Burlington Northern Santa Fe Medical Program Burlington Northern Pre-65 Retiree Program

Summary Plan Description

January 1, 2003

Contents

BNSF
Medical Program
for Burlington Northern Pre-65 Retirees

Pre-65 Retirees who meet BNSF eligibility requirements have the opportunity to continue Medical Program coverage beginning with the first day of the month in which their early retirement benefit commences.

As an early Retiree you will have access to the Blue Cross and Blue Shield PPO Program. However, because you are no longer actively employed, there will be some changes in the Medical Program rules for early Retirees. This Summary Plan Description (SPD) covers benefits available under the BCBS PPO Option for Burlington Northern Pre-65 Retirees only.

You may choose from the following coverage level options under the Pre-65 Retiree Medical Program:

- Retiree only;

- Retiree plus family, which includes coverage for you, your dependent children and your spouse.

Your contributions will be withheld from your pension check unless you make arrangement with Sageo for direct bill and payment. You are no longer eligible for a pre-tax contribution election under the BNSF Internal Revenue Code Section 125 cafeteria plan.

If you have questions regarding your benefits, call the BCBS Customer Service Team at 1-888-399-5945 from 8:00 a.m. to 6:00 p.m. Central Standard Time. You can also access the BCBS web site at **www.bcbsil.com**.

Eligibility and Enrollment

Your Eligibility for Coverage

You are eligible to enroll for early Retiree coverage if you meet the eligibility requirements for the Pre-65 Retiree Medical Program. You must have been a full-time regularly assigned active salaried employee of Burlington Northern, Inc. or its affiliates participating in the Program prior to September 22, 1995 and have remained in a salaried position continuously up to your early retirement date. In addition you must meet all of the following requirements:

- you terminate salaried employment with the Company due to retirement prior to reaching age 65;
- if you retire after June 1, 1994, you have 10 or more years of service with the Company after reaching age 45;
- you are immediately eligible and elect to begin receiving benefits under the BNSF Retirement Plan; and
- you are a U.S. resident at the time of your early retirement and you continue to be a U.S. resident after retirement.

Employees who enter salaried employment with Burlington Northern Santa Fe as a result of a transfer, initial hire or rehire after September 22, 1995, are not eligible for benefits under the Pre-65 Retiree Medical Program. In addition, coverage is not available to other employees or service providers, such as leased employees or independent contractors.

Dependent Eligibility

Family members you may cover as eligible dependents under the Pre-65 Retiree 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 Sageo.

Your children are considered to depend primarily on you for financial support if you provide more than 50% of their support and claim them as dependents on your federal income tax return. Coverage ends the

day before the child's 19th birthday or, if the child is a full-time student, on the first to occur of the following:

• the child's graduation;

• the child's 23rd birthday;

• 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, Sageo, 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 Pre-65 Retiree 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 BCBS 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.

Enrollment

If you are eligible for the Pre-65 Retiree Medical Program, you may enroll in the Blue Cross and Blue Shield PPO Option. You also may enroll your spouse and those dependents that meet the eligibility requirements listed on page 2. ***You must enroll within 31 days after the date you first become eligible for coverage under the Pre-65 Retiree Medical Program.***

If you are enrolled in early Retiree coverage, you cannot change your coverage election during the year unless one of the following Family Status Events should occur:

- Your marriage, divorce, legal separation or annulment;
- Death of your spouse or other covered dependent;
- Birth, adoption, placement for adoption, or marriage of a dependent;
- A dependent satisfies or ceases to satisfy eligibility requirements;
- 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 Qualified Medical Child Support Order under ERISA Section 609, as determined by the Program Administrator; or
- A significant change or loss of spouse or dependent coverage under another group health plan for reason other than your failure to pay premium.

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.

Opting Out of Early Retiree Coverage

If you choose not to elect or continue Pre-65 Retiree Medical coverage for yourself and your dependents, you should be certain you have 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 Pre-65 Retiree 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.

HIPAA Special Enrollment Rules

If you do not elect Pre-65 Retiree Medical coverage for yourself or an eligible dependent when first eligible or in any subsequent year, you may not re-enroll for coverage unless you have the following Special Enrollment Event:

• You waive Pre-65 Retiree coverage because you had other group medical plan coverage and that group medical plan terminates, or the employer sponsoring the other group medical plan ceases to make employer contributions. You should know that failure to pay the required premium for the other group medical coverage is not a termination of the other plan under the HIPAA Special Enrollment Event rules. You will need to provide evidence of the other group coverage, including information on the reasons it has ended; or

• Termination of eligibility for other group medical coverage due to termination of employment of you or your spouse in the event that you are enrolled as a dependent.

You must notify Sageo within 31 days of the termination of your other group medical plan coverage to re-enroll in the Pre-65 Retiree coverage.

Giving Notice of a Family Status Event

You must notify Sageo within 31 days of one of these events in order to change your election. If you have a Family Status Event or if you want to enroll under the HIPAA Special Enrollment Rules, you can log on to www.sageo.com to make the changes. If you prefer to use the phone, you can call the Sageo Resource Line by dialing 1-877-847-2436. Except as noted below (under "Effective Date of Revised Coverage"), if you do not notify Sageo within 31 days, you will have to wait until the next Annual Enrollment unless you have a subsequent Family Status Event or otherwise qualify for HIPAA Special Enrollment, and you give notice within 31 days.

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.

The BCBS PPO Option

The BCBS PPO is a national PPO. This means BCBS has a national network of hospitals and other health care providers who have agreed to provide services covered under the Program at a pre-determined rate.

Choosing an In-Network Provider

You may see any physician you wish. However, if you want to take advantage of Program benefits at a lower cost, you should consider using a BCBS PPO network provider. You and your enrolled dependents can find a BCBS PPO network provider by using the Sageo web site at **www.sageo.com**. If you do not have access to the web site, you can contact Sageo by phone at 1-877-847-2436. The SAGEO information is regularly updated. However, once you select a PPO provider, you should always check with the provider to be certain the provider is in the BCBS PPO network.

Under the PPO, you can go to any physician or health care professional at any time. Each time, you can decide whether to go to an in-network PPO provider or an out-of-network provider. Benefits are greater when you use a PPO in-network provider. If you decide to use an out-of-network provider, you will pay a greater share of the cost of service. You will also be responsible for that part of the out-of-network provider's bill that does not meet the BCBS definition of a "reasonable and customary" charge.

If you decide to rely exclusively on the PPO network providers for your care throughout the calendar year, you will reduce your health care expenses in several ways. For example:

• You will have a lower calendar-year deductible.

• The individual calendar-year out-of-pocket maximum is lower than the out-of-network option.

• You will pay a set dollar copayment for PPO in-network provider office visits.

• You and your covered family members will never incur a charge for PPO in-network services that exceeds “reasonable and customary” levels. (You are required to pay for that portion of out-of-network charges that are not “reasonable and customary” under Program terms.)

In most cases, you will not be required to file a claim form for services provided by PPO in-network providers. Your claim will be submitted automatically to the Claims Administrator by the PPO provider. You will be responsible for paying the individual out-of-pocket amounts and other PPO copayments, however. There is no lifetime dollar limit on the services provided to covered persons by PPO network providers. However, for example, there are dollar limits that apply to certain benefits such as substance abuse benefits.

Out-of-Network Providers

You are not required to use the PPO network providers. You may choose to use out-of-network providers, but you will pay more for their services. You and your dependents will be required to pay a higher calendar-year deductible and a higher out-of- pocket maximum. **Also, preventive care services by out-of-network providers are not covered.** There is a lifetime $750,000 limit on out-of-network services for each covered person. Certain limits also apply to specific benefits. Each January 1, if you have used at least $1,000 of the lifetime limit in the prior year, $1,000 will be restored to the limit. See the chart on page 7 for a comparison of out-of-pocket expenses for network and out-of-network services.

Schedule of BCBS PPO Benefits

PRE-65 RETIREE MEDICAL PROGRAM LIFETIME MAXIMUM	In Network: Unlimited Out-of-Network: $750,000	
BENEFITS	**In Network Coverage**	**Out-of-Network Coverage**
Deductible: (per individual)	$200	$400
Family Deductible:	$400	$800
Out-of-pocket Expense Limitation: The amount of money an individual pays toward covered hospital and medical services during any 1 calendar year, **excluding the deductible**. Office visit, emergency room and prescription drug copays, pre-certification penalties and charges in excess of the BCBS fee schedule do not apply to any out-of-pocket limit.	Individual $1,500	Individual $3,500
Inpatient Hospital Services: Subject to deductible; room allowance based on the hospital's most common semi-private room rate; Skilled Nursing Facility, Hospice and Coordinated Home Care are paid on the same basis; Pre-admission testing paid as part of the subsequent Inpatient Hospital surgical stay.	80%	60%
Outpatient Surgery & Diagnostic Tests: Subject to deductible	80%	60%
Outpatient Emergency: (Hospital & Physician) Emergency Medical and Emergency Accident -- Initial treatment in hospital or physician's office of accidental injuries or sudden and unexpected medical conditions with severe life threatening symptoms. Subject to $50 copay, waived if admitted.	$50 Copayment then 100%	Same as Network
Physician Office Visit: Payments are based on the BCBS fee schedule. Network providers have agreed to accept the BCBS fee schedule as payment in full for covered services, excluding your deductible and any coinsurance. Out-of-Network subject to the deductible.	$15 Copayment then 100%	60%
Well Child & Adult Routine Care: Subject to $15 copay	$15 Copayment then 100%	Not Covered
Chiropractor: Subject to the deductible; $1,000 calendar year maximum or 60 visits whichever is met first.	80%	60%
Durable Medical Equipment (DME): Subject to deductible	80%	60%
Occupational / Physical / Speech Therapy: Subject to the deductible. $5,000 calendar year maximum per therapy	80%	60%
Other Covered Services: Subject to deductible; blood and blood components; leg, arm, and neck braces; private duty nursing; ambulance services; oxygen and its administration; surgical dressings, casts and splints.	80%	
Medical Management / Medical Services Advisory (MSA): Notification required before all elective admissions. Emergency and Obstetric Admission Notification required within 2 business days of admittance. Failure to notify MSA will result in a $500 reduction in benefits		
Transplant Coverage: Transplants in approved facilities paid as any other condition with prior approval by MSA Advisor.		
Prescription Drug--Administered by Caremark **Pharmacy Copays:** $10 generic / $20 brand formulary / $35 brand non-formulary – 34 day supply; **Mail Order Copays:** $20 generic / $40 brand formulary / $70 brand non-formulary – 90 day supply. Copays do not apply to the deductible or coinsurance maximums.		

• Mental health and substance abuse are subject to limits. See Substance Abuse and Mental Health section of SPD for details.
• Penalties for not requesting pre-authorization and charges in excess of reasonable and customary can not be credited toward the deductible and out-of-pocket maximum.
• Some benefits are subject to limits. Examples of limited benefits include infertility treatment, chiropractic treatment, occupational, speech and physical therapies and home health care. See Medical Care Services section of SPD for details on all limitations that apply.

The Schedule of Benefits for Substance Abuse and Mental Health can be found on SPD page 23.

Understanding Deductibles and Copayments

Certain rules apply to deductibles and copayments for the PPO in-network and out-of-network options. It is important that you understand how the rules apply. No matter whether you choose a PPO provider or an out-of-network provider, you and your covered dependent(s) must pay part of the expenses for services and supplies received. Depending on the type of expenses, you will be required to pay a copayment or deductible, and a percentage of the charge. The percentage you pay is sometimes called *coinsuranc*e.

A *copayment* is a per-visit payment required under the PPO option when you or a dependent visits a network physician, or receives emergency care in your physician's office or the emergency room of a hospital. For example, if you are covered under the PPO option and visit a network doctor for a routine physical, you pay $15 at the time of service. There is no additional fee to pay or a deductible to meet. The PPO network copayments are shown in the PPO Schedule of Benefits on pages 7 and 23.

A *deductible* is money you must spend each calendar year for eligible expenses before the Program pays benefits. Calendar-year deductibles are separate from copayments. There are individual and family deductibles under the BCBS PPO network and out-of-network coverage. Both options have individual and maximum family deductibles. Before benefits are paid, you must meet the deductible for the type of provider you have visited, a BCBS in-network provider or an out-of-network provider. The deductibles are shown in the BCBS PPO Schedule of Benefits on pages 7 and 23. Each PPO and non-PPO deductible is separate; however, the non-PPO deductible feeds into the PPO deductible.

When you look at the Schedule of Benefits, you will see the maximum family deductible is equal to two individual deductibles for in- and out-of-network covered expenses. This means that when two or more covered family members incur eligible expenses totaling the family deductible, the Program will begin paying the appropriate percentage for additional expenses for the family for that year. Please note that no more than an individual deductible will be taken from any one family member.

Both the in-network and out-of-network options have calendar-year out-of-pocket expense maximums. *Out-of-pocket expenses* are your portion of the charges made by network and out-of-network providers. Out-of-pocket expenses do not include any deductibles, or any network copayments (including prescription copayments). Under either the network or the out-of-network options, the Program will pay 100% of eligible expenses for the remainder of that calendar year after a Covered Person has met the out-of-pocket maximum. See the BCBS PPO Schedule of Benefits on page 7 for details.

If your early Retiree coverage becomes effective mid-calendar year and you were previously enrolled in BCBS PPO you will be credited with the Deductibles and Copayments (including out-of-pocket maximum expenses) you paid during the part of the year that you were an active employee. If you were enrolled in a different BNSF Medical Program option, you will have to meet any Deductibles and Copayments (including any out-of-pocket expenses) required under BCBS PPO.

Special copayments apply to mental health/substance abuse benefits under the Pre-65 Retiree Medical Program. See page 23 for the Mental Health and Substance Abuse Schedule of Benefits.

The following charges will **not** count toward the annual deductible or out-of-pocket maximums for the in-network or out-of-network benefit options.

- Charges in excess of the BCBS reasonable and customary charges.
- Charges for services and supplies not covered under the BCBS option.
- Charges that exceed the applicable lifetime or calendar year dollar maximums.

• Any penalties paid because the covered person failed to comply with the Program's pre-certification requirements.

• Charges for inpatient admissions and additional inpatient days that have not been certified on review by the pre-certification reviewer.

• Copayments for prescription drugs and office visits.

What You Should Know About Covered Charges

The Program reimburses only those covered charges that are medically necessary and not otherwise excluded or limited under Program terms. If you use the PPO network your charges will be submitted directly to the network Claims Administrator and you will never pay more than the applicable individual out-of-pocket maximum and any required copayment. If you use out-of-network providers, you will need to file a claim with the Claims Administrator for most out-of-network provider charges. You will also pay an out-of-network deductible and the applicable co-insurance up to the out-of-pocket maximum. Only those medically necessary out-of-network covered charges that meet the BCBS definition of reasonable and customary will be paid or reimbursed by the Claims Administrator.

Certain medical services are subject to pre-admission certification. Failure to comply with the BCBS option's pre-admission certification requirement could result in your paying a $500 penalty that will not be included as part of the calendar-year deductible or out-of-pocket maximum. You also will be responsible for paying the penalty for covered medical services that should have been, but were not, pre-certified under the BCBS option. The pre-certification requirements apply to both in-network and out-of-network medical services.

Special rules apply to covered charges for mental health and substance abuse services. See page 23 for the Mental Health and Substance Abuse Schedule of Benefits.

Medically Necessary Charges

A service or supply is *medically necessary* when, in the Claims Administrator's determination, it meets all of the following criteria:

1. It must be provided by a physician, hospital or other covered provider under the BCBS option.

2. It must be commonly and customarily recognized with respect to the standards of good medical practice as appropriate and effective in the identification or treatment of a patient's diagnosed injury or illness.

3. It must be consistent with the symptoms on which the diagnosis and treatment of the illness or injury is based.

4. It must be the appropriate supply or level of service that can safely be provided to a patient. With regard to a person who is an inpatient, it must mean the patient's illness or injury requires that the service or supply cannot be safely provided to that person on an outpatient basis.

5. It must not be primarily for the convenience of the patient, physician, hospital or other covered provider under the Program. It must not be for the purpose of custodial care, convalescent care, rest cures, or domiciliary care.

6. It must not be scholastic, educational or developmental in nature, used for vocational training, or experimental or investigational.

7. It must not be provided primarily for the purpose of medical or other research.

8. It must not be an inpatient admission primarily for diagnostic studies like x-rays, laboratory services or other machine diagnostic tests. If these procedures can be provided safely and adequately on an outpatient basis or in the physician's office, inpatient testing is not medically necessary under the Program.

The Program Administrator has delegated the discretionary authority to determine medical necessity under the Program to the Claims Administrator. The fact that a patient's physician has ordered a particular treatment or supply does not make it medically necessary under the Program. Even if your physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary, the Program will only reimburse services and supplies determined medically necessary by BCBS.

Among the factors the Claims Administrator may consider in determining medical necessity are (1) approval by the U.S. Food and Drug Administration (FDA), if applicable; or (2) whether a service or supply is commonly and customarily recognized by physicians in a particular medical specialty as appropriate for the diagnosis or treatment of the illness or injury. The presence of these or other factors will not automatically result in a determination of medical necessity if the Claims Administrator determines one or more of the eight requirements listed above has not been met.

Reasonable and Customary Charges

Only reasonable and customary charges are paid under the Program. If you use a PPO network provider, the charges from the network provider are subject to a scheduled reimbursement allowance and are not subject to a reasonable and customary determination by the Claims Administrator. Out-of-network provider charges are reasonable and customary if they are within the normal range of charges made by most physicians, hospitals and other providers in the same geographical area. The Claims Administrator has the discretionary authority to determine reasonable and customary amounts under the Program, and will take into consideration the nature and severity of the condition treated, and any complications or unusual circumstances that may require additional time, skill or experience.

Pre-admission Certification and Continued Stay Review

Pre-admission certification and continued stay review refer to the process used to certify the medical necessity and length of inpatient hospital stays during a course of treatment. These reviews are part of the BCBS Medical Services Advisory Program, which is called "MSA". MSA review applies to the PPO network and out-of-network Program options. You, your dependents or your treating physician should request MSA review prior to an inpatient hospital admission. If MSA certification is not obtained prior to an inpatient admission, you will be charged a $500 penalty. If the penalty applies, it will not be counted as part of any calendar-year deductible or out-of-pocket maximum.

Pre-admission Review is not a guarantee of Program benefits. Payment of benefits is subject to the general terms, limitations, and exclusions under the Program.

If your treating physician is in the PPO network, the network provider usually will make certain the MSA review is obtained prior to any inpatient stay in a network hospital. If you have an out-of-network physician and/or are preparing for inpatient admission to an out-of- network hospital, you are responsible for obtaining an MSA review. **Whether care is received from a PPO provider or an out-of-network provider, it is your responsibility to make sure MSA review has been obtained.**

When you contact the MSA be prepared to give the following information:

1. the name of the attending or admitting physician;

2. the name of the hospital where admission is scheduled;

3. the scheduled admission date; and

4. a preliminary diagnosis or reason for the admission.

Under federal law, hospital length of stay in connection with childbirth for the mother or newborn child may not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. The attending physician is not required to obtain pre-certification for a length of stay that does not exceed the federal requirements.

To obtain an MSA review for any inpatient hospital admission or to find out if MSA review is required, call the toll-free number shown on your BCBS PPO option identification card.

When you receive MSA certification or review, your treating physician and the hospital will be advised of the length of stay certified by the MSA reviewer. Continued stay review should be requested by you or your treating physician prior to the end of the certified length of stay if additional inpatient days may be needed.

To obtain MSA certification for additional inpatient days, call the toll-free number shown on your BCBS PPO identification card.

If you and your physician decide to extend your inpatient stay when the MSA reviewer has indicated the Pre-65 Retiree Medical Program will not pay for additional days, you will be responsible for paying for the added days. You may not count your payment toward the calendar year deductible or out-of-pocket maximum. You may appeal the MSA reviewer's denial of additional days under the rules outlined in the "If Your Claim Is Denied" section of the SPD beginning on page 36. All medical decisions regarding your treatment are between you and your physician. The MSA reviewer is responsible for determining only whether the Program will pay for extra inpatient days.

When to Request Pre-admission Certification

Non-emergency or non-maternity admissions: If you or a dependent is planning elective surgery, you, your physician, or anyone on your or your dependent's behalf should *call the MSA toll-free number on your BCBS PPO identification card* to certify the hospital stay within one (1) business day before the inpatient admission.

The Hospital or your physician will be advised by telephone of the MSA review decision. There will be a follow-up notification letter sent first class mail. This letter may not be received prior to your date of admission.

Emergency admissions: If you or a dependent is admitted to the hospital due to a sudden sickness or injury that may result in serious medical complications, loss of life or permanent impairment of bodily functions, you, your treating physician or a friend or relative should *call the MSA toll-free number on your BCBS PPO identification card* within two (2) business days of the emergency admission, or as soon as reasonably possible.

Pregnancy: Although you are not required to call for an MSA review prior to your maternity admission, you should call MSA as soon as you find out that you or your spouse is pregnant but no later than the first trimester of pregnancy in the normal course. The MSA reviewer will monitor the pregnancy and provide educational materials that will help you ask your physician the right questions. Your physician will receive a letter stating you have contacted MSA.

You or your physician should contact MSA within two (2) days after a maternity admission. Under federal law, neither you nor your physician is required to obtain MSA pre-authorization on entering the Hospital to deliver your baby. However, you or your physician must contact the MSA reviewer if the mother is not going to be released within 48 hours of a normal vaginal delivery. If the baby is delivered by Cesarean section and the mother is not going to be released 96 hours after the baby is delivered, then

you or your physician must contact MSA. *Call the MSA reviewer toll free number on your BCBS PPO identification card.*

Special Rules for Mental Health and Substance Abuse Inpatient Care

Emergency Mental Health/Substance Abuse Care: In the event of an emergency mental illness or substance abuse admission, you, or someone on your behalf, must call the Mental Health Unit (MHU) reviewer no later than 48 hours after the emergency admission has occurred. *The MHU reviewer can be reached 24 hours a day, 7 days a week at the toll free number 1-800-851-7498.*

Inpatient Mental Health/Substance Abuse Care: The MHU reviewer must be called if you are requesting non-emergency inpatient Hospital admission. The inpatient admission must be recommended by your physician. You or your physician must call the MHU reviewer one (1) day prior to the inpatient admission. If there are going to be pre-admission tests, then the MHU reviewer must be called one (1) day prior to those tests. *The MHU reviewer can be reached 24 hours a day, 7 days a week at the toll free number 1-800-851-7498.* You or your physician must seek MHU reviewer approval of any extension of the original approved stay. If you or your physician decide to extend inpatient days when the MHU review has indicated the Program will not pay for additional days, you will be responsible for the added days. You may appeal the MHU reviewer's denial of additional days under the rules for Expedited and Written Appeals on SPD page 24.

Mental Health/Substance Abuse Partial Hospitalization: The term "partial hospitalization" means an approved program of a Hospital or Substance Abuse Treatment Facility for the rehabilitation treatment of mental illness or substance abuse, in which the patient spends days only or nights only. If your physician recommends a partial hospitalization treatment program, you must call the MHU reviewer one (1) day prior to scheduling admission. *The MHU reviewer can be reached 24 hours a day, 7 days a week at the toll free number 1-800-851-7498.*

MHU does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and the required services is between you and the physician. MHU determines whether benefits are paid under the BCBS definition of medically necessary. The fact that your physician or health care provider determines a treatment is medically necessary does not mean the Program will cover the treatment.

When you contact MHU you should be able to give the information listed on page 23 of this SPD.

Case Management

In the event you or your dependent needs continuing treatment beyond the acute care setting of the hospital, you will be contacted by a Case Manager. The Case Manager helps to ensure that patients receive care in the most effective setting possible whether at home, as an outpatient or as an inpatient in a specialized facility. The Case Manager will work closely with the patient, the family and the treating physician to determine treatment options and to keep costs manageable. Case Managers also are available to answer questions and provide ongoing support for the family in times of medical crisis.

You, a friend or relative, or the treating physician can request case management by *calling the toll-free number on your BCBS PPO identification car*d. Participation in the case management program is voluntary. There is no penalty if you do not want to participate in case management.

Organ Transplants

Charges made for or in connection with certain organ transplant services that are not determined to be experimental and investigational and that are approved by BCBS are covered the same as benefits for other medical conditions under the Program. *If you or a dependent is or may become a candidate for an*

organ transplant, call the toll-free number on your BCBS PPO identification card. Only the following human organ or tissue transplants are covered under Program terms.

- cornea
- heart valve
- heart
- liver
- kidney
- muscular-skeletal
- lung
- pancreas
- bone marrow
- parathyroid
- heart/lung
- pancreas/kidney

You must call the toll-free number on your BCBS PPO identification card before scheduling any heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant. The Program only covers benefits for these transplants at Hospitals operating a BCBS approved Human Organ Transplant Program. No benefits will be provided for these transplants at any hospital that does not have a BCBS approved Human Organ Transplant Program.

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

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

• If you are a recipient and the donor has no insurance from any source, the benefits described in this SPD will apply to the donor for transplant purposes only. In this case, payments made for the donor will be charged against any BNSF Pre-65 Retiree Medical Program benefit limits that apply to you.

• If you are the donor and no coverage is available to you from any other source, you will be covered under the BNSF Pre-65 Retiree Medical Program. No benefits will be provided for the recipient under the Program.

Transplant benefits begin no earlier than five (5) days prior to transplant surgery and extend no longer than 365 days from date of surgery. Only U.S. or Canadian transportation of a donor organ is covered.

No benefits are provided for transportation by an ambulance for a donor or recipient, or for travel time and related expenses of a medical Provider. No benefits are paid for cardiac rehabilitation if provided after three (3) days after Hospital discharge. No benefits are paid for drugs or treatments that are investigational, as determined by BCBS.

All transplants are subject to MSA reviewer pre-certification and continued stay review. You or your physician must call the MSA reviewer number on your BCBS identification card.

Medical Care Services

The following medically necessary services are covered under the Program subject to the copayments, deductibles and co-insurance maximums that apply to the Program option (in-network or out-of-network) you have elected. Reimbursement of medical expenses is subject to BCBS reasonable and customary limits, and some benefits are subject to annual maximums, as shown on the "Schedule of Benefits chart and the "Substance Abuse and Mental Health" chart on pages 7 and 23. The fact that an annual or lifetime maximum is not listed in the following summary does not mean one or more of the limits have been removed. All Program limits and exclusions apply to all covered charges unless otherwise specified.

Hospital Charges

• Inpatient bed, board and general nursing care when the covered person is in a semi-private room, private room or an intensive care unit.

• Ancillary services (such as operating rooms, drugs, surgical dressings and lab work).

• Inpatient services of a surgeon, radiologist, pathologist and anesthesiologist.

• Pre-admission testing for preoperative tests on an outpatient basis in preparation for scheduled inpatient surgery. Benefits will not be provided for canceled or postponed surgery.

• Emergency care received in the hospital as an outpatient due to accidental injury or the onset of a medical emergency, provided the care is under the order of a physician and, in the case of an accident, is received within 72 hours of the accidental injury. Each time you receive covered services in an emergency room, you must pay a $50.00 copayment. Benefits for emergency accident care and emergency medical care are covered at 100 percent after the $50 copayment and are not subject to the Program deductible. Covered services received for emergency accident care and emergency medical care resulting from criminal sexual assault or abuse will be paid at 100% of the eligible charge, and the emergency room copayment of $50.00 will not apply.

• Outpatient renal dialysis treatments if received in a hospital, a dialysis facility or in the covered person's home under the supervision of a hospital or dialysis facility.

• Outpatient surgical services, including related diagnostic charges, physicians' fees, anesthesia and facility charges, ordered by the treating physician and all furnished by a hospital on the day the procedure is performed.

• Charges for anesthetics and their administration; outpatient diagnostic x-ray and laboratory examinations; x-ray, radium and radioactive isotope treatment; chemotherapy, shock therapy treatments, blood transfusions and blood not donated or replaced; and oxygen and other gases and their administration. Experimental and investigational treatments, as determined by BCBS, in any of these categories are not reimbursable under the Program.

• Charges for rehabilitative therapy by a licensed physical, occupational or speech therapist; prosthetic appliances; dressings; and drugs and medicines lawfully dispensed upon the written prescription of a physician while confined in a hospital.

• Other services and supplies provided they are medically necessary as determined by BCBS.

A *hospital* means an institution that is accredited by the Joint Commission on Accreditation of Healthcare Organizations and/or meets one of the following requirements:

• An institution licensed as a hospital that maintains on its premises all facilities necessary for medical and surgical treatment. The hospital must have the capacity to provide treatment on an inpatient basis, providing 24-hour service by registered graduate nurses under the supervision of physicians licensed to practice medicine.

• An institution that qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals.

• An institution that specializes in treatment of mental illness, alcohol or drug abuse, or other related illness; provides a residential treatment program; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term *hospital* does not include an institution that is primarily a place for rest or a nursing home, convalescent home, skilled nursing facility, or custodial home for the aged or similar institutions.

A *physician* is a licensed medical practitioner who is practicing within the scope of his or her license and who is licensed to prescribe and administer drugs or to perform surgery. Other health care providers whose services are covered subject to the Program 's limitations and exclusions are as follows:

• a licensed podiatrist;

• a registered clinical psychologist with a Ph.D. who meets the criteria established by BCBS;

• a certified nurse-midwife who (a) practices under the standards of the American College of Nurse-Midwives; (b) has an arrangement with a physician for obtaining medical consultation and hospital referral, and (c) has a current license as a registered nurse and is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives, or its predecessor;

• a licensed chiropractor;

• a licensed clinical social worker;

• a certified registered nurse anesthetist;

• a licensed physical therapist;

• a licensed occupational therapist; or

• a licensed speech therapist.

Physician Charges

Benefits are available for surgery performed by a physician, dentist, or podiatrist when medically necessary as determined by BCBS. Surgery performed by a dentist or podiatrist is limited to surgical procedures the practitioners are legally qualified to perform and which the Program would otherwise pay if the surgery is performed by a physician. Oral surgery benefits are limited to the following:

1. surgical removal of complete bony impacted teeth;

2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth;

3. surgical procedures to correct accidental injuries to the same areas described in item 2. above;

4. excision of exostoses of the jaws and hard palate (where not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of celluletes; incision of accessory sinuses, salivary glands or ducts; reduction or dislocation of, or excision of, the temporomandibular joints.

Surgical benefits include:

1. sterilization procedures, even if elective;

2. anesthesia services if administered during a surgical procedure in a hospital or ambulatory surgical facility. Anesthesia services provided by oral and maxillofacial surgeons in the surgeon's office are also covered;

3. assistant surgeon (physician, dentist or podiatrist) to the operating surgeon.

Additional surgical opinion following a recommendation for elective surgery is covered at 100% of reasonable and customary. Benefits are limited to one second-opinion with related diagnostic services. The deductible will not apply. You may request coverage for a third opinion if the second opinion does not resolve the question of surgery. BCBS must approve the request for a third opinion.

Coordinated Home Care Program Charges

A Home Care Program must be an organized skilled patient care program provided in the home. The home care can be provided by a hospital's licensed home health department or by any licensed home health agency. The patient must be unable to leave home without assistance and require supportive medical devices or special transportation. Skilled Nursing Service must be necessary on an intermittent basis under the direction of the patient's physician. The Home Care Program benefit includes:

- Skilled Nursing Service by or under the direction of a registered professional nurse;
- Services of physical therapists;
- Hospital laboratories; and
- Necessary medical supplies.

The Home Care Program does not include and is not intended to provide benefits for private duty nursing service.

The BCBS Medical option covers PPO-based Coordinated Home Care Programs at 80%, subject to the deductible and limited to 40 visits per calendar year. Non-PPO Coordinated Home Care Programs are covered at 60%, subject to the deductible and limited to 40 visits per calendar year.

Hospice Care Charges

A *hospice care program* is a program that provides supportive medical, nursing and other health service through home or inpatient care for a patient who is expected to live six months or less, as determined by a physician.

Hospice care services include any services provided by a hospital, a skilled nursing facility, a home health care agency, a hospice facility or any other licensed facility or agency under a hospice care program.

A *hospice facility* is a facility that primarily provides care for dying patients, is accredited by the National Hospice Organization, meets any state or local licensing requirements.

The BCBS Medical option covers PPO-based hospice care at 80% subject to the deductible. Non PPO-hospice care is covered at 60% subject to the deductible.

Hospice care programs meet the physical, psychological, spiritual and social needs of a dying patient and family members. Hospice care must be given under the direction of the treating physician. In order to be eligible for the hospice care benefit, the patient must have been diagnosed as having six months or less to live. The care is meant to keep the patient as comfortable as possible. Charges for room and board are paid at the contract rate subject to BCBS reasonable and customary limits. Other covered charges include:

• Services provided by a hospice facility on an outpatient basis.

• Services of a hospice ordered home health care agency for part-time or intermittent nursing care by or under the supervision of a nurse or home health aid, as necessary.

• Medical supplies, drugs and medicines lawfully dispensed on the written prescription of a physician; and laboratory services (but only if otherwise payable if the patient was confined in the hospital).

Hospice care charges will **not** be reimbursed for the following:

• Services of a person who is a member of your family or your dependent's family or who normally lives with you or your dependent.

• Services for any period of time when the patient is not under the care of a physician.

• Services for any curative or life-prolonging procedures.

• Services and supplies used primarily to aid you or your dependent in daily living.

Skilled Nursing Facility Charges

A *skilled nursing facility* is a licensed institution (other than a hospital) that specializes in physical rehabilitation on an inpatient basis, or inpatient skilled nursing and medical care. The institution must have all facilities necessary for medical treatment on the premises. It must provide treatment under the supervision of physicians and a full-time nursing staff.

If a patient should need physical rehabilitation or skilled nursing and medical care on an inpatient basis, but no longer needs to be hospitalized for an illness or injury, the Program pays charges for a skilled nursing facility at 80% for PPO facilities, subject to the deductible and 60% for non-PPO facilities, subject to the deductible. Reimbursement is limited to 60 days per calendar year for both PPO and non-PPO facilities combined. No prior hospitalization is required. Charges for room and board, general nursing care and drugs and surgical dressings or supplies are paid subject to the Program's reasonable and customary limits as determined by BCBS.

Infertility Treatment Charges

Benefits for the treatment of infertility and all related services and supplies are subject to a lifetime maximum of $2,500. There is a separate lifetime maximum for prescription drugs. This lifetime maximum is not applied on an individual basis. It is a single lifetime maximum whether you have employee only coverage, employee plus spouse coverage, or any form of family coverage. Infertility means the inability to conceive a child after one year of unprotected sexual intercourse, or the inability to sustain a successful pregnancy.

Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures are provided only when:

1. you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments; and

2. you have not undergone four (4) completed oocyte retrievals, except if a live birth followed a completed oocyte retrieval, two (2) more completed oocyte retrievals are covered.

Benefits are not provided for childbirth services rendered to a surrogate mother; cryo-preservation and storage of sperm, eggs, embryos, except for procedures using a cryo-preserved substance; non-medical costs of an egg or sperm donor.

Procedures must be performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for in-vitro fertilization programs.

Other Covered Charges

• Emergency licensed ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided. No benefits will be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.

• Independent lab and x-ray services rendered by a provider other than a hospital.

• Private duty nursing service for a patient in a hospital or other health care facility only when BCBS determines the services provided are so complex they could not have been provided by the regular nursing staff of the hospital or other health care facility. Only BCBS can make this decision based on the nature of the case. Private duty nursing services at the patient's home will be covered under the Program only when BCBS determines the services could not have been provided by non-professional personnel. No private duty nursing benefits are provided when a nurse resides in the home, or is a member of the patient's or the employee's immediate family.

• Physical therapy from a registered professional physical therapist supervised by a physician. There must be a written plan from the physician and it must be regularly reviewed by the therapist and the physician. The plan must be established before treatment starts. It must specify the type, amount, frequency and length of the therapy and indicate a diagnosis with specific goals for improvement. Benefits for outpatient physical therapy are limited to a maximum of $5,000 each calendar year, PPO and non-PPO providers combined.

• Chiropractic benefits are limited to a maximum of $1,000 or 60 visits, whichever is met first, for PPO and non-PPO services combined each calendar year.

• Occupational therapy from a registered occupational therapist supervised by a physician. There must be a written plan from the physician and it must be regularly reviewed by the physician and therapist. The plan must be established before the treatment starts. It must specify the type, amount, frequency and length of therapy and indicate a diagnosis with specific goals for improvement. Benefits for outpatient occupational therapy will be limited to a maximum of $5,000 per calendar year, PPO and non-PPO providers combined.

• Speech therapy benefits from a licensed speech therapist or a speech therapist certified by the American Speech and Hearing Association. Inpatient speech therapy benefits will be provided only if speech

therapy is not the only reason for admission. Outpatient speech therapy benefits will be limited to a maximum of $5,000 each calendar year, PPO and non-PPO services combined.

• Family planning office visits including tests, counseling, and surgical sterilization procedures for vasectomy and tubal ligation. Reversals of surgical sterilization are not covered.

• Durable medical equipment that can withstand repeated use in the home, is primarily used to serve a medical purpose, and is generally not useful in the absence of sickness or injury. The Claims Administrator will determine whether the Program will pay for rental or purchase of durable medical equipment. Diabetic supplies are not classified as durable medical equipment. Diabetic supplies are covered under the Pre-65 Retiree Medical Program prescription drug benefit.

• Temporomandibular Joint (TMJ) Treatment and related disorders.

• Wellness care from a BCBS network provider. Wellness care includes immunizations; routine mammograms; routine diagnostic tests; routine physical examinations; routine pap smear tests. You will pay a $15 copay and the benefits will be provided at 100% of the BCBS PPO provider's contracted rate. The Program does not reimburse for wellness care from a non-PPO provider.

• Maternity, including initial visit to determine pregnancy, subsequent prenatal visits, postnatal visits and delivery in a hospital or birthing center. The Program does not restrict benefits for any hospital length stay in connection with childbirth for mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section, or require that a provider obtain authorization for prescribing a length of stay not in excess of the above periods.

• Certain services rendered to the newborn are covered including routine inpatient hospital nursery charges; and one routine inpatient exam as long as the exam is by a physician other than the one who delivered the child or administered anesthesia during delivery. **Be certain to enroll your newborn in the BNSF Pre-65 Retiree Medical Program within 31 days of the date of birth by calling Sageo at 877-847-2436.**

• Coverage includes benefits for elective abortions if legal where performed.

• Charges for the purchase, maintenance or repair of internal prosthetic medical appliances consisting of permanent or temporary internal aids and supports for defective body parts, specifically interocular lenses, artificial heart valves, cardiac pacemakers, artificial joints, intrauterine devices and other surgical materials such as screws, nails, sutures and wire mesh, and exclude all other prostheses.

• Surgical benefits for a mastectomy include coverage for

– reconstruction of the breast on which the mastectomy has been performed;

– surgery and reconstruction of the other breast to produce a symmetrical appearance; and

– prostheses and coverage for any complications on all stages of mastectomy, including lymphedema.

• Prosthetic appliances, special appliances and surgical implants if (a) required to replace all or part of an organ or tissue of the human body; or (b) required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue. These benefits include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances). Call the toll free number

on your BCBS identification card to find out what intra-oral devices used to treat TMJ and related disorders may be covered.

• Allergy testing, treatment and immunizations.

• Radiation therapy treatment, provided it is not experimental or investigational in nature, as determined by BCBS.

• Chemotherapy, provided it is not experimental or investigational in nature, as determined by BCBS.

• Shock therapy treatments.

• Wigs/hairpieces after radiation or chemotherapy (limited to a lifetime maximum of $500).

• Cardiac rehabilitation services in BCBS approved programs when received within a 6-month period following a covered inpatient hospital admission for myocardial infarction, coronary artery bypass surgery, or percutaneous trans-luminal coronary angioplasty. Benefits are limited to 36 outpatient treatment sessions within the 6-month period.

Remember that all covered charges must be medically necessary as determined by BCBS. Non-PPO medically necessary charges will be reimbursed at the Program's reasonable and customary level as determined by BCBS.

Special Rules for Mental Health and Substance Abuse Benefits

The Pre-65 Medical Program option includes Mental Health and Substance Abuse Benefits that may be subject to certain rules and some limitations. The deductible, copayments, and other information is shown on the Schedule of Benefits for Mental Health and Substance Abuse chart on page 23.

Pre-Certification Required

Mental health and substance abuse benefits are available under the Program. You may choose a network or out-of-network medical care provider. **Whatever medical care provider you choose, you will need to have all inpatient mental health and substance abuse treatment pre-certified through the MHU reviewer.**

You must call the MHU reviewer for pre-certification at this toll-free number: 1-800-851-7498. You can call twenty-four (24) hours a day, seven (7) days a week. If you do not pre-certify inpatient treatment, you will be responsible for the first $500 of cost in addition to all deductibles, co-payments and out-of-pocket expense limits.

Benefits for Mental Illness, Alcohol and Drug Abuse

If you or a covered dependent incurs covered expenses for treatment of mental illness, alcohol or drug abuse, the Program provides the following benefits subject to the limits in the Schedule of Benefits for Mental Health and Substance Abuse on page 23 of this SPD.

• Covered expenses incurred during inpatient confinement in a BCBS PPO network hospital due to mental illness.

• Covered expenses incurred during inpatient confinement in a BCBS PPO network hospital due to alcohol or drug abuse.

• Covered expenses for outpatient treatment in a network facility or by a PPO network provider for mental illness, or drug or alcohol abuse after meeting the deductible.

• Covered expenses for a MHU approved out-of-network hospital confinement due to mental illness or alcohol or drug abuse, or for outpatient treatment, after meeting the deductible.

Special Outpatient Limits and Exclusions

Outpatient benefits for the treatment in a non-PPO hospital or facility will be reimbursed at 60% of reasonable and customary to the extent the benefits are covered expenses under the Program and are subject to 25 visits per year maximum combined for mental health and chemical dependency.

Covered Expenses

Covered expenses must be medically necessary and pre-certified by the MHU reviewer. Benefits are subject to the limits in the Schedule of Benefits for Mental Health and Substance Abuse Treatment on page 23 of this SPD and the Special Limits on this page and include the following medical services and supplies:

• Hospital room and board and medically necessary services and supplies while an inpatient.

• Licensed ambulance service to or from the nearest hospital where needed medical care and treatment can be provided.

• Outpatient hospital charges for medical care and treatment.

• Outpatient charges by a facility licensed to furnish mental health services for care and treatment of mental illness.

• Physician or psychologist charges for professional services.

• Charges for anesthetics and their administration, diagnostic x-ray and laboratory examinations, blood transfusions and blood not donated or replaced, and oxygen and other gases and their administration.

Schedule of Benefits for Mental Health and Substance Abuse

Service	**In-Network** (Percentage of medically necessary covered expense paid by the Program with no deductible)	**Out-of-Network** (Percentage of medically necessary covered expense paid by Program with no deductible)
Inpatient treatment in a hospital	80%	60% of reasonable and customary rates
Inpatient treatment in a residential facility other than a hospital	80%	60% of reasonable and customary rates
Partial hospitalization	80%	60% of reasonable and customary rates
Maximum length of patient stay per calendar year	45 days per year — for mental health and substance abuse combined —minus any days of treatment that are not authorized	10 days per year for mental health and substance abuse combined
Outpatient treatment	80% No limit to the number of visits; A Case Manager must certify and monitor care	60% Mental health care treatment must be provided by a Ph.D., MD or MSW 25 visit limit
Maximum Benefits Mental health treatment	No separate lifetime dollar maximum; subject to overall program lifetime maximum. [1]	
Maximum Benefits Substance abuse treatments	$25,000 per person combined lifetime maximum for inpatient and outpatient treatment from a network provider. $5,000 per person lifetime maximum if you receive care from an out-of-network provider. This applies to inpatient or outpatient services. No annual out-of-pocket maximum.	
Pre-authorization and review	Pre-authorization is required for all inpatient care; failure to obtain pre-authorization will result in a $500 penalty. All coverage is subject to medical necessity determination.	

[1] The Lifetime Maximum for the BCBS Medical option can be found on SPD page 7.

Procedure for MHU Pre-Authorization

When you contact the MHU reviewer, you, a family member, or the attending physician or Provider should have the following information:

• name of the attending physician or of the admitting physician or Provider;

• name of the hospital or facility where the admission or service has been scheduled;

• the type of scheduled admission or the date of the proposed service;

• a diagnosis or reason for the admission or service.

The MHU reviewer will follow-up with the physician or Provider. If the MHU reviewer determines the services are not medically necessary, you or your physician may ask for an expedited appeal.

Expedited Appeal for MHU Denial

If you or your physician or Provider do not agree with the MHU reviewer prior to or while receiving services or treatment, you have the right to ask for an expedited appeal. You or the physician or Provider must contact the MHU reviewer and request an expedited appeal. You and/or your physician or Provider will be notified by the MHU of its determination within twenty-four (24) hours, or in the case of inpatient treatment before the last MHU approved day. If you and/or your physician or Provider do not agree with the decision, you may ask for a further appeal as described below.

Written Appeal of Expedited Appeal Denial

You and your physician or Provider is responsible for making medical decisions regarding your treatment. In some cases, the written appeal process will not be completed until you are no longer an inpatient, or until your treatment has been completed. If you disagree with an expedited appeal denial, or if you disagree with a denial of a claim that you have submitted after treatment has ended, you or your physician or Provider may submit a written request for appeal within 180 days of the denial to the following:

Appeals Coordinator
Health Care Service Corporation
Mental Health Unit
P.O. Box 2307
Chicago, Illinois 60690-2307

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.

You may submit additional information or comments with your appeal. 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 judgement, 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.

Within 60 days of receiving your request for review, the Claims Administrator will send you its final decision on the Claim.

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, you may exercise "Your Rights under ERISA" as explained beginning on SPD page 51.

Expenses Not Covered

Covered expenses for mental illness or substance abuse treatment will not include, and no payment will be made for, expenses incurred:

• For conditions that are (1) within the scope of usual medical practice; and (2) normally handled by non-mental health and substance abuse clinicians;

• In excess of the amount that the provider has agreed to accept for the service; or

• For services or supplies for which benefits are not payable under the section titled “What the Program Does Not Cover” beginning on SPD page 29.

Outpatient Prescription Drug Benefit

Effective January 1, 2003, 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, for a specified copayment. Your prescription drug copayments do not apply toward your Pre-65 Retiree Medical Program deductible or out-pocket maximums.

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 800-378-7559.

Participating Pharmacy Benefit

You may fill a prescription for up to a 34-day supply, or 100 units, at any participating pharmacy by showing your Caremark Identification card and paying the applicable copayment.

Retail prescription copayments are as follows:

- $10 for each generic prescription;
- $20 for each brand name prescription on the Primary Drug List;
- $35 for each brand name prescription not on the Primary Drug List.

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 one of the Caremark Mail Service pharmacies you will pay:

- $20 for each generic prescription;
- $40 for each brand name prescription on the Primary Drug List;
- $70 for each brand name prescription not on the Primary Drug List.

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 for individuals age 27 or over;

• 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.

What the Program Does Not Cover

In addition to the limitations and exclusions described under the specific benefits listed in this SPD, the Program will **not** reimburse charges for the following:

• Services that are not medically necessary as determined by BCBS.

• Services or supplies that are not specifically mentioned in this benefit booklet.

• Custodial care services.

• Services or supplies received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental illness.

• Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

• Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned as covered in this SPD.

• Blood derivatives which are not classified as drugs in the official formularies.

• Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

• Routine foot care.

• Hearing aids or examinations for the prescription or fitting of hearing aids.

• Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or surgical treatment for correction of refractive errors, including radial keratotomy. Any exceptions must be specifically identified as a BCBS PPO option benefit. If you enrolled in the Vision Care Plan which is a separate plan and not part of the BCBS PPO option, refer to the SPD for the Vision Plan that gives information on Vision Care Plan benefits.

• Routine preventive care received from out-of-network providers.

• Diagnostic services as part of routine physical examinations or check-ups, premarital examinations, determination of auditory problems, surveys, casefinding, research studies, screening, or similar procedures or tests which are investigational, unless specifically mentioned as covered in this SPD.

• Services and supplies for human organ or tissue transplants other than those specifically named as covered in this SPD.

• Plastic or cosmetic surgery, reconstructive surgery, or other services or supplies that improve, alter or enhance appearance except where requested due to injury while covered under the Program, or to repair a congenital birth defect, or as otherwise stated as a covered benefit in this SPD.

• Charges that a person is not legally required to pay.

• Confinement in a hospital operated by the U.S. government or any of its agencies, except care of a non-military service-related illness or injury received by an employee at a Veterans Administration facility.

• Procedures, services or supplies (including drugs) that BCBS determines to be *experimental or investigational* using one or more of the following criteria:

– The medical or surgical procedure or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include, but are not limited to, Phase I, II and III clinical trials.

– The prevailing opinion within the appropriate specialty of the United States medical profession is that the medical or surgical procedure or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. BCBS will determine if this item is true based on:

1. Published reports in authoritative medical literature.

2. Regulations, reports, publications and evaluations issued by government agencies, such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.

– A drug, medical supply, or medical device that is subject to FDA approval may be determined experimental or investigational if:

1. It does not have FDA approval.

2. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation.

3. It has FDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use. BCBS will determine if a use is an accepted off-label use based on published reports in authoritative medical literature and entries in the following drug compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, and The United States Pharmacopeia Dispensing Information.

– A hospital's institutional review board acknowledges that the use of the medical or surgical procedure or supply is experimental or investigational and subject to that board's approval.

– A hospital's institutional review board requires that the patient, parent or guardian give an informed consent stating that the medical or surgical procedure or supply is experimental or investigational or part of a research project or study; or federal law requires such a consent.

BCBS has the discretionary authority to interpret and apply the definition of experimental and investigational in determining whether medical services and supplies are covered charges under Program.

• Any injury resulting from, or in the course of, any employment for wage or profit, except for exempt employees injured while performing duties for BNSF or a BNSF affiliate.

• Any injury or sickness covered under any Workers' Compensation or similar law, except for exempt employees injured while performing duties for BNSF or a BNSF affiliate.

• Custodial services not intended primarily to treat a specific injury or sickness, or any education or training.

• Reports, evaluations, examinations or hospitalizations not required for health reasons as determined by BCBS.

• Reversal of voluntary sterilization procedures and certain infertility services not specifically listed as covered under the Program.

• Transsexual surgery and related medical or psychological services.

• Amniocentesis, ultrasound or any other procedures requested solely for sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder.

• Over-the-counter disposable or consumable supplies, including orthotic devices, unless the latter are determined to be medically necessary by BCBS.

• The following drugs and medicines: diet pills, minoxidil, Retin-A after age 26 unless medically necessary, and non-prescription drugs of any kind.

• Speech therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.

• Charges in excess of reasonable and customary as determined by BCBS.

• Treatment of teeth/peridontium except for emergency dental work to stabilize teeth due to injury to sound natural teeth.

• Treatment that is not medically necessary, even if it is prescribed, recommended or approved by a physician. BCBS has the discretionary authority to determine whether hospitalization or other health care services or supplies are medically necessary.

• Expenses for which benefits are payable under another benefit plan or under insurance provided by an employer, or for which an employer pays all or part of the cost.

• Services or supplies furnished before coverage under the Program became effective.

• Care, treatment, services or supplies that are not recommended or approved by your physician.

• Services and supplies furnished, paid for, or for which benefits are provided or required under any law of a government (for example, Medicare) whether or not that payment or benefits are received, except a government plan for its own employees, Medicaid or similar legislation of any state.

• Room and board, education or training while you or a dependent is confined in a facility that is primarily a school, a place of rest, a place for the aged or a nursing home.

• Expenses for permanent property improvements, even if they are directly related to medical care (such as central air conditioning, a swimming pool or wheelchair ramp).

• Care designed primarily to assist a patient in meeting the activities of daily living.

• Services or supplies furnished to you or a dependent as an inpatient on a day when the patient's physical or mental condition could be safely diagnosed or treated on an outpatient basis.

• Counseling services including marriage, family, child, career, social adjustment, pastoral or financial counseling, except as specifically described in the Program.

• Missed appointments or the completion of claim forms.

• Treatment of injuries sustained during the commission of a felony or other criminal act.

• Treatment of injuries sustained as the result of war or any act of war or international armed conflict.

• Services or supplies for medical care paid for or expected to be paid for by any persons (or the insurers of such persons) considered to be responsible for the condition giving rise to the charges as a result of a judgment, settlement or otherwise. See page 45 under "Right of Reimbursement".

• Charges made by any provider who is a member of your family or your dependent's family.

• Expenses incurred by you or your dependents to the extent that amounts are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. The Claims Administrator will take into account any adjustment option chosen under such part by you or any one of your dependents.

• Charges to the extent that payment is unlawful where the person resides when the expenses are incurred.

• Occupational Therapy, Physical Therapy and Speech Therapy that is considered "maintenance" by BCBS.

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 34 -37 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 Pre-65 Retiree Medical Program terms and to make both initial claim determinations and final claim review decisions on ERISA appeals to Blue Cross and Blue Shield (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 the Pre-65 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 the Pre-65 Retiree 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 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 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 a BCBS PPO 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 BCBS or call the Benefits Help Line at 800-234-1283 to request a claim form.

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 PPO 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 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 Program's claim review procedures and applicable time limits; and
- if the Claim 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 Pre-65 Retiree 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.

If you are appealing a denial of a mental illness or substance abuse benefit under the Medical Benefits Program, there are special procedures. You will find those procedures in the Mental Health and Substance Abuse section of this SPD. *See page 24.*

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 judgement, 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:

Blue Cross and Blue Shield of Illinois (BCBSIL)
Claim Review Section
P.O. Box 2401
Chicago, Illinois 60690

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 51 of this SPD.

When Coverage Ends

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

- The date you fail to pay the required contribution.

- The date the Pre-65 Retiree Medical Program is terminated by BNSF or by the BNSF affiliate that offers early Retiree medical coverage for all eligible early Retiree classes, or for the early Retiree class to which you belong.

- The date benefits paid to you equal the lifetime maximum benefit payable under the BNSF Pre-65 Retiree Medical Program. (Coverage for enrolled dependents who have not reached their lifetime maximum benefit will not be affected if your dependents continue to meet the Program's eligibility requirements.) Benefits paid on behalf of you, your spouse, or dependent child under the BNSF Medical Program for active salaried employees will count toward the lifetime maximum under this Program.

- The beginning of the month in which you reach age 65. When you reach age 65, your spouse and dependents under age 65 will continue to be covered under this Pre-65 Medical Program until the *first to occur* of the following:

    - For a spouse, the beginning of the month in which the spouse reaches age 65.

    - For a dependent child, the date the child no longer meets the Program's eligibility for dependent coverage.

Continuation of Coverage Under COBRA

Eligibility

When you first become eligible for Pre-65 Retiree Medical Program coverage you will receive a COBRA continuation notice. This notice is required under the Consolidated Omnibus Reconciliation Act of 1985 and final regulations issued in 2001. You may choose between COBRA continuation or alternative early Retiree coverage under the Pre-65 Retiree Medical Program described in this Summary. If you choose Pre-65 Medical Program coverage under this Summary, the following COBRA rules will apply.

If one of the following COBRA qualifying events occur, your covered spouse and/or dependents may elect up to 36 months of coverage measured from the date coverage is lost.

- You and your spouse are legally separated or divorced resulting in your spouse losing coverage under the Pre-65 Retiree Medical Program;

- Your dependent child either marries or reaches the maximum age under the Pre-65 Retiree Medical Program and no longer qualifies for coverage under the Pre-65 Retiree Medical Program.

  For example: If your dependent child is a full-time student at an accredited college and the child reaches age 23 two years after your early retirement date, and you waived COBRA and elected coverage under the Pre-65 Retiree Medical Program, the child may elect 36 months of COBRA continuation from the date the child turns age 23.

If more than one qualifying event occurs, no more than 36 months of total COBRA continuation coverage will be available. COBRA continuation coverage will be terminated even if the full COBRA continuation period has not ended on the first to occur of the following:

- The COBRA beneficiary fails to make the required contributions when due.

- The COBRA beneficiary first becomes entitled to Medicare benefits after the initial COBRA qualifying event.

- BNSF terminates the Pre-65 Retiree Medical Program and does not maintain any other group health program for eligible employees or retirees.

Notification

If a qualifying event other than divorce, legal separation, loss of dependent status or entitlement to Medicare occurs, Sageo, the COBRA Administrator, will be notified of the qualifying event by your Employer. Sageo will send you an election form. To continue Pre-65 Retiree 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.

If a divorce, legal separation, or loss of dependent status occurs, you or your covered spouse or dependent must notify Sageo that a qualifying event has occurred. This notification must be received by the Sageo within 60 days of the later of:

- the date of such event, or

- the date your eligible spouse or dependent would lose coverage on account of such event.

Failure to promptly notify Sageo of these events will result in loss of the right to continue coverage for your spouse or dependents, as the case may be.

After receiving this notice, Sageo will send an election form within 14 days. If your spouse or dependents wish to elect continuation coverage, the election form must be returned to Sageo within 60 days from the later of:

- the date the form is received by the qualified beneficiary, or

- the date the qualified beneficiary's coverage ends due to the qualifying event.

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 “Opting Out of Early Retiree Coverage” on page 4).

Cost

If your spouse or dependent elects to continue coverage, they must pay the entire cost of coverage (BNSF's contribution and the pre-65 retiree portion of the contribution), plus a 2% administrative fee for the duration of COBRA continuation.

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

Coordination of Benefits

The following Program rules on coordination of benefits with group health plans other than Medicare will apply to non-Medicare entitled early Retires, their spouses and dependent children covered under the Pre-65 Retiree Medical Program.

The Pre-65 Retiree Medical Program provides for coordination of benefits when medical expenses incurred by you or your covered dependents are covered by a governmental program other than Medicare or Medicaid; automobile no-fault coverage; group, blanket or franchise insurance coverage, including student coverage; the California Unemployment Insurance Code; service plan contracts; group or individual practice or other pre-payment plans; or coverage under a labor-management trusteed plan, union welfare plan or any type of employer-sponsored plan.

Coverage under an individual policy or contract is not included. Each plan or part of a plan that has the right to coordinate benefits is treated as a separate plan. This coordination of benefits provision ensures that the total benefits available to you will not exceed 100% of the allowable expenses. An “allowable expense” is any medically necessary, reasonable and customary medical expense for which you or your dependents are covered under at least one medical plan. When benefits from a plan are in the form of services, not cash payments, the reasonable cash value of the service will be used to coordinate benefits. An allowable expense does not include the difference between the cost of a private and semiprivate room, except while the person’s stay in a private room is medically necessary.

If benefits are payable under more than one group plan, 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.

When you are covered under more than one group plan, the plan that pays your benefits first, without regard to any other plan, is called the primary plan. If this Program is the primary plan for you or your covered dependents, your medical expenses will be covered under this Program first. If this Program is the secondary plan for you or your covered dependents, this Program will cover eligible expenses that are not covered under your primary plan. In no event will this Program, if it is your secondary plan, exceed the amount of benefits that would be payable to you if this were your primary plan.

For purposes of this coordination in benefits provision, an "allowable expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan covering a person provides benefits in the form of services (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans covering the person is not an allowable expense.

A plan without a coordinating provision is always the primary plan. If all plans have a coordinating provision:

- The plan covering the eligible person directly, rather than as a dependent, is primary and the others secondary.
- If a child is covered under both parents’ plans, the plan of the parent whose birthday occurs earlier during the calendar year is primary. If both parents have the same birthday, the plan covering the

parent longer is primary. When the parents are separated or divorced, their plans pay in the following order:

– The plan of the parent with custody of the child.

– The plan of the spouse of the parent with custody of the child.

– The plan of the parent not having custody of the child.

However, if the terms of a court decree have established financial responsibility for the child's health care expenses, the benefits of that plan are determined first.

If none of the above applies, the plan covering the patient longest is primary. When this Pre-65 Retiree Medical Program is the secondary plan, its payment is reduced to coordinate with the primary plan's benefits.

The plan that covers the person as an active employee, or as a dependent of an active employee, pays before the plan that covers an individual as a laid-off or retired employee or such employee's dependent. If the other plan does not have this same rule, then this rule will not apply if the result is that each plan determines its benefits after the other.

Special Rules for Medicare Entitled Dependents

If your spouse or dependent is entitled to Medicare due to disability, when you take early retirement, the Pre-65 Medical Program will coordinate with Medicare for their coverage.

The Pre-65 Retiree Program will pay benefits after Medicare makes its payment. Your spouse or dependent must submit a Medicare Explanation of Benefits (EOB) with a claim for benefits under the Pre-65 Retiree Program. Then the Pre-65 Retiree Program will calculate the Program benefits. The Medicare EOB amount will be offset against what the Pre-65 Retiree Program would pay if there were no payments from Medicare. This is called coordination of benefits with Medicare. This coordination will occur even if your spouse or dependent does not apply for Medicare when eligible. If there is no Medicare EOB to submit because your spouse or dependent has not applied for Medicare when eligible, the Pre-65 Retiree Medical Program will make a determination as to what Medicare would pay if your spouse or dependent were covered under Medicare. It is important for your spouse or dependent to apply for Medicare if Social Security disabled and Medicare entitled when first eligible.

Cost of Pre-65 Retiree Coverage

BNSF shares in the cost of your coverage. The actual cost of coverage may change from year to year depending on the overall experience of the Pre-65 Retiree Medical Program. BNSF reserves the right to change the percentages you are required to contribute for Pre-65 Medical Program coverage. There is no guarantee the percentage of your contribution or the actual cost of your coverage will remain the same from year to year. You will be notified of any changes prior to their effective date.

General Information Affecting Your Right to BNSF Pre-65 Retiree Medical Program Benefits

Your Provider Relationships

The choice of a health care provider, whether in-network or out-of-network, is solely your choice and BCBS will not interfere with your relationship with any health care provider.

BCBS does not furnish health care services. It provides access to discounted or rate negotiated network health care services and it makes payments to health care providers for covered services under the Program which you receive. BCBS is not liable for any act or omission of any network provider or the agent or employee of any network provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a health care provider are not provided by BCBS. Any contractual relationship between BCBS and a health care provider in the network is not a contract for providing services. It is a contract for discounted or negotiated rates intended to reduce the overall cost of services for those persons electing to use a network health care provider.

Recovery of Overpayments

If you or a Program beneficiary should receive a benefit payment from this Program in excess of the payment that should have been received, the Claims Administrator has the right to recover the amount of the overpayment. In addition, if the overpayment is not returned, the Claims Administrator reserves the right to deduct the overpayment from future Pre-65 Retiree Medical Program benefits payable to you if the overpayment was made to you. If the overpayment was made to any other beneficiary under the Program, the excess payment may be deducted from future Pre-65 Retiree Medical Program benefits payable to that beneficiary.

No Assignment of Benefits

The Program will not prevent a medical care provider from receiving payment for eligible charges for covered services if there is a valid assignment of benefits. The Program Administrator has the discretionary authority to determine whether an assignment of benefits to a medical provider is valid. You may not commit benefits payable to you to pay your personal debts or other obligations that are not otherwise covered under a valid assignment of Program benefits. You may not sell any right or interest you or a covered dependent may have in any benefit under this Program.

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 the Company and Sageo immediately.

No Guarantee of Benefit

Participation in this Program does not guarantee your right to any benefit under the Program.

Amendment or Termination of Program

The Pre-65 Retiree Medical Program, including all or some of the Program options available for Pre-65 Retiree election, may be amended or terminated by BNSF at any time and for any reason. BNSF reserves the right to amend, modify or terminate the Program, including any benefits offered under one or more of

the available Program options. BNSF does not guarantee that Pre-65 retirees will always have access to a particular Program option, even though the Program option may be available to active employees of BNSF. BNSF also reserves the right to amend eligibility rules, and the method of determining Pre-65 retiree contributions. There are no vested rights under the Pre-65 Retiree Medical Program and any right to benefits is limited to claims incurred before the first to occur of the following events:

- Amendment of the Pre-65 Retiree Medical Program.
- Termination of the Pre-65 Retiree Medical Program.
- Expiration of the period that claims can be accepted by the Claims Administrator.
- Failure to pay the cost of coverage under the Program.
- Any dependent covered under the Program, no longer meeting the eligibility requirements under the Program.
- Any Retiree, spouse or dependent covered under the Program, meeting the Program's lifetime maximum.
- Any other event listed under the section of the SPD entitled "When Coverage Ends".

Right of Reimbursement

This Program has a right to recovery for the following health care expenses:

• Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your covered dependent(s).

• Expenses to the extent they are covered under the terms of any automobile medical; automobile no-fault; uninsured or underinsured motorist; Workers' Compensation; government insurance (other than Medicaid); or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your covered dependent(s).

If you or a covered dependent incurs health care expenses as described above, the Claims Administrator will automatically have a lien on the proceeds of any recovery by you or your dependent(s) from such party to the extent of any benefits provided to you or your dependent(s) by the Program. You or your dependent(s) or their representative shall execute such documents as may be required to secure the right of the Program to reimbursement. The Program must be reimbursed for the lesser of the following amounts:

• The amount actually paid by the Program; or

• The amount actually received from the third party at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or otherwise.

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 for Burlington Northern Pre-65 Retirees to protect the privacy and security of your confidential health information. As an employee welfare benefit plan under ERISA, the Program is subject to the HIPAA privacy rules. Pursuant to the HIPAA privacy rules, the 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 Program's uses and disclosures of your protected health information and your rights and 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

Pre-65 Retiree 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 pre-65 Retiree contributions are deposited in the VEBA. Benefits for the Burlington Northern Pre-65 Retiree Medical Program are self-insured by BNSF.

Program Name and Program Number

The Pre-65 Retiree Medical Program is made available under the Burlington Northern Santa Fe Corporation Group Medical Program. The Pre-65 Retiree 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 an affiliate of BNSF whose retirees are eligible to participate in the Pre-65 Retiree Medical Program.

Company Name and Identification Number

The Pre-65 Retiree Medical Program is sponsored by Burlington Northern Santa Fe Corporation, Employer Identification Number 41-1804964.

BCBS Separate Financial Arrangements with Providers

BCBS of Illinois, acting as claims administrator for the Program, has its own contracts with certain Providers ("Administrator Providers") in the BCBS service area to provide and pay for health care services to all persons enrolled under BCBS health policies and contracts. Under certain circumstances described in BCBS contracts with Administrator Providers, BCBS may:

• receive substantial payments from Administrator Providers with respect to services rendered to you for which BCBS was obligated to pay the Administrator Provider, or

• pay Administrator Providers substantially less than their claim charges for services, by discount or otherwise, or

• receive from Administrator Providers other substantial allowances under the BCBS contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable under the BNSF Pre-65 Retiree Medical Program, and the calculation of all required deductible and coinsurance amounts payable by you are based on the eligible chart or provider's claim charge for covered services you receive, reduced by the Average Discount Percentage ("ADP") as determined by BCBS, applicable to your claim. BNSF has been advised that BCBS may receive such payments, discounts and/or other allowances during the term of the agreement between BNSF and BCBS. Neither BNSF nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the BCBS determined ADP.

To help you understand how BCBS 's separate financial arrangements with the Administrator Providers work, please consider the following example:

a. Assume you go into the hospital for one night and the normal, full amount the hospital bills for covered services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the BNSF Pre-65 Retiree Medical Program deductible and coinsurance amounts.

c. However, for purposes of calculating your deductible and coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the hospital's eligible charge would be reduced by the ADP applicable to your claim. In this example, if the applicable ADP were 30%, the $1,000 hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the coinsurance portion of the $1,000 hospital bill after it has been reduced by the ADP. In this example, if you coinsurance obligation is 20%, you personally will have to pay 20% of $700 or $140. You should note that your 20% coinsurance is based on the full $1,000 hospital bill, after it is reduced by the applicable ADP.

e. After taking into account the deductible and coinsurance amounts, BCBS will satisfy its portion of the hospital bill. In most cases, BCBS has a contract with hospitals that allows BCBS to pay less, and requires the hospital to accept less, than the amount of money BCBS would be required to pay if it did not have a contract with the hospital.

Therefore, in the example above, since the full hospital bill is $1,000, your deductible has already been satisfied, and your coinsurance is $140, then BCBS has to satisfy the rest of the hospital bill, or $860. Assuming BCBS has a contract with the hospital, BCBS will usually be able to satisfy the $860 bill that remains after your deductible and copayment by paying less, often substantially less, than $860 to the hospital. BCBS receives, and keeps for its own account, the difference between the $860 bill and whatever BCBS ultimately pays under its contracts with Administrator Providers, and neither you nor BNSF are entitled to any part of these savings.

Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers

BCBS must inform you that other Blue Cross and Blue Shield plans outside of Illinois ("Host Plan Providers") may have contracts similar to the contracts described above with certain Providers ("Host Plan Providers") in their service area.

When you receive health care services from a BCBS Host Plan Provider that does not have a direct contract with BCBS of Illinois, the BCBS Host Plan will process your claim in accordance with its applicable contract, if any, with the Host Plan Provider. Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums under the BNSF Pre-65 Retiree Medical Program will be calculated on the basis of the Host Plan Provider's eligible charge for covered services rendered to you or the agreed upon cost between the BCBS Host Plan and BCBS of Illinois for covered services that the Host Plan passes to BCBS of Illinois, whichever is lower. Keep in mind that the term "Host Plan" does not apply to the BNSF Program in which you are enrolled. The term Host Plan just refers to the local BCBS administrator in the region the medical services are provided.

Often, the agreed upon cost between the Host Plan and BCBS of Illinois is a simple discount. Sometimes, however, the agreed upon cost may be in the form of an estimated discount or an average discount

received or expected by the BCBS Host Plan based on separate financial arrangements or other non-claims transactions between BCBS of Illinois and the BCBS Host Plan Providers.

The estimated or average discount may be adjusted in the future to correct for over or under estimation of past determinations of the agreed upon cost.

In other instances, laws in a small number of states dictate the basis upon which your deductible and out-of-pocket maximum, or any other BNSF Pre-65 Retiree Medical Program benefit maximum will be determined, using the state's statutory method.

In some instances, BCBS of Illinois has entered into agreements with other BCBS plans ("Servicing Plans") to provide on behalf of BCBS of Illinois, claim payments and certain administrative services for you. Under these agreements, BCBS of Illinois will reimburse each BCBS Servicing Plan for all claim payments made on behalf of BCBS for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Servicing Plan Providers in their region. The Servicing Plan will process your claim in accordance with the Servicing Plan's applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by BCBS for claim payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required deductible and out-of-pocket maximum under the BNSF Program will be calculated on the basis of the Servicing Plan Provider's eligible charge for covered services rendered to you or the cost agreed on between the Servicing Plan and BCBS of Illinois for covered services, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis on which your coinsurance is calculated. When covered services are rendered in those states, the coinsurance amount will be calculated using the state's statutory method.

Program Administrator and Agent for Service of Legal Process

The Pre-65 Retiree Medical Program Administrator's name, address and telephone number are as follows:

Employee Benefits Committee
c/o The Burlington Northern and Santa Fe 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 (the "Committee") is the Program Administrator. The Program Administrator has delegated the discretionary authority to interpret Program provisions relating to the payment of benefits to BCBS for both initial claims processing and for ERISA appeals requested in writing by Program participants and beneficiaries. The Committee retains the

discretionary authority to determine whether a Retiree or dependent is eligible for initial or continued enrollment in the Program. The discretionary authority delegated to the Claims Administrator 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 Pre-65 Retiree Medical Program BCBS PPO Option (including out-of-network claims)

The Claims Administrator for the Pre-65 Retiree Medical Program is:

Blue Cross and Blue Shield of Illinois
Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690
Phone: 888-399-5945

Claim Appeal Coordinator for Mental Health and Substance Abuse is:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Health Care Service Corporation
Mental Health Unit
P.O. Box 2307
Chicago, Illinois 60690-2307
Phone: 1-800-851-7498

Named Fiduciary

Blue Cross and Blue Shield is the Named Fiduciary under ERISA for all ERISA appeals regarding Program benefit matters. The BNSF Employee Benefits Committee retains the discretionary authority to determine eligibility and enrollment rights under the Pre-65 Retiree Medical Program.

COBRA Administrator

Sageo
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 Pre-65 Retiree Medical Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Pre-65 Retiree Medical Program participants will be entitled to:

Receive Information About Your Pre-65 Retiree 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 Pre-65 Retiree 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 Pension and Welfare Benefit 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 Pre-65 Retiree Medical Program Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Pre-65 Retiree 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 Pre-65 Retiree 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 Pre-65 Retiree Medical Program. The people who operate the Pre-65 Retiree 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

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 37) 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 to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 Program 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

The next page lists the PWBA area offices.

Offices of the Pension and Welfare Benefits 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 Pre-65 Retiree benefits, call Sageo Customer Care Representative at 1-877-847-2436.

For questions regarding the services under the BCBS option, call Member Services at 1-888-399-5945.

This SPD is only a summary of the BNSF BCBS PPO option under the Program. It does not constitute a contract. The Pre-65 Retiree 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.