year Maximum Visits in any one plan year.

Explanation of Some Important Program Provisions

Calendar Year Deductible
This is the amount of Covered Medical Expenses you pay each plan year before benefits are paid

Lifetime Maximum Benefit
Unlimited.

Routine Mammogram
Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred by a female age 40 or over for one mammogram each calendar year.

Routine Screening for Cancer
Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred for:

- a digital rectal exam and a prostate specific antigen (PSA) test for a male age 40 or over; and
- colorectal cancer screening for persons age 50 or over, for routine screening for cancer.

Mouth, Jaws and Teeth
Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:

- services rendered; and
- supplies needed;

for the following treatment of or related to conditions of the:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, "**physician**" includes a **dentist**.

Surgery needed to:
- Treat a fracture, dislocation, or wound.
- Cut out:
  teeth partly or completely impacted in the bone of the jaw;
  teeth that will not erupt through the gum;
  other teeth that cannot be removed without cutting into bone;
  the roots of a tooth without removing the entire tooth;
  cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered 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.

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, replace, restore or reposition:
- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut

due to injury.

Any such teeth must have been:
- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the plan year of the accident or the next one.

If:
- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical Expenses include only charges for:

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

Except as provided for injury, not included are charges:
- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- for root canal therapy;
- for routine tooth removal (not needing cutting of bone).

Not included are charges:
- to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures or bridgework;
- for non-surgical periodontal treatment;
- for dental cleaning, in-mouth scaling, planing or scraping;
- for myofunctional therapy; this is:
  muscle training therapy; or
  training to correct or control harmful habits.

General Exclusions

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.

- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.

- Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

    there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

    if required by the FDA, approval has not been granted for marketing; or

    a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

    the written protocol or protocols used by the treating facility, or 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 states that it is experimental, investigational, or for research purposes.

  However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

    the disease can be expected to cause death within one year, in the absence of effective treatment; and

    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 Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

  Also, this exclusion will not apply with respect to drugs that:

    have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

    are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.
- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for **custodial care**.

- Those for services and supplies:
  Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

  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 entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically listed as covered.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.
- Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically listed as covered.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Program.
- Those for or in connection with speech therapy. 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.
- Those for 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 surgical procedures may be covered subject to meeting the Aetnas selection criteria..
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:
  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.

  Repair an injury. Surgery must be performed:
  in the calendar year of the accident which causes the injury; or
  in the next calendar year.
- Those to the extent they are not **reasonable charges**, as determined by Aetna.
- Those for the reversal of a sterilization procedure.
- Those for a service or supply furnished by a **Preferred Care Provider** in excess of such provider's **Negotiated Charge** for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

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

Effect of Benefits Under Other Plans

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   c. If there is not such a court decree:

      If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:
   The benefits of a plan which covers the person on whose expenses claim is based as a:

   - laid-off or retired employee; or
   - the dependent of such person;

   shall be determined after the benefits of any other plan which covers such person as:

   - an employee who is not laid-off or retired; or
   - a dependent of such person.

   If the other plan does not have a provision:

   - regarding laid-off or retired employees; and
   - as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

   The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

   If the other plan does not have a provision:

   - regarding right of continuation pursuant to federal or state law; and
   - as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses incurred in a calendar year will be reduced by all "other plan" benefits payable for those expenses. When the coordination of benefits rules of this Plan and an "other plan" both agree that this Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Effect On Benefits Of This Program.

When this Program is secondary, the maximum benefits payable under this Program, when combined with benefits already paid by coordinating plans, will not be more than what this Program would have paid had it been the only plan responsible for coverage. In other words, the total benefits normally payable under this Program will be reduced by the amount of benefits paid by all other plans for the same services and supplies. Benefits payable under other plans include benefits that would have been payable had proper claim been made for them.

Right To Receive And Release Needed Information.
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this Program and other plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility Of Payment.
Any payment made under another Plan may include an amount which should have been paid under This Program. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under This Program. Aetna will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Effect of Medicare

Health Expense Coverage under this Plan will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

  having refused it;

  having dropped it;

  having failed to make proper request for it.

These are the changes:

- The amount of "regular benefits" under a;; Health Expense Benefits will be figured. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount Medicare provides for the expenses involved, this Plan will pay the difference. Otherwise, this Plan will pay no benefits. This will be done for each claim.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.

- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

Subrogation and Right of Recovery Provision

Definitions

As used throughout this provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness, or condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a "Covered Person" includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation

Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness, or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury**,** illness, or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitutes such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury, or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that this plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

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

The Covered Person shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The plan reserves the right to notify responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

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

Exclusion

This plan does not cover services and supplies, in the opinion of the Claims Administrator or its authorized representative, that are associated with injuries, illness, or conditions suffered due to the acts or omissions of a third party.

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Program has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this Program may have with respect to such overpayment.

Reporting of Claims

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. Your Employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received.

All benefits are payable to Preferred Care Providers or to you. However, this Program has the right to pay any health benefits to the service provider.

This Program may pay up to $ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

Names of **physicians**, **dentists** and others who furnish services.
Dates expenses are incurred.
Copies of all bills and receipts.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Board and Room Charges

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

Body Mass Index:

This is 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.

Brand Name Drug

A **prescription drug** which is protected by trademark registration.

Companion

This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  physical restoration services to help patients to 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.
- Makes charges.

Custodial Care

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Directory
This is a listing of **Preferred Care Providers** in the **Service Area** covered under this Program. A current list of participating providers is available through Aetna's online provider directory, DocFind, at www.aetna.com.

Durable Medical and Surgical Equipment
This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:
- 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;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

Effective Treatment of Alcoholism Or Drug Abuse
This means 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.

These are not effective treatment:
- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

Emergency Admission
One where the **physician** admits the person to the **hospital** or **treatment facility** right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:
- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by Aetna,
  reasonably be expected to result in:
  placing the person's health in serious jeopardy; or
  serious impairment to bodily function; or
  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
This means the 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 his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- 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
This means 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 his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
- placing the person's health in serious jeopardy; or

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

Generic Drug

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

Home Health Care Agency

This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one **physician** and one **R.N.**; and
- has full-time supervision by a **physician** or a **R.N**.; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

Home Health Care Plan

This is 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

This is care given to a **terminally ill** person by or under arrangements with a **Hospice Care Agency**. The care must be part of a **Hospice Care Program**.

Hospice Care Agency

This is an agency or organization which:

- Has **Hospice Care** available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:
  skilled nursing services; and
  medical social services; and
  psychological and dietary counseling.
- Provides or arranges for other services which will include:
  services of a **physician**; and
  physical and occupational therapy; and
  part-time home health aide services which 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 which include at least:
  one **physician**; and
  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.
- Develops a **Hospice Care Program** to meet those needs.
- Provides an ongoing quality assurance program. This includes 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

This is a written plan of **Hospice Care**, which:

- Is established by and reviewed from time to time by:
  a **physician** attending the person; 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 person's medical and social needs; and
  a description of the care to be given to meet those needs.

Hospice Facility

This is a facility, or distinct part of one, which:

- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- 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 such **physician** must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a **R.N.**
- Has a full-time administrator.

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick 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.
- Makes charges.

L.P.N.

This means a licensed practical nurse.

Mail Order Pharmacy

An establishment where **prescription drugs** are legally dispensed by mail.

Mental Disorder

This is 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.

For the purposes of benefits under this Program, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

Morbid Obesity:

This means a **Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

NME Patient

This is a person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

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

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare 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 Aetna's attention.

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

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- 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

This is the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Program.

Non-Occupational Disease
A non-occupational disease is a disease that does not:
- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:
- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not:
- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

Non-Specialist
A **physician** who is not a **specialist**.

Non-urgent Admission
One which is not an **emergency admission** or an **urgent admission**.

Orthodontic Treatment
This is any:
- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:
- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:
- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Pharmacy
An establishment where **prescription drugs** are legally dispensed.

Physician
This means a legally qualified physician.

Preferred Care
This is a health care service or supply furnished by:
- A person's **Primary Care Physician** or any other **Preferred Care Provider**.
- A **Non-Preferred Care Provider** on the referral of the person's **Primary Care Physician** and if approved by Aetna.
- Any health care provider for an **emergency condition** when travel to a **Preferred Care Provider** or referral by a person's **Primary Care Physician** prior to treatment is not feasible and
- A Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible.

Preferred Care is also care which is recommended and approved by the BHCC.

Preferred Care Provider
This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:
- the service or supply involved; and
- the class of employees of which you are member.

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
Any of the following:
- A drug, biological, compounded **prescription** or contraceptive device which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable contraceptive drug prescribed to be administered by a paid healthcare 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 healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.
- Disposable diabetic supplies.

Primary Care Physician
This is the **Preferred Care Provider** who is:
- selected by a person from the list of Primary Care Physicians in the **Directory**;
- responsible for the person's on-going health care; and
- shown on Aetna's records as the person's Primary Care Physician.

Psychiatric Physician
This is a **physician** who:
- specializes in psychiatry; or
- has the training or experience to do the required evaluation and treatment of mental illness.

R.N.
This means a registered nurse.

Reasonable Charge
Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:
- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:
- unusual; or
- not often provided in the area; or

- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:
- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the prevailing charge in other areas.

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

Semiprivate Rate

This is the **charge** for **board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Service Area

This is the geographic area, as determined by Aetna in which **Preferred Care Providers** for this Program are located.

Specialist

A **physician** who:
practices in any generally accepted medical or surgical sub-specialty; and
is providing other than routine medical care.

A **physician** who:
practices in such a sub-specialty; and
is providing routine medical care (such as could be given by a **primary care physician**),
will not be considered a Specialist for purposes of applying this Program's provisions.

Surgery Center

This is a freestanding ambulatory surgical facility that:
- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- Is directed by a staff of **physicians**. At least one of them 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 which 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 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area 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 a **R.N.**
- Is equipped and has trained staff to handle medical emergencies.
- It must have:
  a **physician** trained in cardiopulmonary resuscitation; and
  a defibrillator; and
  a tracheotomy set; and

a blood volume expander.

- Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a 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.
- Keeps a medical record on each patient.

Terminally Ill

This is a medical prognosis of 6 months or less to live.

Treatment Facility (Alcoholism Or Drug Abuse)

This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and **effective treatment of alcoholism or drug abuse**.
- Makes charges.
- 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**.
- 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 with a **hospital** in the area for, any other medical services that may be required.

  Supervision by a staff of **physicians**.

  Skilled nursing care by licensed nurses who are directed by a full-time **R.N.**

Treatment Facility (Mental Disorder)

This is 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 with a **hospital** in the area 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**.
- Makes charges.
- Meets licensing standards.

Urgent Admission

One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider

This is:

- A freestanding medical facility which:
  Provides unscheduled medical services to treat an urgent condition if the person's **physician** is not reasonably available.

  Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.

  Makes charges.

  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.

  Has a full-time administrator who is a licensed **physician**.

- A **physician's** office, but only one that:
  has contracted with Aetna to provide urgent care; and is, with Aetna's consent, included in the **Directory** as a Preferred Urgent Care Provider.

It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition

This means a sudden illness; injury; or condition; that:

- is severe enough to require prompt medical attention to avoid serious deterioration of the covered person's health;
- includes a condition which would subject the covered person 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 the covered person's **physician** becomes reasonably available.

Outpatient Prescription Drug Benefit

Your prescription drug benefit is administered by Caremark Inc. Under the Caremark program, you can fill prescriptions at network retail pharmacies or through one of Caremark's Mail Service pharmacies. Your prescription drug copayments or coinsurance amounts do not apply toward your medical program deductible or out-pocket maximum.

Included in your prescription drug benefit program is a "Primary Drug List" (formulary). A Primary Drug List, or formulary, is a list of preferred prescription medications that are proven to be effective in meeting the patient's clinical needs. These drugs are generally lower in cost than other available drugs. For a list of prescription drugs included in the Primary Drug List refer to Caremark's web site at www.caremark.com or call their toll free number at 1-800-378-7559.

Participating Pharmacy Benefit

You may fill a prescription for up to a 34-day supply at any participating pharmacy by showing your Caremark Identification card and paying the applicable charge.

Retail prescription costs are as follows:

Prescription Drug Type	**Coinsurance**	**Copayment**
Applies to Plan:	**BYO 2,4,6,8,10 & 12**	**Aetna EPO & BYO 1,3,5,7,9,11**
Generic	25%* (Minimum $10; Maximum $100)	$10
Formulary Brand	25%* (Minimum $25; Maximum $100)	$25
Non-Formulary Brand	25%* (Minimum $40; Maximum $100)	$40

**Of total prescription cost up to maximum listed.*

For a list of participating pharmacies refer to Caremark's web site at www.caremark.com or call 800-378-7559.

If you use a non-participating pharmacy, you will pay **100 percent of the prescription price**. You will then need to submit a paper claim form, along with the original prescription receipt(s) to Caremark for reimbursement of covered expenses. In most cases this option will cost you more. The time limit to file a paper claim with Caremark is 365 days from the prescription fill date.

Mail Order Pharmacy Benefit

Caremark's Mail Service Program provides a way for you to order up to a 90-day supply of maintenance or long-term medication for direct delivery to your home.

For prescriptions received from Caremark Mail Service you will pay:

Prescription Drug Type	**Coinsurance**	**Copayment**
Applies to Plan:	**BYO 2,4,6,8,10 & 12**	**Aetna EPO & BYO 1,3,5,7,9,11**
Generic	25% (Minimum $20; Maximum $200)	$20
Formulary Brand	25%* (Minimum $50; Maximum $200)	$50
Non-Formulary Brand	25%* (Minimum $80; Maximum $200)	$80

*Of total prescription cost up to maximum listed.

Information on how to use the mail order pharmacy benefit is included in the packet with your Caremark Identification Card.

For questions about mail order prescriptions, call 1-800-378-7559 or visit Caremark's web site at www.caremark.com.

Covered Prescription Drugs

The term covered prescription drug means:

• A Prescription Legend Drug for which a written prescription is required;

• Oral or injectable insulin dispensed only upon the written prescription of a physician;

• Insulin needles and syringes;

• A compound medication of which at least one ingredient is a Prescription Legend Drug;

• Tretinoin for individuals through age 26;

• Any other drug that, under the applicable state law, may be dispensed only upon the written prescription of a physician;

• Oral contraceptives;

• Prenatal vitamins, upon written prescription;

• An injectable drug, excluding injectable infertility drugs, for which a prescription is required, including needles and syringes;

• Oral infertility drugs (up to a $2,500 lifetime maximum);

• Glucose test strips;

• Growth hormones (managed through Caremark's Specialty Pharmacy and Services) and anabolic steroids (available only through Caremark's Mail Service Program); and

• A drug that has been prescribed for a particular use for which it has not been approved by the Food and Drug Administration (FDA) only if it meets the following criteria:

– The drug is recognized for the specific use in any one of the following established reference compendia: the United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluation, the American Hospital Formulary Service, or any peer-reviewed national professional medical journal;

– The drug has been otherwise approved by the FDA; and

– The drug has not been contraindicated by the FDA for the use prescribed.

Limitations

No payment will be made under the Program for the following expenses:

• For non-legend drugs, other than those specified above under “Covered Prescription Drugs”;

• To the extent that payment is unlawful where the person resides when expenses are incurred;

• For charges that the person is not legally required to pay;

• For charges that would not have been made if the person was not covered under the Program;

• For experimental drugs or for drugs labeled “Caution —limited by federal law to investigational use”;

• For drugs that are not considered essential for the necessary care and treatment of an injury or sickness, as determined by the Claims Administrator for the Program or by the retail pharmacy administrator;

• For drugs obtained from a non-participating mail order pharmacy;

• For any prescription filled in excess of the number specified by the physician or dispensed more than one year from the date of the physician's order;

• For more than a 34-day supply when dispensed in any one prescription order through a retail pharmacy;

• For more than a 90-day supply when dispensed in any one prescription order through a participating mail order pharmacy;

• For indications not approved by the Food and Drug Administration;

• To the extent that the person is covered under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law (any adjustment option chosen under such part will be taken into account);

• For immunization agents, biological sera, blood or blood plasma;

• For therapeutic devices or appliances, including support garments and other non-medicinal substances, excluding insulin syringes;

• For drugs used for cosmetic purposes;

• For tretinoin (Retin-A) for individuals after age 26;

• For administration of any drug;

• For medication that is taken or administered — in whole or in part — at the place where it is dispensed, or while a person is a patient in an institution that operates — or allows to be operated on its premises — a facility for dispensing pharmaceuticals;

• For prescriptions that an eligible person is entitled to receive without charge from any Workers' Compensation or similar law or any public program other than Medicaid;

• For nutritional or dietary supplements, anti-obesity drugs or anorexiants;

• For contraceptive devices, including implantable contraceptive devices;

• For vitamins, excluding prenatal vitamins, upon written prescription;

• For oral infertility drugs after the $2,500 dollar lifetime maximum has been exhausted; or

• For smoking cessation products.

Claims Procedures

In general, health services and benefits must be medically necessary to be covered under the Medical Benefit Program. Medical necessity determinations are made on either a pre-service, concurrent, or post-service basis, as described below. Under Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Medical Benefit Program. The procedures described on pages 53-57 are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

The Company has delegated the discretionary authority to interpret BNSF Medical Program terms and to make both initial claim determinations and final claim review decisions on ERISA appeals to Aetna (Claims Administrator)**.** The BNSF Employee Benefits Committee retains the discretionary authority to determine whether you and/or your dependents are eligible to enroll for coverage and/or to continue coverage under Program terms.

Definitions

Claim--A claim is any request for a program benefit made in accordance with these claims procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures.

Claimant--As an individual covered by a Medical Benefit Program, you become a claimant when you make a request for a program benefit or benefits in accordance with these claims procedures.

Incorrectly Filed Claim--Any request for benefits that is not made in accordance with these claims procedures is considered an incorrectly filed claim.

Authorized Representative--Means an individual who has been identified in writing as the representative of an individual covered by a Medical Benefit Program and signed by the Claimant; however, in the case of a claim involving urgent care, a health care professional with knowledge of the Claimant's medical condition will be permitted to act as the Authorized Representative of the individual covered by the Medical Benefit Program. An Authorized Representative may act on behalf of a Claimant with respect to a benefit claim or appeal under these procedures. An assignment for purposes of payment does not constitute appointment of an Authorized Representative under these claims procedures. Unless the Claimant indicates otherwise in the authorization, all information and notifications regarding the claim will be sent to the Authorized Representative and not to the Claimant.

No individual may receive "protected health information" without the Program having received an "authorization" from the Claimant to the extent required by the Health Insurance Portability and Accountability Act of 1996, and its applicable regulations ("HIPAA").

Pre-Service Claim (pre-certification/ pre-authorization)--A claim is a pre-service claim if benefits under the Program are conditional on receiving approval in advance of obtaining the medical care.

Urgent Care Claim--A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods that otherwise apply (1) could seriously jeopardize the claimant's life or health or ability to regain maximum function or (2) would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. On receipt of a claim, the Claims Administrator will make a determination of whether it involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim will be treated as an urgent care claim. If the requested medical care has already been provided, the claim will be considered a post-service claim.

Concurrent Care Claims--A concurrent care decision occurs when the Benefit Program approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (1) where reconsideration of the approval results in a reduction or termination of the initially-approved period of time or number of treatments; and (2) where an extension is requested beyond the initially-approved period of time or number of treatments.

Post-Service Claim--A post-service claim is any claim for a benefit under this Benefit Program that is not a pre-service claim or an urgent care claim. Post-service claims are claims that involve only the payment or reimbursement of the cost for medical care that has already been provided.

How to File a Claim

*N*o claim forms are necessary when you or a dependent uses an Aetna network provider. However, at the start of each calendar year, the Claims Administrator may ask you to complete a claim form to update personal data.

If you or a dependent uses an out-of-network provider, you must submit a completed claim form before benefits can be paid. You may obtain a claim form from Aetna or from the Forms and Enrollment folder on the Benefits Intranet site at: http:// www.bnsfweb.bnsf.com/departments/hr/benefits/index.html.

Complete and sign the form and submit your claim to the Claims Administrator. When you submit your claim, include with it a copy of your medical bill showing the following:

• Employee's name and subscriber identification number with alpha prefix as shown on your identification card;

• Patient's full name;

• Nature of the sickness or injury;

• Type of service or supply furnished;

• Date or dates the service was rendered or the purchase was made;

• Itemized charges for each service or supply; and

• Provider of service with address and tax ID number.

You must submit separate claims for yourself and each of your covered dependents who have incurred medical expenses. Incomplete claim forms will not be processed.

All network and out-of-network claims must be filed no later than two (2) years after the date a service is received. Claims not filed within two (2) years from the date a service is received will not be eligible for payment under Program terms.

Timeframe for Deciding Initial Benefit Claims

Pre-Service Claims--Your benefit Program requires that you pre-certify for inpatient care, skilled nursing, coordinated home care and private duty nursing. The Claims Administrator will notify you or your representative of the determination within 15 days after receipt of the claim. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Administrator will notify you or your representative within 15 days after receiving the claim. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed and you or your representative must provide the specified information within 45 days after receiving the notice. The timeframe for deciding the claim will be suspended from the date the extension notice is sent until the date the missing necessary information is provided to the Claims Administrator.

Urgent Care Claim--The Claims Administrator will decide an initial urgent care claim within 72 hours after receiving the claim. However, if necessary information is missing from the request, you or your representative will be notified within 24 hours after receiving the claim to specify what information is needed. The specified information must be provided to the Claims Administrator within 48 hours after receiving the notice. The Claims Administrator will decide the claim within 48 hours after the receipt of the specified information.

Concurrent Care Claims--When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request the extension at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, the Claims Administrator will notify you or your representative of the determination within 24 hours after receiving the claim.

Post-Service Claim--The Claims Administrator will notify you or your representative of the determination within 30 days after receiving the claim. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Administrator will notify you or your representative within 30 days after receiving the claim. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed and you or your representative must provide the specified information within 45 days after receiving the notice. The timeframe for deciding the claim will be

suspended from the date the extension notice is sent until the date the missing necessary information is provided to the Claims Administrator.

Notification of Initial Benefit Determination

Each time a claim is submitted, you or your representative will receive a written Explanation of Benefits form that will explain how much was paid towards the claim or whether the claim was denied, in whole or in part. If a claim is denied, in whole or in part, the Claims Administrator will give you or your representative a written notice of the denial and the reason for the denial. The Claim Denial Notice will include the following:

- explain the specific reason(s) for the denial;
- provide the specific reference to pertinent Medical Benefit Program provisions on which the denial was based;
- provide a description of any additional information necessary to reverse the denial, or in the case of an incomplete claim to perfect the claim;
- provide an explanation of the Medical Benefit Program's claim review procedures and applicable time limits; and
- if the Claims Administrator used or relied on internal guidelines, protocols, or other criteria, the letter will specify the criterion; and a copy of such rule, guideline, protocol or other criteria, and reasonable access to relevant documents, records and other information relevant to the Claim will be provided free of charge on request.

If Your Claim is Denied

The Medical Benefit Program is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA has special rules that must be followed when you or your representative chooses to appeal an adverse benefit decision (denied claim).

You have a right to appeal any claim denial, including any denial at the pre-service (pre-certification/ pre-authorization) level. It does not make any difference whether the denial is a complete denial or a partial denial. You or your representative should file a written request for appeal as soon as you receive a denial of benefits that you believe should be covered under the Medical Benefit Program but no later than **180** days from the date you receive notice that your claim has been denied. Failure to comply with this important deadline may cause you to forfeit any right to appeal the denial. If the claim is an Urgent Care Claim, you may appeal the decision and receive an expedited decision, please see below.

A person who did not make the initial decision shall decide your appeal. The review on appeal will not give any deference to the initial decision and will take into account all information submitted by you, regardless of whether it was submitted or considered in the initial decision.

Along with your written request for a review, you may submit any additional documents and written issues and comments you believe should be considered during the review. You should also include any clinical documentation from your physician that would substantiate coverage of the denied claim.

Upon request, you or your representative will be provided reasonable access to and copies of all documents, records and other information relevant to your claim, free of charge, including:

- information relied upon in making the benefit determination;
- information submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon in making the benefit determination;
- descriptions of the administrative processes and safeguards used in making the benefit determination;
- records of any independent reviews conducted by the Claims Administrator;
- if the claim was based on a medical judgment, including determinations about whether a particular service is experimental, investigational or not medically necessary or appropriate, an explanation of the scientific or clinical judgment for the decision applying the term of the Program, or an explanation for the denial; and

- expert advice and consultation obtained by the Claims Administrator in connection with your denied claim, whether or not the advice was relied upon in making the benefit determination.

Your request for an appeal should be addressed to:

Aetna Inc.
P.O. Box 14586
Lexington, KY 40512-4586

Timeframes for Deciding Benefits Appeals

Pre-Service Claims--The Claims Administrator will provide a written decision on the appeal of a pre-service claim within 30 days after receipt of the appeal.

Urgent Care Claims--The Claims Administrator will decide the appeal of an urgent care claim within 72 hours after receipt of the appeal.

Post-Service Claims--The Claims Administrator will decide the appeal of a post-service claim within 60 days after receipt of the appeal.

Concurrent Care Claims--The Claims Administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. Appeal of a denied request to extend a concurrent care decision will be decided in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

Notification of Decision on Appeal

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

- the specific reasons for the appeal decision;
- a reference to the specific Medical Benefit Program provision(s) on which the decision was based;
- a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to or copies of all documents, records, and other information relevant to the determination (see prior page for a list of such documents); and
- a statement indicating entitlement to receive, upon request and without charge, a copy of any internal rule, guideline, protocol or similar criterion relied on in making the adverse decision regarding your appeal, and/or an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

The Claims Administrator's decision on appeal is final and binding. Benefits under this Program will be paid only if the Claims Administrator decides, in its sole discretion, that you are entitled to them. If you continue to disagree with the decision, you may exercise "Your Rights under ERISA" as explained on page 67 of this SPD.

Appeal for External Review

Aetna's external review process gives members the opportunity to have certain coverage denials reviewed by independent physician reviewers. An appeal will be eligible for external review if the following are satisfied:

- the standard levels of appeal have been exhausted,
- the appeal is made by the member or the member's authorized representative,
- the coverage denial is based on Aetna's determination that the proposed or rendered service or supply is not medically necessary or is experimental or investigational, and
- the cost of the service or supply at issue for which the member is financially responsible exceeds $ 500.

If upon the final standard level of appeal Aetna upholds the coverage denial and it is determined that the member is eligible for external review, the member will be informed in writing of the steps necessary to request an external review.

An independent review organization (IRO) refers the case for review by a neutral, independent physician with appropriate expertise in the area in question. Once all necessary information is submitted, the external review requests will generally be decided within 30 days of the request. Expedited reviews are available when a member's physician certifies that a delay in service would jeopardize the member's health. The decision of the independent external expert reviewer is binding on Aetna, the Company and the Health Plan. Members will not be charged a professional fee for the review.

When Coverage Ends

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

• The date your employment terminates;

• The date the BNSF Medical Program is terminated or, if you work for a BNSF Participating Affiliated Company, the date the BNSF affiliate terminates its participation in the Program;

• The date you are no longer eligible for coverage under Program rules;

• The first day of the payroll period for which you fail to make the required contributions for Program coverage; or

• The date benefits paid to you equal the lifetime maximum benefit payable under the Program. (Coverage for enrolled dependents who have not reached their lifetime maximum benefit will not be affected if you continue to be an eligible Employee.)

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

• The date you are no longer eligible for Program coverage for any reason; or

• The date the dependent no longer meets the Program's eligibility rules for dependent coverage. (Dependent eligibility is described on page 8 of the SPD.)

Note: If you die while an active employee, your covered dependents will remain in the BNSF Medical Program for six months from your date of death. Coverage during this benefit extension is provided at no charge to your dependents. At the end of the six month period, your dependents may enroll in COBRA (see page 60) or, if eligible, a BNSF retiree medical program.

Continuation of Coverage

Family and Medical Leaves of Absence

Under the Family and Medical Leave Act of 1993 (FMLA), you may be entitled to up to a total of 12 weeks of unpaid, job-protected leave during each calendar year for the following:

• For the birth of your child, to care for your newborn child, or for placement of a child in your home for adoption or foster care;

• To care for your spouse, child or parent with a serious health condition; or

• For your own serious health condition.

If your FMLA leave is a paid leave, your pay will be reduced by your before-tax contributions as usual for the coverage level in effect on the date your FMLA leave begins. If your FMLA leave is unpaid, you will be required to pay your contributions directly to YBR until you return to active pay status.

If you notify your Employer that you are terminating employment during your FMLA leave, your BNSF Medical Program coverage will end on the date of your notification. If you do not return to work on your expected FMLA return date, and you do not notify your Employer of your intent either to terminate your employment or to extend the period of leave, your Program coverage will end on the date you were expected to return.

You may not change your BNSF Medical Program elections during your FMLA leave unless an Annual Enrollment occurs, or unless you are on a paid FMLA leave and you have a Family Status Event or a special enrollment event under HIPAA.

Other Approved Leaves of Absence

If you take an approved leave of absence other than an FMLA leave — and your leave is a paid leave —your pay will be reduced by the contribution required for the Medical Program coverage in effect on the date prior to the start of your leave. After your authorized leave period ends, your Medical Program coverage will end and you will receive a COBRA continuation notice.

If your approved leave is unpaid, you will be required to pay your contributions directly to YBR until you return to active pay status. After your authorized leave period ends, Medical Program coverage will end and you will receive a COBRA continuation notice.

Military Leaves

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) requires the Employer to provide COBRA coverage for up to 24 months from the first day of absence, or if earlier, until the day after the date you are required to apply for or return to active employment with your Employer. However, BNSF provides that if you are absent from work due to military service, you may elect to continue coverage under the Program (including coverage for enrolled dependents) for the duration of your military leave. Your contributions for continued coverage will be the same as for similarly situated active participants in the Program.

Whether or not you continue coverage during military service, you may reinstate coverage under the Program on your return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Program, except to the extent that you had not fully completed any required waiting period prior to the start of military service.

Continuation of Coverage Under COBRA

(Consolidated Omnibus Budget Reconciliation Act of 1985 as Amended)

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the BNSF Medical Program. The information that follows generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law. COBRA continuation coverage can become available to you when you would otherwise lose your BNSF Medical Program coverage due to a "qualifying event". It can also become available to other members of your family who are covered under the BNSF Medical Program when they would otherwise lose their BNSF Medical Program coverage because of a qualifying event.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of BNSF Medical Program coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You and your eligible dependents could become qualified beneficiaries if coverage under the BNSF Medical Program is lost because of a qualifying event.

Eligibility

You or your covered dependents will become eligible for COBRA continuation coverage after any of the following qualifying events result in the loss of BNSF Medical Program coverage:

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

• Your hours of employment are reduced; or

• Your employment ends for any reason other than your gross misconduct.

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

• Your spouse dies;

• Your spouse's hours of employment are reduced;

• Your spouse's employment ends for any reason other than his or her gross misconduct;

• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

• You become divorced or legally separated from your spouse.

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

• The parent-employee dies;

• The parent-employee's hours of employment are reduced;

• The parent-employee's employment ends for any reason other than his or her gross misconduct;

• The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or

• The child stops meeting the eligibility requirements for a "dependent child."

Notification

The BNSF Medical Program will offer COBRA continuation coverage to you and your family as qualified beneficiaries only after the COBRA Administrator, Your Benefits Resources ("YBR"), has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, or your death, your employer must notify YBR of the qualifying event. YBR will send you an election form. To continue Medical Program coverage, you must return the election form within 60 days from the later of:

• the date you receive the form; or

• the date your coverage ends due to a qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse, your entitlement to Medicare (under Part A, Part B or both) or a dependent child's losing eligibility for coverage as a dependent child), you or your covered dependent must notify YBR's Customer Care Service by phone that a qualifying event has occurred. This notification must be received by YBR within 60 days after the later of:

• the date of such event; or

• the date you or your eligible dependent would lose coverage on account of such event.

Failure to promptly notify YBR of these events will result in loss of the right to continue coverage for you and your dependents. After receiving this notice, YBR will send you an election form within 14 days. If you or your dependents wish to elect continuation coverage, the election form must be returned to YBR within 60 days from the later of:

• the date you receive the form; or

• the date your coverage ends due to the qualifying event.

Once YBR receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your spouse, and parents may elect COBRA continuation coverage on behalf of their children.

If you are eligible for trade adjustment assistance (TAA) pursuant to the Trade Act of 1974 and you did not elect continuation coverage within the initial 60-day election period, you may elect continuation coverage within 60 days of the first day of the month in which you become eligible for TAA, but no later than 6 months from the date health coverage is lost. If you elect continuation coverage during this second election period, your coverage will begin on the first day of the second election period, rather than the date health coverage is lost. The period between the loss of coverage and the beginning of the second election period does not count as a break in coverage for purposes of the coverage rules under HIPAA (as described in the section titled "Electing the Opt-Out Option" on page9).

Cost

If you elect to continue coverage, you must pay the entire cost of coverage (BNSF's contribution and the active employee portion of the contribution), plus a 2% administrative fee for the duration of COBRA continuation.

If you or your covered dependent is Social Security disabled as defined by Title II or Title XVI of the Social Security Act within 60 days of loss of coverage due to your termination of employment or reduction in hours, you may elect to continue coverage for the disabled person only or for some or all of COBRA eligible family members

for up to 29 months. You must pay 102% for the first 18 months of COBRA continuation and 150% for the 19th through the 29th month of coverage.

For COBRA coverage to remain in effect, payment must be received by YBR by the first day of the month for which the payment is due, subject to a 30-day grace period. (Your first payment is due no later than 45 days after your election to continue coverage, and it must cover the period of time back to the first day of your COBRA continuation coverage.)

Duration

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is your death, your entitlement to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of your employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until 36 months after the date of Medicare entitlement.

> For example: if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the BNSF Medical Program is determined by the Social Security Administration to be disabled and you notify YBR of the disability before the end of the initial 18 months of COBRA continuation coverage and within 60 days following the date you or a covered dependent is determined to be disabled by the Social Security Administration, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

If the disabled individual should no longer be considered to be disabled by the Social Security Administration, you must notify YBR within 30 days following the end of the disability. Coverage that has exceeded the original 18-month continuation period will end when the individual is no longer Social Security disabled.

Second qualifying event extension of 18-month period of continuation coverage

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

The COBRA beneficiary must experience the second qualifying event during the first 18 months of COBRA continuation, and must provide notice to the COBRA Administrator within the required time period. COBRA continuation coverage will end sooner if the BNSF Medical Program terminates and BNSF does not provide replacement medical coverage, or if a person covered under COBRA:

• First becomes covered under another group health plan after the loss of coverage due to your termination or reduction in hours, unless the new group coverage is limited due to a pre-existing condition exclusion. This Program will be primary for the pre-existing condition and secondary for all other eligible health care expenses, provided contributions for COBRA coverage continue to be paid. Coverage may only continue for the remainder of the original COBRA period;

• Fails to make required contributions when due;

• First becomes entitled to Medicare benefits after the initial COBRA qualifying event; or

• Is extending 18-month coverage because of disability and is no longer disabled as defined by the Social Security Act.

If You Have Questions

Questions concerning the BNSF Medical Program or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the BNSF Medical Program Informed of Address Changes

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator. You can contact the COBRA Administrator at the below address:

Your Benefits Resources
2300 Discovery Lane
Orlando, Florida 32826
Phone: 1-877-847-2436

General Information Affecting Your Right to BNSF Medical Program Benefits

Right to Information

You must provide the Program Administrator and the Claims Administrator with any information they consider necessary to administer the Program. If the information you give on an enrollment form or claim application is wrong, or if you omit important information, your Program coverage may be canceled or your claim may be denied. If your address should change, or if a spouse's or dependent child's address should change, you must notify your Employer immediately.

No Guarantee of Employment

Participation in this Program does not guarantee your employment with BNSF or any related BNSF Employer. Neither does it guarantee your right to any benefit under the Program.

Program Termination and Amendment

The Program has been established for the exclusive benefit of eligible Employees and their eligible dependents. BNSF reserves the right to amend, modify or terminate the Program, including any of the benefits, or the amount of any required employee contributions, at any time and for any reason. If any change in the Program should occur, you will be notified within a reasonable amount of time.

No Vested Rights

Your Program benefits are not vested. Your right to benefits is limited to claims incurred before the first to occur of the following events.

- Amendment of the Program.
- Termination of the Program.
- Expiration of the period that claims can be accepted by the Claims Administrator.
- Termination of your eligibility to participate.

Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 and its applicable regulations (HIPAA) is a federal law that, in part, requires group health plans, like the Burlington Northern Santa Fe Group Medical Program to protect the privacy and security of your confidential health information. As an employee welfare benefit plan under ERISA, the Medical Program is subject to the HIPAA privacy rules. Pursuant to the HIPAA privacy rules, the Medical Program will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, program administration or as required or permitted by law. A description of the Medical Program's uses and disclosures of your protected health information and your rights hand protections under the HIPAA privacy rules is set forth in the Notice of Privacy Practices, which will be furnished to you and can also be accessed on the BNSF intranet site at http://bnsfweb.bnsf.com/departments/hr/index.html. You can also receive a copy of the Notice of Privacy Practices by contacting the BNSF Privacy Official, P.O. Box 961055, Fort Worth, Texas 76161, (Phone) 800-234-1283.

Administrative Information

Program Costs

Medical Program benefits and administrative costs are paid from a tax-qualified Internal Revenue Code Section 501(c)(9) trust, commonly referred to as a VEBA. Employer contributions and the contributions of eligible Employees who elected to reduce their pay on a before-tax basis under the BNSF Internal Revenue Code Section 125 cafeteria plan, are deposited in the VEBA. Benefits under the BNSF Medical Program options, including the Aetna High Deductible Health Program option, are self-insured by BNSF. Benefits under the HMO options are insured by the relevant HMO. Please review your HMO materials for additional details.

Program Name and Plan Number

The Aetna High Deductible Health Program option is made available under The Burlington Northern Santa Fe Corporation Group Medical Program. The Medical Program is a participating Program in the Burlington Northern Santa Fe Group Benefits Plan, a consolidated welfare benefits program under ERISA that files its annual returns under Plan Number 501.

Company and Employer

The terms “BNSF,” “Company,” and "Employer" as used in this SPD refer to Burlington Northern Santa Fe Corporation, or a Participating Affiliated Company of BNSF whose employees are eligible to participate in the Medical Program.

Company Name and Identification Number

The Medical Program is sponsored by Burlington Northern Santa Fe Corporation, Employer Identification Number 41-1804964.

Program Administrator and Agent for Service of Legal Process

The BNSF Medical Program Administrator’s name, address and telephone number is as follows:

Employee Benefits Committee
c/o BNSF Railway Company
2500 Lou Menk Drive
Fort Worth, Texas 76131
800-234-1283

The agent for service of legal process is:

Mr. Jeffrey R. Moreland
Executive Vice President Law & Government Affairs and Secretary
2500 Lou Menk Drive
Fort Worth, Texas 76131

The Burlington Northern Santa Fe Employee Benefits Committee is the Program Administrator. The Program Administrator has delegated to Aetna the discretionary authority to interpret Program provisions relating to the payment of benefits, initial claims processing and for ERISA claim appeals requested in writing by Program participants and beneficiaries. The Employee Benefits Committee retains the discretionary authority to determine whether an Employee or dependent is eligible for initial or continued enrollment in the Program. The discretionary authority delegated to Aetna includes the authority to interpret the provisions of the Program for purposes of resolving any inconsistency or ambiguity, correcting any error, or supplying information to correct any omission.

Claims Administrator for the BNSF Medical Program Aetna High Deductible Health Program Option (including out-of-network claims)

The Claims Administrator for the Option is:

Aetna
P.O. Box 14586
Lexington, KY 40512-4586
Phone: 800-826-2386

Named Fiduciary

Aetna is the Named Fiduciary under ERISA for all ERISA claim appeals regarding claims for Program benefits. The BNSF Employee Benefits Committee retains the discretionary authority to determine eligibility and enrollment rights under the Medical Program.

COBRA Administrator

Your Benefits Resources
2300 Discovery Lane
Orlando, Florida 32826
Phone: 1-877-847-2436

Program Year

The Program Year is the calendar year.

Your Rights Under ERISA

As a participant in the BNSF Medical Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Medical Program participants will be entitled to:

Receive Information About Your Medical Program Benefits

• Examine, without charge, at the Program Administrator's office and other locations, such as worksites and union halls, all documents governing the Medical Program, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Program with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

• Obtain, upon written request to the Program Administrator, copies of documents governing the operation of the Program, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) an updated summary plan description. The Program Administrator may make a reasonable charge for the copies.

• Receive a summary of the Program's annual financial report. The Program Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Medical Program Coverage

• Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Medical Program as a result of a COBRA qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Medical Program for the rules governing your COBRA continuation coverage rights.

• Reduction or elimination of exclusionary periods, if any, for coverage for preexisting conditions under your group health coverage, if you have creditable coverage from another health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment in some group health plans.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Program participants, ERISA imposes duties upon the people who are responsible for the operation of this Medical Program. The people who operate the BNSF Medical Program, called *fiduciaries* of the Program, have a duty to do so prudently and in the interest of you and other Program participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

to provide the materials and pay you up to $110 a day until you receive the materials, unless the
If your claim for a benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. After completion of the appeal process (see page 57) you have the right to bring a civil action under ERISA Section 502(a).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Program Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Program Administrator materials were not sent because of reasons beyond the

control of the Program Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the Program's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that Program fiduciaries misuse the Program's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — for example, if it finds your claim is frivolous.

You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Assistance With Your Questions

If you have any questions about the Program, you should contact the Program Administrator.

If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Program Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The next page lists the EBSA area offices.

Offices of the Employee Benefits Security Administration
U.S. Department of Labor

Atlanta Regional Office
61 Forsyth Street, S.W.
Suite 7B54
Atlanta, GA 30303
Phone: 404/562-2156

Boston Regional Office
One Bowdoin Square
7th Floor
Boston, MA 02114
Phone: 617/424-4950

Chicago Regional Office
200 W. Adams Street
Suite 1600
Chicago, IL 60606
Phone: 312/353-0900

Cincinnati Regional Office
1885 Dixie Highway
Suite 210
Ft. Wright, KY 41011-2664
Phone: 606/578-4680

Dallas Regional Office
525 Griffin Street
Room 707
Dallas, TX 75202-5025
Phone: 214/767-6831

Detroit District Office
211 W. Fort Street
Suite 1310
Detroit, MI 48226-3211
Phone: 313/226-7450

Kansas City Regional Office
City Center Square
1100 Main
Suite 1200
Kansas City, MO 64105-2112
Phone: 816/426-5131

Los Angeles Regional Office
790 E. Colorado Boulevard
Suite 514
Pasadena, CA 91101
Phone: 818/583-7862

Miami District Office
111 N.W. 183rd Street
Suite 504
Miami, FL 33169
Phone: 305/651-6464

New York Regional Office
1633 Broadway, Room 226
New York, NY 10019
Phone: 212/399-5191

Philadelphia Regional Office
Gateway Building
3535 Market Street
Room M300
Philadelphia, PA 19104
Phone: 215/596-1134

St. Louis District Office
815 Olive Street
Room 338
St. Louis, MO 63101-1559
Phone: 314/539-2691

San Francisco Regional Office
71 Stevenson Street
Suite 915
P.O. Box 190250
San Francisco, CA 94119-0250
Phone: 415/975-4600

Seattle District Office
1111 Third Avenue
Suite 860
MIDCOM Tower
Seattle, WA 98101-3212
Phone: 206/553-4244

Washington, D.C. District Office
1730 K Street, N.W.
Suite 556
Washington, DC 20006
Phone: 202/254-7013

Who to Call About Your Benefits

For questions regarding the enrollment process or your Medical Program benefits, call YBR Customer Care Representative at 1-877-847-2436.

For questions regarding the services under the Aetna High Deductible Health Program option, call Member Services at 1-800-826-2386.

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

This SPD is only a summary of the BNSF Aetna High Deductible Health Program option under the Program. It does not constitute a contract. The Medical Program has been established under a plan document. If there are any differences between this SPD and the plan document, the plan document will control.