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

Summary Plan Description

Effective January 1, 2005

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BNSF
Medical Program
for Santa Fe Pacific 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.

Depending on your location, as an early Retiree, you will have access to many of the same BNSF Medical Program benefits as active salaried employees. 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) identifies the Medical Program elections available to early Retirees and covers the benefits available under those options for Santa Fe Pacific Pre-65 Retirees only.

Pre-65 Retirees may, depending on their geographic location, elect from the following Pre-65 Retiree Medical Program options:

- The Blue Cross and Blue Shield Preferred Provider Organization (BCBS PPO) Base Plan;
- The Blue Cross and Blue Shield PPO (BCBS PPO) Plus Plan;
- The CIGNA Network Plan where available;
- The CIGNA Preferred Provider Organization (CIGNA PPO); or
- An HMO (Health Maintenance Organization), if you live in a region where HMO options are available.

Pre-65 spouses of retirees covered by the "Over-65 Indemnity Program" will automatically be covered by the CIGNA PPO option.

The CIGNA Network Plan, CIGNA PPO, and BCBS PPO medical options feature a Health Reimbursement Account (HRA). This **BNSF-funded** account is yours to use for qualified medical expenses during the year that aren't paid by the plan (for example, deductibles or copays for office visits or prescriptions). Any unused balance remaining at year-end can be carried forward to the next year. More details can be found beginning on page 71.

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.

Generally, you are required to enroll your spouse and dependent children in the same Pre-65 Retiree Medical Program option in which you are enrolled. However, if you enroll in the CIGNA Network or CIGNA PPO option, your dependent over age 65 will be enrolled in the CIGNA Indemnity Program. If this is your situation, please refer to the Summary Plan Description for the "Post-65 Retiree Indemnity Program" for benefit information.

The Company shares the cost of Medical Program coverage with you. Your contributions will be withheld from your pension check unless you make arrangements with Your Benefits Resources (YBR) 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.

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 or are a "under age 65" dependent of a retiree covered under the "Over 65 Retiree Indemnity Program". You must have been a full-time regularly assigned active salaried employee of Santa Fe Pacific Corporation 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 terminated salaried employment with the Company due to retirement prior to reaching age 65;
- if you retired after June 1, 1994, you had 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.

In the case of salaried employees (1) whose employment is terminated for reasons other than cause as a result of the transaction described in the Comprehensive Outsourcing Agreement between The Burlington Northern and Santa Fe Railway Company and International Business Machines Corporation ("IBM") dated August 12, 2002, (ii) who have attained age 40 at the date of such termination of employment, (iii) who are employed by IBM or an affiliate of IBM after such termination of employment, and (iv) who timely execute an appropriate release in the form prepared by the Company or an affiliate of the Company, then for purposes of meeting the above eligibility requirements, service with IBM or its affiliates shall be treated as service with the Company, and termination of employment with IBM shall be treated as termination of employment with the Company.

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 (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 YBR.

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 on the first to occur of the following:

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

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

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

• the child's marriage; or

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

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

Eligible enrolled children who are mentally or physically disabled may retain coverage beyond age 19 (or age 23, if they are full-time students when they become disabled) if their disability occurred before reaching the 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 the Claims Administrator 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

You must enroll within 31 days after the date you first become eligible for coverage under the Pre-65 Retiree Medical Program. Your enrollment elections will remain in place for the calendar year in which you enroll. You are allowed to change enrollment elections during the year ***only if you have an eligible Family Status Event as described on page 4.***

Annual Enrollment

Each year you have the opportunity to change your coverage option election during Annual Enrollment. If you do not wish to change the Pre-65 Retiree Medical Program option you chose in the prior year, the prior option will automatically renew, if the option is available and you continue to be eligible for coverage. If a Program option is no longer available, and you fail to make a new election, your coverage level will remain the same and you and your dependents will be automatically enrolled in the Blue Cross and Blue Shield PPO Base Plan.

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.

Changing Your Election During the Year

If you are enrolled in the Pre-65 Retiree Medical Program, you cannot change your coverage election during the calendar year unless one of the following eligible 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;
- A change in residence but only if it results in the need to change health care networks as determined by YBR;
- A Qualified Medical Child Support Order under ERISA Section 609, as determined by the Program Administrator;
- 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; 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 you benefit selections will be based on the type of event you experience. You can make only those changes that directly relate to the event and are consistent with the event.

HIPAA Special Enrollment Rules

If you do not elect Pre-65 Retiree Medical coverage for yourself or an eligible dependent when first eligible, 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 YBR within 31 days of the termination of your other group medical plan coverage to re-enroll in the Pre-65 Retiree medical coverage.

Giving Notice of a Family Status Event

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

Benefit Changes Due to Relocation or Closing of an HMO

If you originally elected CIGNA Network coverage and move out of the geographic area served by the CIGNA Network, or if you originally elected HMO coverage and later relocate outside the HMO service area, you can change your Pre-65 Retiree Medical Program election within 31 days after the date of your relocation. You may not change your coverage level election until the next Annual Enrollment unless you have a Family Status Event.

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

If you do not request a change within 31 days of one of these events, you will have to wait until Annual Enrollment to change your coverage under the Pre-65 Retiree Medical Program.

Understanding Deductibles and Copayments

The Deductible and Copayment rules for individual and family coverage can be found in the Benefits Section of the SPD for the Pre-65 Retiree Medical Program option you elected. If your coverage becomes effective mid-calendar year and you stay within the same Medical Program option you had as an active employee, 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 change Medical Program options upon your early Retirement, you will have to meet any Deductibles and Copayments (including any out-of-pocket expenses) required under the new Medical Program option.

Special Rules for Mental Health and Substance Abuse Benefits

The Pre-65 Retiree Medical Program option you elect includes Mental Health and Substance Abuse benefits that may be subject to certain rules and some limitations. For example, under the CIGNA PPO option, Mental Health and Substance Abuse Benefits end for dependents once they reach age 65, even though you may still be under age 65. Therefore, if your spouse is age 65 or older, he or she is no longer eligible for Mental Health and Substance Abuse benefits under the CIGNA PPO option. However, this same rule does not apply if, for example, you are enrolled in the BCBS option. Information on any deductibles, copayments, or out-of-pocket expenses that you are responsible for paying can be found in the Schedule of Benefits for Mental Health and Substance Abuse for the Pre-65 Medical Program option you elect.

The BCBS PPO Options

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. The BCBS PPO option offers two plans—the Base Plan and the Plus Plan.

BCBS PPO Base Plan

This option, designed for those who require a basic level of medical coverage, has the highest annual deductible and out-of-pocket maximum, and pays the lowest percentage of medical costs through coinsurance. Additionally, you pay a percentage of your prescription drug costs rather than a specific copay amount. (See Outpatient Prescription Drug Benefit on page 67.)

BCBS PPO Plus Plan

This option provides more coverage for those who have frequent health care needs or require frequent prescription medications. The BCBS PPO Plus Plan has a lower annual deductible and out-of pocket maximum than the BCBS PPO Base Plan, and pays a higher percentage of medical costs through coinsurance. The BCBS PPO Plus Plan features a flat-dollar copay for prescription drugs. (See Outpatient Prescription Drug Benefit on page 67.)

Choosing an In-Network Provider

With both the BCBS Base and the BCBS Plus Plan, 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 YBR web site at **www.ybr.com/benefits**. If you do not have access to the web site, you can contact YBR by phone at 1-877-847-2436. The YBR 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 both the Base and Plus Plan, 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 BCBS PPO Schedule of Benefits on page 11 for a comparison of out-of-pocket expenses for network and out-of-network services.

BCBS PPO Schedule of Benefits

LIFETIME MEDICAL PROGRAM LIFETIME MAXIMUM	In Network: Unlimited Out-of-Network: $750,000			
BENEFITS	**In Network Coverage**		**Out-of-Network Coverage**	
	Base Plan	**Plus Plan**	**Base Plan**	**Plus Plan**
Deductible: (per individual)	$500	$350	$1,000	$700
Family Deductible:	$1,000	$700	$2,000	$1,400
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 drugcopays, pre-certification penalties and charges in excess of the BCBS fee schedule <u>do not</u> apply to any out-of-pocket limit.	Individual $2,000 (No family maximum)	Individual $1,500 (No family maximum)	Individual $4,000 (No family maximum)	Individual $3,000 (No family maximum)
Inpatient Hospital Services: 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% After Deductible	85% After Deductible	60% After Deductible	65% After Deductible
Outpatient Surgery & Diagnostic Tests: .	80% After Deductible	85% After Deductible	60% After Deductible	65% After Deductible
Outpatient Emergency: (Hospital & Physician) Emergency Medical and Emergency Accident -- Initial treatment of accidental injuries or sudden and unexpected medical conditions with severe life threatening symptoms. Subject to $50 copay, waived if admitted.	100% after $50 Copayment	100% after $50 Copayment	Same as Network	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.	Primary Care – 100% after $15 Copayment Specialist Care –- $25 Copayment then 100%	Primary Care – 100% after $15 Copayment Specialist Care – $25 Copayment then 100%	60% After Deductible	65% After Deductible
Well Child & Adult Routine Care: Subject to Office Visit copay.	100% after Office Visit Copayment	100% after Office Visit Copayment	Not Covered	Not Covered
Chiropractor: $1,000 calendar year maximum or 60 visits whichever is met first. Out-of-Network limit of $1,000 per year or 60 visits.	$25 Copayment	$25 Copayment	60% After Deductible	65% After Deductible
Durable Medical Equipment (DME):	80% After Deductible	85% After Deductible	60% After Deductible	65% After Deductible
Occupational / Physical / Speech Therapy: $5,000 calendar year maximum per therapy.	$25 Copayment	$25 Copayment	60% After Deductible	65% After Deductible
Other Covered Services: Blood and blood components; leg, arm, and neck braces; private duty nursing; ambulance services; oxygen and its administration; surgical dressings, casts and splints.	80% After Deductible	85% After Deductible	60% After Deductible	65% After Deductible
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 <u>with prior approval by MSA Advisor.</u>**
Prescription Drug --Administered by Caremark See page 67 for pharmacy benefits

- Mental health and substance abuse are subject to limits. See Substance Abuse and Mental Health section of SPD
- 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 28.

Understanding Deductibles and Copayments

Certain rules apply to deductibles and copayments for the PPO (Base and Plus Plans) 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 *coinsurance*.

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 Schedule of Benefits on pages 11 and 28.

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 Base and Plus Plans for both in network and out-of-network coverage. Both options have individual maximum and 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 page 11. 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 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 the 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 11 for details.

If your early Retiree coverage becomes effective mid-calendar year and you were previously enrolled in the 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 28 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 28 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 on page 89. 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 29.

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 a partial hospitalization treatment program is recommended by your physician, 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 28 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
- kidney
- bone marrow
- heart valve
- muscular-skeletal
- parathyroid
- heart
- lung
- heart/lung
- liver
- pancreas
- 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 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 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 "BCBS PPO Schedule of Benefits" chart and the "Substance Abuse and Mental Health" chart on pages 11 and 28. 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% (Base Plan) or 85% (Plus Plan), subject to the deductible and limited to 40 visits per calendar year. Non-PPO Coordinated Home Care Programs are covered at 60% (Base Plan) or 65% (Plus Plan), 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, and meets any state or local licensing requirements.

The BCBS Medical option covers PPO-based hospice care at 80% (Base Plan) or 85% Pus Plan), subject to the deductible. Non PPO- hospice care is covered at 60% (Base Plan) or 65% (Plus Plan), 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% (Base Plan) or 85% (Plus Plan) for PPO facilities, subject to the deductible and 60% (Base Plan) or 65% (Plus Plan) 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:

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

– 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) 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 Pre-65 Retiree Medical Program within 31 days of the date of birth by calling YBR at 1-877-847-2436.**

• 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 excluding 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.

Substance Abuse and Mental Health

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 28 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.

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

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 shown on page 28 and the Special Limits (see above) 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 **Inpatient treatment in a residential facility other than a hospital**	80% 80%	60% of reasonable and customary rates 60% of reasonable and customary rates
Partial hospitalization	80%	60% of reasonable and customary rates
Maximum length of patient stay per calendar year **Outpatient treatment**	45 days per year — for mental health and substance abuse combined —minus any days of treatment that are not authorized 80% No limit to the number of visits	10 days per year for mental health and substance abuse combined 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 can be found on SPD page 11.

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 does 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 does 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 judgment, including determinations about whether a particular service is experimental, investigational or not medically necessary or appropriate, an explanation of the scientific or clinical judgment for the decision applying the term of the Program, or an explanation for the denial; and
- expert advice and consultation obtained by the Claims Administrator in connection with your denied claim, whether or not the advice was relied upon in making the benefit determination.

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 100.

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 63

The CIGNA Network Option

The CIGNA Network is an exclusive provider arrangement that requires you to select a Primary Care Physician from the CIGNA Network in the geographic region covered by the Network.

Choosing a Primary Care Physician

You must choose a Primary Care Physician (PCP) for yourself and your dependents from CIGNA's Network list for the geographic region where you live. The Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your dependents. You can make your initial selection by using the YBR web site at **www.ybr.com/benefits**. If you do not have access to the web site, you can contact YBR by phone at 1-877-847-2436. The YBR information is regularly updated. However, once you select a Primary Care Physician, you should always check with the provider to be certain they are in the CIGNA Network. You may also log onto the CIGNA web site at www.cigna.com or call CIGNA member services at 1-800-244-6224 to identify CIGNA Network Primary Care Physicians in your region. If you do not choose a PCP one will be assigned to you by CIGNA.

There are no out-of-network benefits under the CIGNA Network option. All services must be provided or authorized by your Primary Care Physician. If you obtain medical services from a doctor who does not participate in the CIGNA Network, you will be responsible for all associated costs. If you obtain medical services without the referral of the CIGNA Network Primary Care Physician, you will be responsible for the entire cost of those services. The Primary Care Physician's role is to provide or arrange for the medical care for you and any dependents. You and your dependents are responsible for contacting and obtaining the authorization of the Primary Care Physician, as required, prior to seeking medical care. If your dependent is a minor, you are responsible for seeking the Primary Care Physician's authorization.

You may request a transfer from one Primary Care Physician to another through CIGNA by calling member services at 1-800-244-6224. Any transfer will be effective on the first day of the month following the month in which the CIGNA processes the change request. In addition, if at any time a Primary Care Physician ceases to be a Network provider, you or your dependent will be notified for the purpose of selecting a new Primary Care Physician.

In most cases, you will not be required to file a claim form for services provided by Cigna in-network providers. The CIGNA Network Primary Care Physician or the Network provider referred by the Primary Care Physician will submit your claim automatically to the Claims Administrator. You will be responsible for paying a portion of the expense of most services, however. That portion is the copayment. There is no lifetime dollar limit on the services provided to covered persons by CIGNA Network providers. However, there are limits that apply to certain benefits including, but not limited to, mental health and substance abuse benefits. See the Summary of Benefits on pages 33 and 34 of this SPD.

No Out-of-Network Providers

You may not use out-of-network providers under the CIGNA Network option. In the event that a specific health service that is covered under the CIGNA Network option cannot be provided by or through a Network provider, you may be eligible for out-of-network services. You must obtain the authorization of your Primary Care Physician before you access out-of-network services. This authorization must be obtained in advance of you or your dependents receiving the services. All CIGNA Network option covered health services are subject to this provision. **If you use out-of-network service providers without obtaining the advance authorization of your Primary Care Physician through referral documents designated by CIGNA Healthcare, you will be responsible for the full cost of the out-of-network services.**

Direct Access for OB/GYN Services

Females covered under the CIGNA Network option are allowed direct access to a licensed/certified obstetrician/gynecologist as long as the physician is in the CIGNA Network. There is no need to obtain the Primary Care Physician's authorization for visits to a participating network ob/gyn for pregnancy, well-woman gynecological exams, primary and preventive gynecological care, or acute gynecological conditions.

Guest Privileges

If you or a dependent will be residing temporarily in another location where there is a CIGNA Network of providers, you may be eligible for CIGNA Network medical benefits at that location. To apply for "guesting" privileges, you will need to call CIGNA Member Services at the number on your CIGNA identification card.

If you are traveling outside the CIGNA Network area and you need to seek urgent care, you must contact Member Services for approved providers.

CIGNA Network Summary of Benefits	
BENEFITS	**IN-NETWORK BENEFITS PAID BY PROGRAM**
Lifetime Maximum	Unlimited [1]
Calendar year deductible Individual Family	 $350 $700
Calendar year out -of-pocket maximum	None
Office Visit Illness/Injury ***Preventive Care*** Routine Preventive Care (including immunizations) Well Woman Care (including Pap Test) Routine Mammograms Initial Vision and Hearing Screening by PCP for Children through age 16 Routine Vision Exams (limited to one exam every two calendar years)	 Primary Care – 100% after $15 copayment Specialist Care—100% after $25 Copayment 100% after Office Visit copayment 100% after Office Visit copayment 100% 100% after Office Visit copayment 100% after $10 copayment
Independent X-Ray and Lab	100%
Outpatient Hospital X-Ray and Lab	100% after deductible
Emergency Doctor's Office Emergency Room/Urgent Care Facility	 100% after Office Visit copayment 100% after $50 copayment (waived if admitted)
Maternity Initial Visit Delivery/Prenatal/Postnatal Care ***Hospitalization*** [2]	 100% after Office Visit copayment 100% after deductible 100% after deductible
Outpatient Surgical Facility	100% after deductible
Surgery Surgeon's fees Second Opinion Consultation	 100% after deductible 100% after Office Visit copayment
Infertility (limited to testing, diagnosis, and corrective procedures only[3]) Office Visit Surgery ***Outpatient Rehabilitation*** Physical, Speech[4], Occupational and Chiropractic Therapy	 100% after Office Visit copayment 100% after deductible 100% after Office Visit copayment (Up to 60 days per calendar year)

[1] Certain mental health and substance abuse benefits are limited with respect to number of treatments or number of days per calendar year. See the Summary of Benefits for Mental Health and Substance Abuse on page 45.
[2] All inpatient hospital admissions require Pre-Admission Certification and Continued Stay Review. If your admission/stay is not authorized there may be a reduction or denial of coverage.
[3] Charges for in-vitro fertilization, artificial insemination, or any other similar procedure are not covered.
[4] Speech therapy which is not restorative in nature will not be covered.

CIGNA Network Summary of Benefits

BENEFITS	IN-NETWORK BENEFITS PAID BY PROGRAM
Special Services	
Skilled Nursing Facility	100% after deductible; up to 60 days per calendar year
Home Health Care	100% after deductible; unlimited visits
Hospice – Inpatient	100% after deductible
Hospice – Outpatient	100% after deductible
Durable Medical Equipment	100% after deductible
External Prostheses	100% after deductible (Up to a $10,000 per calendar year maximum)
Ambulance (for true emergency)	100% after deductible
***Prescription Drug*--**<u>**Administered by Caremark**</u> See page 67 for pharmacy benefits	

Understanding Copayments

Certain rules apply to deductibles and copayments for the CIGNA Network option. It is important that you understand how the rules apply. 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.

A *copayment* is a per-visit payment required when you or a dependent visits your Primary Care Physician or a CIGNA Network provider referred by your Primary Care Physician. For example, if you visit your Primary Care Physician for treatment, you pay $15 at the time of service. There is no additional fee to pay or a deductible to meet. The CIGNA Network copayments are shown in the CIGNA Network Summary of Benefits chart on pages 33 and 34.

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. Examples include charges for inpatient or out-patient surgery, non-routine diagnostic testing, or inpatient hospital charges. All expenses **except in-network physician office visits, tests associated with routine physical exams, x-ray and lab charges at independent imaging centers or labs, and prescription drugs are subject to the deductible.** Before benefits are paid, you must meet the deductible for the type of in-network service provided. The deductibles are shown in the CIGNA Network Summary of Benefits on page 33 and 34.

When you look at the Summary of Benefits, you will see the maximum family deductible is equal to two individual deductibles for in-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.

Remember that if you do not obtain a referral from your Primary Care Physician, even if you use the services of a network provider, you may have to pay for the entire cost of the services. Your cost will not be limited to the copayment or deductible shown in the CIGNA Network Summary of Benefits.

What You Should Know About Covered Services

The BNSF Pre-65 Retiree Medical Program covers only those medical services and supplies that are medically necessary and not otherwise excluded or limited under Program terms. The CIGNA Network option requires that medical services or supplies be authorized by your Primary Care Physician, and performed by a participating CIGNA Network provider. After you have paid the copayment for the network services you are receiving, in most cases the Program will pay the remainder of the covered expenses.

Special rules apply to covered charges for mental health and substance abuse services. See page 45 for the Mental Health and Substance Abuse Summary 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 participating in the CIGNA Network, and except for certain emergencies must be authorized ahead of time by your Primary Care Physician.
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 services or supplies as medically necessary, the Program will only reimburse services determined medically necessary by the Claims Administrator.

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.

Emergency Room Treatment

After you pay the required copayment under the Summary of Benefits on pages 33 and 34 of this SPD, the Program pays 100% of the covered charges provided that the following requirements are met:

• the emergency services are received from or preauthorized by your or your dependent's Primary Care Physician; or

• the emergency services are not pre-authorized by the Primary Care Physician, but are authorized by CIGNA within 48 hours of admission in the case of hospital confinement or as soon as reasonably possible. Contact CIGNA member services at 1-800-244-6224 in this case.

In all events, if you have a life or limb threatening emergency, you should seek treatment at the nearest hospital emergency room. The Program will pay the cost of coverage provided you or your representative contacts either your Primary Care Physician or Member Services within 48 hours.

Urgent Care Situations

Some medical conditions are not an emergency, but require prompt medical attention. There are urgent care situations such as a sore throat, high temperature, or an ear or eye infection. If you have an urgent care situation you should contact your Primary Care Physician first, and then follow the instructions you receive. If you experience an urgent care situation while out of the CIGNA Network region, you should seek treatment. You will be responsible for paying the bill at the time you receive treatment. Keep a copy of the bill and call Member Services when you return home for instructions on how to receive reimbursement.

Transplant Program

Organ transplant services that are not determined to be experimental and investigational and that are approved by the Claims Administrator are covered. *If you or a dependent is or may become a candidate for an organ transplant, call the toll-free number on your CIGNA Network identification card.* Certain transplants will not be covered under the Program's CIGNA Network option based on the list of excluded expenses shown under the section titled "What the Program Does Not Cover" beginning on page 63.

The following transplants are covered at CIGNA authorized Life Source Centers:

- heart
- lung
- lung/liver
- allogenic bone marrow
- simultaneous kidney and pancreas

Kidney and cornea transplants are covered at locally contracted CIGNA Network provider locations. Your Primary Care Physician must refer you to the Network provider.

Covered charges for transplants eligible for reimbursement under the Program include charges for immunosuppressive medication, organ procurement costs and donor's medical costs if not covered under

another medical plan. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other medical plan. *Call the toll-free number on your CIGNA Network identification card for information on transplant programs.*

Medical Care Services

The following medically necessary services are covered under the Program subject to the services being provided by, or referred to another CIGNA Network provider by, your or your dependent's Primary Care Physician. You are responsible for all copayments.

Hospital Charges

A *hospital* means an institution participating in the CIGNA Network in the area where you reside 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.

• A free-standing surgical facility that meets all licensing, administrative, staffing and operating requirements established by the Claims Administrator.

The term *hospital* does not include an institution that is primarily a place for rest, a place for the aged or a nursing home.

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, and who is a participating physician in the CIGNA Network in the area where you reside.

The following services are covered:

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

• 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 the Primary Care Physician, or CIGNA member services is notified of inpatient emergency admission within 48 hours as described on page 37 of this SPD.

• Outpatient surgical facility services, including physicians' fees, anesthesia and facility charges, that are furnished by a hospital on the day the procedure is performed and are ordered by the Primary Care Physician.

• Charges for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium and radioactive isotope treatment; chemotherapy, blood transfusions and blood not donated or replaced; and oxygen and other gases and their administration, when authorized by the Primary Care Physician. Experimental and investigational treatments 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 only upon the written prescription of the Primary Care Physician while confined in a hospital.

• Other services and supplies provided they are medically necessary and required for the care of the patient as determined by CIGNA.

Home Health Care Services

Home health care agency medical services and supplies are covered as follows only if there is a home health care treatment plan authorized by the Primary Care Physician on file for the patient:

• Part-time or intermittent nursing care by or under the supervision of a registered graduate nurse.

• Part-time or intermittent services of a home health care aide.

• Physical, occupational or speech therapy subject to applicable Program limitations.

• Medical supplies; durable medical equipment used in the course of rendering home health care services; drugs and medicines lawfully dispensed on the written prescription of a physician; and laboratory services, but only to the extent that such charges would otherwise be covered under the Program had the person been confined in a hospital or skilled nursing facility as a registered bed patient. Home health care charges do **not** include any of the following:

  • Charges that exceed the home health care maximum or the maximums applicable to private duty nursing care or physical, occupational or speech therapy under the Program's Summary of Benefits.

  • Care or treatment that is not stated in the home health care treatment plan.

  • The services of a person who is a member of your family or your dependent's family or who normally lives in your home or your dependent's home.

  • A period when a person is not under the continuing care of the Primary Care Physician or a physician referred by the Primary Care Physician.

A *home health care agency* must primarily provide skilled nursing and other therapeutic services and be licensed to provide these services, if licensing is required. It must maintain complete medical records on each of its patients. There must be a full-time administrator who follows rules and policies established by a professional group that includes physicians. If there are no licensing requirements in the home health care agency's locale, the Claims Administrator must approve the agency.

A *home health care aide* must be trained in providing care of a medical or therapeutic nature, and must report to and be under the direct supervision of the Home Health Care Agency.

A *home health care treatment plan* is a written plan for the care and treatment in the patient's home. To qualify, the plan must be approved in writing by the Primary Care Physician or a CIGNA Network physician referred by the Primary Care Physician. The physician must certify that the patient would require confinement in a hospital or skilled nursing facility without the home health care plan.

Hospice Care Services

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 the person's Primary Care 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 that is participating in the CIGNA Network.

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, and is approved by the Claims Administrator or is participating in the CIGNA Network.

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 Primary Care Physician or a CIGNA Network physician referred by the Primary Care 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. Other covered charges include:

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

• Services of a physician, psychologist, social worker, family counselor or ordained minister for individual and family counseling. Bereavement counseling is available under the Program within one year of the covered person's death, and is limited to 3 sessions.

• Pain relief treatment, including drugs, medicines and medical supplies.

• Services of a 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 the Primary Care 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 Services

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, and it must be participating in the CIGNA Network.

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 CIGNA Network option pays charges for a skilled nursing facility that is participating in the CIGNA Network. Payment is limited to semi-private room charges up to 60 days per calendar year, if admitted either directly from the hospital, or within thirty (30) days of discharge from a hospital stay. No copayment applies. No prior hospitalization is required. You must access skilled nursing facility services through your Primary Care Physician.

Infertility Treatment

Services for testing, diagnosis, and corrective procedures approved by CIGNA are covered subject to the CIGNA Network Summary of Benefits limitations. Procedures for correction of infertility are covered. **In vitro fertilization, artificial insemination, GIFT and ZIFT embryo transplantation, or related procedures are not covered under the CIGNA Network option. Call the CIGNA toll-free number to confirm that any infertility treatment you may be considering is covered.**

Other CIGNA Network Provider Covered Services

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

• Independent lab and x-ray services rendered by a provider referred through the Primary Care Physician, other than a hospital.

• Outpatient private duty nursing subject to referral by written order from the Primary Care Physician. There must be a written order from the physician and nursing notes indicating the care is non-custodial.

• Outpatient short term rehabilitation up to a maximum of 60 calendar days (two months) per condition. The following therapies are included under this limitation: physical therapy, speech therapy, and occupational therapy. Chiropractic therapy, including all treatments administered by chiropractors, has a 60-calendar-day limit per condition.

• 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 and require a copayment.

• Temporomandibular Joint (TMJ) subject to referral by the Primary Care Physician. This benefit does not cover orthodontic treatment. Appliances are covered subject to medical necessity and must be pre-authorized by calling CIGNA Member Services.

• Dental care limited to accidental injury of sound, natural teeth sustained while covered under the plan.

• Non-elective, therapeutic abortion for the covered retiree, covered spouse or any dependent.

• Routine mammogram — a single baseline mammogram for women age 35 to 39, a mammogram every one to two years for women age 40 to 49, and/or annual mammogram for women age 50 and older.

• Elective second surgical opinion.

• Outpatient pre-admission testing ordered by the Primary Care Physician or a physician referred by the Primary Care Physician.

• 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.

• 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, excluding 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.

• Charges for initial purchase and fitting of external prosthetic devices that are used as a replacement or substitute for a missing body part and are necessary to alleviate or correct an illness, injury or congenital defect, including only artificial arms and legs and terminal devices such as a hand or hook. Replacement of such prostheses is covered only if needed due to normal body growth and subject to an annual limitation.

• Routine preventive care for adults and children (including immunizations), and well-woman care (including Pap test) rendered by the Primary Care Physician, or in the case of a female participant by an OB/GYN participating in the CIGNA Network.

• Allergy testing, treatment and immunizations. The patient must pay the office visit copayment whether the patient sees a physician or nurse.

Substance Abuse and Mental Health

Benefits for Mental Illness, Alcohol and Drug Abuse

Mental health and substance abuse benefits are available under the Program for retirees and dependents under age 65. If your spouse is age 65 or older, these benefits are not available. You will need to have all mental health and substance abuse treatment pre-certified through CIGNA Behavioral Health. This includes all inpatient and outpatient care.

You must call CIGNA Behavioral Health for pre-certification at this toll-free number: 800/291-6012. If you do not pre-certify treatment, the Program will not pay for your care. ***Failure to obtain pre-certification will result in no payment under the BNSF Pre-65 Retiree Medical Program.***

The total number of days for which benefits are payable for expenses incurred in any calendar year while a patient is confined as an inpatient in a network hospital due to mental illness, alcohol or drug abuse will not exceed the inpatient days shown in the Summary of Benefits for Mental Health and Substance Abuse on page 45. The following services are available and require pre-certification by CIGNA Behavioral Health:

- Services during confinement in a network hospital due to mental illness.
- Services during confinement in a network hospital due to alcohol or drug abuse.
- Services for outpatient treatment in a network facility or by a network provider for mental illness, or drug or alcohol abuse after first deducting the required copayment.

Covered Expenses

Covered expenses must be medically necessary and pre-certified by CIGNA Behavioral Health. Benefits are subject to the Summary of Benefits for Mental Health and Substance Abuse Treatment on page 45 and include the following medical services and supplies:

- Network hospital or residential facility 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 network hospital charges for medical care and treatment.
- Outpatient charges by a network facility licensed to furnish mental health services for care and treatment of mental illness.
- Network participating 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.

Expenses Not Covered

Covered expenses will not include, and no payment will be made for, expenses incurred:

- Without obtaining pre-certification from CIGNA Behavioral Health, whether for inpatient or outpatient treatment;

• 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;

• For services or supplies for which benefits are not payable under the section titled "What the Program Does Not Cover" beginning on page 63; or

• After a dependent reaches age 65.

Summary of Benefits for Mental Health and Substance Abuse		
Service	**In-Network** (Percentage of covered expense paid by the Program with no deductible)	**Out-of-Network** (Percentage of covered expense paid by Program with no deductible)
Inpatient treatment in a hospital	80%	50% of reasonable and customary rates
Inpatient treatment in a residential facility other than a hospital	80%	50% of reasonable and customary rates
Day treatment at hospital or residential facility	80%	50% of reasonable and customary rates
Maximum length of inpatient stay	45 days per year — for mental health and substance abuse combined—minus any days of treatment not authorized	10 days per year for mental health and substance abuse combined
Structured outpatient substance abuse program	$5 copay per visit $150 maximum out-of-pocket per program Limit of 2 programs per year	Covered under outpatient treatment (below)
Outpatient treatment	80% No limit to the number of visits CIGNA Behavioral Health must certify and monitor care	50% Mental health care treatment must be provided by a PhD, MD or MSW 25 visit limit per year
Mental health treatment **Substance abuse treatment**	No lifetime dollar maximum. $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 a PPO out-of-network provider. This applies to inpatient or outpatient services. No annual out-of-pocket maximum.	
Preauthorization and review by CIGNA Behavioral Health	**Pre-authorization is required for all care; failure to obtain pre-authorization will resultin no payment. All coverage is subject to medical necessity determination by CIGNA Behavioral Health.**	

The CIGNA PPO Option

The CIGNA PPO is a national Preferred Provider Organization. This means CIGNA has a national network of hospitals and other health care providers who have agreed to provide services covered under the BNSF Medical 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 CIGNA PPO network provider. You and your enrolled dependents can find a CIGNA network provider by using the YBR web site at **www.ybr.com/benefits**. If you do not have access to the web site, you can contact YBR by phone at 1-877-847-2436. The YBR information is regularly updated. However, once you select a PPO provider, you should always check with the provider to be certain they are in the CIGNA PPO network. You may also log onto the CIGNA website at www.cigna.com or call CIGNA member services at 1-800-244-6224 to identify PPO providers.

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 Program's 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 exceed CIGNA's "reasonable and customary" levels. (You are required to pay for that portion of out-of-network charges that are not "reasonable and customary" as determined by CIGNA.)

In most cases, you will not be required to file a claim form for services provided by PPO in-network providers. The PPO provider will submit your claim automatically to the Claims Administrator. 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, there are limits that apply to certain benefits including, but not limited to, mental health and 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 you will have to meet 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. If you move from the CIGNA PPO option to another option offered under the BNSF Pre-65 Retiree Medical Program, the amount of out-of-network benefits paid under the CIGNA PPO option will apply to any lifetime limit on benefits under the new BNSF Pre-65 Retiree Medical Program option you elect. Certain limits also apply to specific benefits including, but not limited to, mental health and substance abuse 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 pages 48 and 49
for a comparison of out -of-pocket expenses for network and out-of-network services.

CIGNA PPO Summary of Benefits

	IN-NETWORK BENEFITS PAID BY PROGRAM	OUT-OF NETWORK BENEFITS PAID BY PROGRAM
Lifetime Maximum	Unlimited[1]	$750,000
Calendar year deductible Individual Family	 $350 $700	 $700[2] $1400
Calendar year out-of-pocket maximum	Individual - $1,500 (No family maximum)	Individual - $3,000 (No family maximum)
Office Visit Illness/Injury	Primary Care – 100% after $15 Copayment Specialist Care – 100% after $25 Copayment	65% after deductible
Preventive Care Routine Preventive Care for Children and Adults Well Woman Care (including Pap Test)	100% after Office Visit Copayment 100% after Office Visit Copayment (85% for x-ray/lab if billed by a separate outpatient diagnostic facility such as a hospital)	**Not Covered**
Routine Mammogram	85% if billed by a separate outpatient diagnostic facility such as a hospital or imaging center.	65% after deductible
Independent X-Ray and Lab	85% after deductible	65% after deductible
Emergency Emergency Room/Urgent Care Facility (for true emergency)	100% after $50 copayment (waived if admitted)	100% after $50 copayment (waived if admitted)
Maternity Initial Visit Delivery/Prenatal/Postnatal Care	100% after Office Visit Copayment 85% after deductible	65% after deductible 65% after deductible
Hospitalization	85% after deductible	65% after deductible
Outpatient Surgical Facility	85% after deductible	65% after deductible
Surgery	85% after deductible	65% after deductible
Infertility (limited to testing, diagnosis, and Corrective procedures only) Office Visit Surgery *Outpatient Rehabilitation*[3] Physical Therapy Speech Therapy Occupational Therapy Chiropractic Therapy[4]	100% after Office Visit Copayment 85% after deductible $25 Copayment	65% after deductible 65% after deductible 65% after deductible

[1] Certain mental health and substance abuse benefits are limited with respect to number of treatments or number of days per calendar year. See the Summary of Benefits for Mental Health and Substance Abuse on page 62.
[2] Non-compliance penalties and charges in excess of reasonable and customary are not counted for deductible and out-of-pocket maximum.
[3] Maximum of 60 days per condition
[4] Maximum $1,000 per year or 60 visits, whichever comes first.

Special Services Skilled Nursing Facility Home Health Care Hospice – Inpatient Hospice – Outpatient	85% after deductible	65% after deductible
Durable Medical Equipment	85% after deductible	65% after deductible
External Prostheses	85% after deductible	65% after deductible
Ambulance (for true emergency)	85% after deductible	85% after deductible
Prescription Drug--Administered by Caremark See page 67 for pharmacy benefits		

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 *coinsurance*.

A *copayment* is a per-visit payment required under the PPO option when you or a dependent visits a network physician, receives outpatient rehabilitative therapy, or receives emergency care in your physician's office or the emergency room of a hospital. For example, if you are covered under the CIGNA 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 Summary of Benefits chart on pages 48 and 49.

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 for both in network and out-of-network benefits. Before covered expenses are paid for you must meet the deductible for the type of provider you have visited.. The deductibles are shown in the CIGNA PPO Summary of Benefits charts on pages 48 and 62.

When you look at the Summary of Benefits chart on page 48, you will see the maximum family deductible is equal to two individual deductibles for in network and out-of-network covered expenses. This means that when two or more family 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 the eligible expenses for the remainder of that calendar year after a covered person has met the out-of-pocket maximum. See the CIGNA PPO Summary of Benefits charts on pages 48 and 62 for details.

Special copayments apply to mental health/substance abuse benefits under the Pre-65 Retiree Medical Program. See page 62 for the Mental Health and Substance Abuse Summary of Benefits.

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

- Charges in excess of reasonable and customary charges.
- Charges for services and supplies not covered under the CIGNA PPO option.
- Charges that exceed the applicable lifetime or calendar year dollar maximums.
- Any penalties paid because the covered person failed to comply with the CIGNA PPO 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 BNSF Pre-65 Retiree Medical Program reimburses only those covered charges that are medically necessary and not otherwise excluded or limited under Program terms. If you use the CIGNA 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 Claim Administrator for most out-of-network provider charges. You will also pay an out-of-network deductible and an out-of-pocket maximum. Only those medically necessary out-of-network covered charges that meet CIGNA's 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 CIGNA PPO 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 full cost for medical services that should have been, but were not, pre-certified under the CIGNA PPO option. The pre-authorization requirements apply to both in-network and out-of-network medical services. See below for details.

Special rules apply to covered charges for mental health and substance abuse services. See page 62 for the Mental Health and Substance Abuse Summary 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 CIGNA 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 services or supplies as medically necessary, the Program will only reimburse services determined medically necessary by CIGNA.

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 made by 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 (PAC) and continued stay review (CSR) refer to the process used to certify the medical necessity and length of hospital stays during a course of treatment. PAC and CSR apply to the CIGNA PPO network and out-of-network option. You, your dependents or your treating physician should request PAC prior to an inpatient hospitals admission. If PAC 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. In addition, reimbursement of your or your dependent's medical expenses may be reduced or denied.

If your treating physician is in the CIGNA PPO network, the network provider usually will make certain that PAC 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 PAC. **Whether care is received from a CIGNA PPO provider or an out-of-network provider, it is your responsibility to make sure PAC has been obtained.**

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 PAC for any inpatient hospital admission or to find out if PAC is required, call the toll-free number shown on your CIGNA PPO identification card.

When you receive PAC, your treating physician and the hospital will be advised of the length of stay certified by the PAC reviewer. Continued stay review (CSR) 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 CSR for additional inpatient days, call 1-800-244-6224, the toll-free number shown on your CIGNA PPO identification card.

If you and your physician decide to extend your inpatient stay when the CSR reviewer has indicated the 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 CSR reviewer's denial of additional days under the Program's appeal provisions found on page 91. All medical decisions regarding your treatment are between you and your physician. The CSR reviewer is responsible for determining only whether the Program will pay for extra inpatient days.

When to Request Preadmission Certification

Non-emergency 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 PAC toll-free number on your CIGNA PPO identification card* to certify the hospital stay within the 7-day period before the inpatient 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 PAC toll-free number on your CIGNA PPO identification card* within 48 hours after the admission.

Pregnancy: You should *call the PAC toll-free number on your CIGNA PPO identification card* by the end of the third month of pregnancy.

Inpatient Mental Health/Substance Abuse Care: Call at least 7 days before the inpatient admission. CIGNA requires that all mental health/substance abuse care be pre-certified under PAC. This includes out-patient and in-patient treatment by in-network and out-of-network providers.

Case Management

In the event you or your dependent needs continuing treatment beyond the acute care setting of the hospital, a Case Manager will contact you. 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 CIGNA PPO identification card*. Participation in the case management program is voluntary. There is no penalty if you do not want to participate in case management.

Transplant Program

Charges made for or in connection with organ transplant services that are not determined to be experimental and investigational and that are approved by the Claims Administrator are covered. *If you or*

a dependent is or may become a candidate for an organ transplant, call the toll-free number on your CIGNA PPO identification card. Certain transplants will not be covered under the Program's CIGNA PPO option based on the list of excluded expenses shown under the section titled "What the Program Does not Cover" beginning on page 63.

Covered charges for transplants eligible for reimbursement under the Program's CIGNA PPO option include charges for immunosuppressive medication, organ procurement costs and donor's medical costs if not covered under another medical plan. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other medical plan. *Call the toll-free number on your CIGNA PPO identification card for information on transplant programs.*

Medical Care Services

The following medically necessary services are covered under the Program's CIGNA PPO option subject to the copayments, deductibles and out-of-pocket maximums that apply. Reimbursement of medical expenses is subject to the CIGNA's determination of the reasonable and customary limits.

Hospital Charges

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.

• A free-standing surgical facility that meets all licensing, administrative, staffing and operating requirements established by the Claims Administrator.

The term *hospital* does not include an institution that is primarily a place for rest, a place for the aged or a nursing home.

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.

The following charges are covered:

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

• 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.

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

• Charges for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium and radioactive isotope treatment; chemotherapy, blood transfusions and blood not donated or replaced; and oxygen and other gases and their administration. Experimental and investigational treatments 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 only upon the written prescription of a physician while confined in a hospital.

• Other services and supplies provided they are medically necessary and required for the care of the patient as determined by CIGNA.

Multiple Surgical Reduction for the Out-of-Network Option

In the event multiple surgeries are performed during one operation out-of-network, the major or primary surgical procedure is paid as any other surgery, subject to CIGNA's reasonable and customary limits. There will be a 50% payment reduction for the secondary surgical procedure subject to the terms and conditions of the Program.

Home Health Care Charges

Charges made by a home health care agency for the following medical services and supplies are covered only if there is a home health care treatment plan on file for the patient:

• Part-time or intermittent nursing care by or under the supervision of a registered graduate nurse.

• Part-time or intermittent services of a home health care aide.

• Physical, occupational or speech therapy subject to applicable Program limitations.

• Medical supplies; durable medical equipment used in the course of rendering home health care services; drugs and medicines lawfully dispensed on the written prescription of a physician; and laboratory services, but only to the extent that such charges would otherwise be covered under the Program had the person been confined in a hospital or skilled nursing facility as a registered bed patient. Home health care charges do **not** include any of the following.

> • Charges that exceed the home health care maximum or the maximums applicable to private duty nursing care or physical, occupational or speech therapy under the Program's schedule of covered in-network and out-of-network charges. No payment is made if the patient has otherwise exceeded any Program lifetime maximum benefits that apply.
>
> • Care or treatment that is not stated in the home health care treatment plan.
>
> • The services of a person who is a member of your family or your dependent's family or who normally lives in your home or your dependent's home.
>
> • A period when a person is not under the continuing care of a physician.

A *home health care agency* must primarily provide skilled nursing and other therapeutic services and be licensed to provide these services, if licensing is required. It must maintain complete medical records on each of its patients. There must be a full-time administrator who follows rules and policies established by a professional group that includes physicians. If there are no licensing requirements in the home health care agency's locale, the Claims Administrator must approve the agency.

A *home health care aide* must be trained in providing care of a medical or therapeutic nature, and must report to and be under the direct supervision of the Home Health Care Agency.

A *home health care treatment plan* is a written plan for the care and treatment in the patient's home. To qualify, the plan must be approved in writing by a physician who certifies that the patient would require confinement in a hospital or skilled nursing facility without the home health care plan.

Out-of-network home health care visits are limited to 40 visits per Program Year reduced by any in-network visits. Each visit by an employee of a home health care agency will be considered one visit, and each four hours or less of home health care aid services will be considered one home health care visit.

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, and is approved by the Claims Administrator.

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 for a network hospice, or at an out-of-network hospice facility's most common daily rate for a semi-private room, subject to CIGNA's reasonable and customary limits. Other covered charges include:

- Services provided by a hospice facility on an outpatient basis.
- Services of a physician, psychologist, social worker, family counselor or ordained minister for individual and family counseling. Bereavement counseling is available under the PPO in-network option only. The hospice benefit includes a total of three bereavement counseling sessions.
- Charges for pain relief treatment, including drugs, medicines and medical supplies.
- Services of a 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. Reimbursement is limited to semi-private room charges up to 60 days per calendar year.

No prior hospitalization is required. Charges for room and board are paid at the contract rate for a network skilled nursing facility, or at an out-of-network facility's most common daily rate for a semiprivate room, subject to CIGNA's reasonable and customary limits.

Infertility Treatment Charges

Charges for testing, diagnosis, and corrective procedures approved by CIGNA are covered subject to the PPO Summary of Benefits limitations. Procedures for correction of infertility are covered. **In vitro fertilization, artificial insemination, GIFT and ZIFT embryo transplantation, or related procedures are not covered under the CIGNA PPO option. Call the CIGNA toll-free number to confirm that any infertility treatment you may be considering is covered.**

Other Covered Charges

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

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

• Outpatient private duty nursing subject to approval under the PAC requirement on pages 53 and 54, and limited to 40 visits per calendar year for out-of-network services. There must be a written order from the physician and nursing notes indicating the care is non-custodial.

• Outpatient short term rehabilitation up to a maximum of 60 consecutive days (two months) per condition. The following therapies are included under this limitation: physical therapy, speech therapy, and occupational therapy. Chiropractic therapy, including all treatments administered by chiropractors, has a 60-consecutive-day limit per condition or $1,000 per year limit on benefits, whichever occurs first. Chiropractic therapy will be reviewed for medical necessity on the 35th visit.

• 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 and require a copayment.

• TMJ subject to pre-approval by the Claims Administrator. This benefit does not cover appliances and orthodontic treatment.

• Dental care limited to accidental injury of sound, natural teeth sustained while covered under the Program.

• Non-elective, therapeutic abortion for the covered retiree, covered spouse or any dependent.

• Routine mammogram — a single baseline mammogram for women age 35 to 39, a mammogram every one to two years for women age 40 to 49, and/or annual mammogram for women age 50 and older.

• Elective second surgical opinion.

• Outpatient pre-admission testing.

• 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.

• 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, excluding 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.

• Charges for initial purchase and fitting of external prosthetic devices that are used as a replacement or substitute for a missing body part and are necessary to alleviate or correct an illness, injury or congenital defect, including only artificial arms and legs and terminal devices such as a hand or hook. Replacement of such prostheses is covered only if needed due to normal body growth.

• When services are rendered by a PPO physician, routine preventive care for adults and children (including immunizations), and well-woman care (including Pap test).

• Allergy testing, treatment and immunizations. The patient must pay the office visit copayment or the cost of a shot (whichever is less) whether the patient sees a physician or nurse.

• Foot orthotics only when determined to be medically necessary by the Claims Administrator.

Substance Abuse and Mental Health

Pre-Certification Required

Mental health and substance abuse benefits are available under the Program for retirees and dependents under age 65. You may choose a network or out-of-network medical care provider. Whatever medical care provider you choose, you will need to have all mental health and substance abuse treatment pre-certified through CIGNA Behavioral Health. This includes all inpatient and outpatient care.

You must call CIGNA Behavioral Health for pre-certification at this toll-free number: 800/291-6012. If you do not pre-certify treatment, the Program will not pay for your care. This requirement applies to CIGNA PPO network providers and out-of-network providers. ***Failure to obtain pre-certification will result in no payment under the BNSF Pre-65 Retiree Medical Program.***

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, CIGNA Behavioral Health will pay the following subject to the percentage limits in the Summary of Benefits for Mental Health and Substance Abuse on page 62.

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

• Covered expenses incurred during confinement in a 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 first deducting the required network copayment.

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

Covered Expenses

Covered expenses must be medically necessary and pre-certified where required under the Program. Benefits are subject to the Summary of Benefits for Mental Health and Substance Abuse Treatment on page 62 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.

Expenses Not Covered

Covered expenses will not include, and no payment will be made for, expenses incurred:

• Without obtaining pre-certification from CIGNA Behavioral Health, whether for inpatient or outpatient treatment;

• 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 page 63.

Summary of Benefits for Mental Health and Substance Abuse

Service	In-Network (Percentage of covered expense paid by the Program with no deductible)	Out-of-Network (Percentage of covered expense paid by Program with no deductible)
Inpatient treatment in a hospital	80%	50% of reasonable and customary rates
Inpatient treatment in a residential facility other than a hospital	80%	50% of reasonable and customary rates
Day treatment at hospital or residential facility	80%	50% of reasonable and customary rates
Maximum length of inpatient stay	45 days per year — for mental health and substance abuse combined—minus any days of treatment not authorized	10 days per year for mental health and substance abuse combined
Structured outpatient substance abuse program	$5 copay per visit $150 maximum out-of-pocket per program Limit of 2 programs per year	Covered under outpatient treatment (below)
Outpatient treatment	80% No limit to the number of visits; CIGNA Behavioral Health must certify and monitor care	50% Mental health care treatment must be provided by a Ph.D., MD or MSW 25 visit limit per year
Maximum benefits **Mental health treatment** **Substance abuse treatment**	No lifetime dollar maximum. $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 a PPO out-of-network provider. This applies to inpatient or outpatient services. No annual out-of-pocket maximum.	
Preauthorization and review by CIGNA Behavioral Health	Pre-authorization is required for all care; failure to obtain pre-authorization will result in no payment. All coverage is subject to medical necessity determination by CIGNA Behavioral Health.	

What the Program Does Not Cover

(applicable to BCBS PPOs, CIGNA Network and CIGNA PPO except as noted)

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 (please note that the limitations and exclusions listed apply to all Program options unless otherwise noted):

• Services that are not medically necessary as determined by the Claims Administrator.

• 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 Program option benefit. If you enrolled in the Vision Care Plan, which is a separate plan and not part of the Pre-65 Retiree Medical Program option, refer to the SPD for the Vision Care Plan that gives information on Vision Care Plan benefits.

• Diagnostic services as part of routine physical examinations or check-ups, premarital examinations, determination of auditory problems, surveys, case finding, 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, treatments, or supplies (including drugs) that the Claims Administrator 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. The Claims Administrator 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. The Claims Administrator 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 consent.

The Claims Administrator 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.

• 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 the Claims Administrator.

• 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 the Claims Administrator.

• 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 the Claims Administrator.

• Treatment of teeth/peridontalium 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. The Claims Administrator 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 93 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 are considered "maintenance" by the Claims Administrator.

• Charges to the extent of the exclusions imposed by any certification requirement under the Program.

• Replacement of external prostheses due to wear and tear, loss, theft, or destruction, or any biomechanical external prosthetic devices.

• Charges for or in connection with an elective abortion unless the physician certifies in writing that the pregnancy would endanger the life of the mother or the expenses are incurred to treat medical complications due to an abortion **(applicable to the CIGNA Network and CIGNA PPO options only)**.

• Services or supplies received from a provider other than your Primary Care Physician unless referred or preauthorized by your PCP and/or approved by the Claims Administrator **(applicable to the CIGNA Network option only)**.

• Routine preventive care received from out-of-network providers **(applicable to BCBS PPOs and CIGNA PPO options only.)**

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. Your prescription drug copayments or coinsurance amounts 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 1-800-378-7559.

Participating Pharmacy Benefit

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

Retail prescription costs are as follows:

Prescription Drug Type	BCBS Plan		CIGNA Network	CIGNA PPO
	Base Plan	Plus Plan		
Generic	25%* (Minimum $10; Maximum $100)	$10	$10	$10
Formulary	25%* (Minimum $25; Maximum $100)	$25	$25	$25
Non-Formulary	25%* (Minimum $40; Maximum $100)	$40	$40	$40

*Of total prescription cost up to maximum listed.

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

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

Mail Order Pharmacy Benefit

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

For prescriptions received from one of the Caremark Mail Service pharmacies you will pay:

Prescription Drug Type	BCBS Plan		CIGNA Network	CIGNA PPO
	Base Plan	Plus Plan		
Generic	Two times retail* (Minimum $20; Maximum $200)	$20	$20	$20
Formulary	Two times retail* (Minimum $50; Maximum $200)	$50	$50	$50
Non-Formulary	Two times retail* (Minimum $80; Maximum $200)	$80	$80	$80

*Of total prescription cost up to maximum listed.

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

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

Covered Prescription Drugs

The term *covered prescription drug* means:

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

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

• Insulin needles and syringes;

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

• Tretinoin for individuals through age 26;

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

• Oral contraceptives;

• Prenatal vitamins, upon written prescription;

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

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

• Glucose test strips;

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

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

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

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

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

Limitations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

• For drugs used for cosmetic purposes;

• For tretinoin 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.

Your Health Reimbursement Account (HRA)

Beginning in 2005, all BNSF Pre-65 Retiree Medical options (except HMO's) feature a Health Reimbursement Account or HRA. Features include:

- The HRA is financed solely with contributions from BNSF. You don't contribute to your HRA; BNSF funds the entire amount. The amounts contributed to your HRA by BNSF are not taxable to you as income, nor are any distributions taxable to you provided you use them for qualified medical expenses.

- On the first day of the calendar year, BNSF will contribute $350 to your individual HRA for you or $700 if you cover any family members on your medical coverage election. You will receive a new contribution each year.

- You can use your HRA to reimburse eligible medical expenses incurred by you, your spouse, or your tax dependents (i.e. claimed as a dependent on your federal income tax return during the relevant period). Eligible expenses include:

    - Expenses that were applied to your annual deductible;
    - Copays for office visits or prescription drugs;
    - Coinsurance amounts;
    - Qualified over-the-counter medications that treat an illness or injury (i.e., not for general health); or
    - Transportation services necessary to receive medical care.

- If you do not spend your entire HRA account during the year unused amounts in your HRA are carried over from year-to-year.

- The HRA is administered by *Your Spending Account* (YSA) which means you may pay for eligible HRA expenses with the YSA debit card.

Qualified Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, as described on page 3, the HRA account will be adjusted as follows:

Mid-Year Change in Coverage Category

- If you move from the single coverage category to any of the other three coverage categories your HRA amount will be increased by the incremental difference between the single HRA amount ($350) and the family HRA amount ($700). The balance going forward will be the original $350, less reimbursements, plus the additional $350.

- If you move from family coverage to single coverage your HRA amount will be reduced to $350 and the balance will be $350 less previous reimbursements.

    Example: A participant exhausted the $700 family HRA amount prior to a qualified status change. As a result of the change, their coverage category changed to "You Only". The participant had already used their $350 allotment for the year, so theibalance will be adjusted to $0.00. (Note: BNSF will not attempt to recoup the difference of $350.)

Example: A participant had family coverage and had received reimbursements of $250 from the HRA. As a result of a qualified status change, their coverage category changed to "You Only". The HRA allotment will be reduced to $350 and the balance in the HRA will be $100. ($350 allotment - $250 already reimbursed)

Example: A participant had "You Only" coverage and had received reimbursements of $250 from the HRA. As a result of a qualified status change, their coverage category changed to "You + Family". The HRA allotment will be increased to $700. The balance in the HRA will be $450. ($700 allotment - $250 already reimbursed)

Divorce or Legal Separation

In the case of divorce or legal separation, your HRA balance will stay with your account. Your spouse will have a COBRA enrollment opportunity, and if your ex-spouse enrolls in COBRA coverage in either the CIGNA Network or BCBS PPO option, he or she will receive an HRA allotment at the time of enrollment.

Example: A participant has family coverage ($700 HRA). The participant gets divorced on July 1st. At that time, the participant had used $250 of the HRA. Due to the divorce, the participant now has single coverage.

The participant's HRA allotment will be adjusted from $700 to $350 due to the coverage change. The remaining HRA balance is $100. If the spouse enrolls in COBRA coverage, the spouse will receive their own HRA balance. The amount will be $350 or $700 depending upon the coverage category.

Example: A participant has family coverage ($700 HRA). The participant gets divorced on July 1st. At that time, the participant had used $500 of the HRA. Due to the divorce, the participant now has single coverage.

The participant's HRA allotment will be adjusted from $700 to $350 due to the coverage change. The remaining HRA balance is $0. If the spouse enrolls in COBRA coverage, the spouse will receive their own HRA balance. The amount will be $350 or $700 depending upon the coverage category.

Medicare Age Attainment

Medicare-eligible retirees and their dependents are not eligible for the HRA, so when you or your spouse turns 65 your HRA is affected. When you turn 65, you, your spouse and any dependents will cease being eligible for the Pre-65 Retiree Medical Program and your HRA balance will be forfeited.

If your spouse turns 65 before you and you have no dependents, your HRA allotment will be adjusted to $350, less any amounts already reimbursed.

Example: You had family coverage with a HRA amount of $700 and $250 had been used when your spouse turned 65. Only you remain eligible for the HRA, and the balance is $100 ($350 allotment - $250 already reimbursed).

Death

If you die while covered under the Santa Fe Pre-65 Retiree Medical Program, your balance will be forfeited. However, if your dependents continue coverage, your dependents will be given a new HRA allotment upon enrollment.

Eligible Expenses

You may use your HRA for reimbursement of health care expenses that are not paid by your medical or dental coverage or that are not eligible for reimbursement through some other source. Expenses eligible for reimbursement from your HRA can include the following (for a more complete list see the YSA Web site at www.byr.com/benefits):

- Medical, dental, or vision deductibles.

- Medical, dental, or vision copayments.

- Medical, dental, and vision expenses not reimbursed through coordination of benefits with a second ary payer.

- Vision care, including examinations, eyeglasses and contact lenses.

- Hearing care, including examinations and hearing aids.

- Dental care, including orthodontia expenses and dentures, but excluding cosmetic dental procedures.

- Emergency room visits.

- Expenses for operations or treatments, including obstetrical expenses, legal abortion, legal vasectomy, therapy, or x-ray treatment.

- Expenses that exceed Medical or Dental Program maximums.

- Routine checkups or visits to a doctor or clinic not covered by your medical or dental coverage.

- Out -of-pocket costs for prescription drugs, insulin and Laetrile, but only if Laetrile is prescribed by a doctor and purchased and used in a location where its sale and use are legal.

- Non -prescription drugs used for medical care.

- Outpatient mental health care.

- Charges for psychologists, chiropractors and physical therapy for medical care.

- Expenses for care in an institution other than a hospital, including the cost of meals and lodging, when confinement is medically necessary.

- Tuition fees for a special school for physically or mentally handicapped children, if the main reason for using the school is that it has resources for relieving the handicap.

- Tuition fees for a special school, such as one that teaches Braille or lip reading, that helps your dependent compensate for or overcome a physical handicap and prepares him or her for attendance at a regular school or for daily life.

- Tutoring fees for handicapped children provided the teacher is qualified to work with children who have severe learning disabilities.

- Charges for medical care included in the tuition fee of a college or private school.

• Educational devices for the blind.

• Charges for Braille reading material to the extent it is more expensive than non-Braille literature.

• Guide dogs for the blind or deaf, including training charges.

• Installation and repairs of special telephone and television equipment for the deaf.

• Installation and operating costs of special equipment in a car used by a physically handicapped person.

• Smoking cessation or weight loss programs prescribed by a physician.

• Treatment of obesity.

• Durable medical equipment, including wheelchairs, crutches and inclinators.

• Artificial limbs.

• Portable air conditioners purchased only for the use of a sick person.

• Fluoride treatment of your home's water if treatment is recommended by a dentist.

• Transportation costs directly related to and primarily for receiving medical care, including parking and mileage. Mileage is reimbursed at the current IRS mileage rate for medical expenses.

• Lasik Surgery.

• Other expenses that are considered allowable expenses for medical care under Internal Revenue Code Section 213(d), or as published by the Internal Revenue Service.

Excluded Expenses

The following expenses are not eligible for reimbursement from your HRA:

• Your contributions for medical and dental coverage under the BNSF Cafeteria Plan.

• Premium contributions for other health care plans, Life and Accidental Death and Dismemberment Insurance, and automobile insurance whether BNSF plans or the plans of another employer.

• Non-prescription drugs used for general health purposes.

• Marriage or family counseling.

• Household help prescribed by a physician.

• The salary of a licensed practical nurse (L.P.N.) who cares for a normal, healthy newborn child.

• Dancing, swimming and other types of lessons prescribed by a physician for the general improvement of health.

• Membership fees and other costs for smoking cessation or weight loss programs when the programs are for purposes of general health and well-being.

• Health club programs, including resort hotels, health clubs, gyms or steam baths.

• Custodial care while confined.

• Remedial reading classes for non-handicapped children.

• Meals and lodging while you are away from home for medical treatment that is not provided at a medical facility or for the relief of a specific condition, even if the trip is made on the advice of a doctor.

• Cosmetic surgery or procedures (including cosmetic dental procedures) as defined under Internal Revenue Code Section 213(d).

• Illegal operations, treatments or drugs.

• Funeral or burial expenses.

• Toiletries and cosmetics.

• Vitamins for general health purposes.

• Bottled water.

• Maternity clothes and uniforms.

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

• Expenses incurred prior to the date of your enrollment in the Health Reimbursement Account.

In addition, you will not be reimbursed for any expenses that are covered for you or your eligible Dependents under the provisions of any health care plan or insurance policy or that are reimbursed through any other source.

Claims Procedures

There are two ways to access funds in your Health Reimbursement Account. One is by using the YSA Debit Card and the other is to pay for eligible expenses through other means and file a claim for reimbursement.

- **YSA Debit Card**
  If you are eligible for the HRA, you will be issued a YSA MasterCard that you can use to pay for eligible expenses rather than paying out-of-pocket and submitting a claim for reimbursement. You will be sent one debit card, but you can request additional cards for your spouse and eligible dependents by calling YSA.

  You can use the YSA card at providers such as doctor offices, pharmacies, hospitals, and dentist offices as long as the provider is set up to process debit transactions. The YSA card allows the provider to be paid for services immediately. YSA card transactions are validated electronically at the time of the service or via paper documentation afterward. ***You should retain receipts for all transactions in case they are required for "substantiation" (documentation of the claim).*** If receipts are required, you will receive an email containing instructions and a link to YSA for printing

of a cover sheet to include with the documentation. It is important that you follow the instructions so that your receipts can be matched to your claim. If YSA does not have your email address, you will receive a letter containing instructions.

If the Claims Administrator determines that you have used the YSA card for an ineligible expense, or you do not provide the required documentation when requested, your account will be considered in "overpayment" status and your YSA card will be suspended until the overpayment is recovered or appropriate documentation is received.

Further details about the YSA card can found online at www.ybr.com/benefits by clicking on Your Spending Account on the left hand side.

- **Non Debit Card Claims Reimbursement**
  If you choose not to use the YSA card to pay for eligible expenses, you can file a manual claim for reimbursement. You can be reimbursed for eligible expenses as they are incurred, up to the maximum amount in your HRA. To file a reimbursement claim, you can access the web site for Your Spending Account, complete an online claim form, print the form, then fax or mail to YSA along with your receipts. Alternatively, you can download a claim form from the Forms and Enrollment Folder on the Benefits page of the BNSF web site and fax or mail to YSA.

If Your Claim is Denied

An appeal for a denied HRA claim should be addressed to:

Your Spending Account
Benefit Determination Review Team
P.O. Box 1444
Lincolnshire, IL 60069

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 Pre-65 Retiree Medical Program option you enrolled in. (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 Medical Program for active salaried employees will count toward the lifetime maximum under the Program option you elect.
- The beginning of the month in which you reach age 65. When you reach age 65, you are eligible for Post-65 Retiree Medical Program coverage. Contact YBR to enroll in the Post-65 Retiree Medical Program. Your spouse and dependents will be enrolled in the same Post-65 Retiree Medical Program option in which you are enrolled. However, if you enroll in the Post-65 Indemnity option and elect coverage for dependents, your dependents under age 65 will be enrolled in the CIGNA PPO option.
- For a dependent child or spouse, the date the child or spouse no longer meets the Pre-65 Retiree Medical Program's eligibility for dependent coverage. (Dependent eligibility is described on page 3 of the SPD.)

Continuation of Coverage Under COBRA

(Consolidated Omnibus Budget Reconciliation Act of 1985 as Amended)

This section contains important information about your covered dependent's right to COBRA continuation coverage, which is a temporary extension of coverage under the Pre-65 Retiree Medical Program. The information that follows generally explains COBRA continuation coverage, when it may become available to your family, and what you need to do to protect the right to receive it. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA").

What is COBRA Continuation Coverage?

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

Eligibility

Your covered dependents will become eligible for COBRA continuation coverage after any of the following qualifying events result in the loss of Pre-65 Retiree Medical Program coverage:

• If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Pre-65 Retiree Medical Program because you and your spouse are legally separated or divorced resulting in loss of coverage under the Pre-65 Retiree Medical Program.

• Your dependent children will become qualified beneficiaries if they lose coverage under the Pre-65 Retiree Medical Program because 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.

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Notification

The Pre-65 Retiree Medical Program will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator, Your Benefits Resources (YBR), has been notified that a qualifying event has occurred. If a qualifying event other than divorce, legal separation, loss of dependent status or entitlement to Medicare occurs, your employer will notify YBR of the qualifying event. YBR 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.

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

• The date of such event; or

• The date your eligible dependent would lose coverage on account of such event.

YBR 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.

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

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

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

Duration

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

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• 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; or

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

If You Have Questions

Questions concerning the Pre-65 Retiree Medical Program or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Pre-65 Retiree Medical Program Informed of Address Changes

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

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

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, the CIGNA Network option or an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. If the primary plan is a closed panel plan (the CIGNA Network option is such a plan) and the secondary plan is not a closed panel plan (that is, an indemnity plan), the secondary plan shall pay or provide benefits as if it were primary when a covered person uses a non-network provider (that is self-refers outside the CIGNA Network), except for emergency services or authorized CIGNA Network Primary Care Physician referrals that are paid or provided by the primary plan. 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 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 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 a disability, the Pre-65 Retiree Medical Program will coordinate with Medicare for their coverage regardless of which Program coverage option you have chosen. (Special rules apply to HMOs. See page 83 of this Summary for those rules.)

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 when first eligible.

Pre-65 Retiree HMO Coverage Option

If you are under age 65 and live in an area where an HMO is offered, you may elect to enroll in a traditional HMO option. If you are under age 65 and your spouse is age 65 or over, your spouse will be enrolled in a Medicare+Choice HMO if you elected HMO coverage. However, if there is no Medicare+Choice coverage available for your spouse through the HMO you elected, you will need to elect one of the other Pre-65 Retiree Medical Program options if you wish to elect spousal coverage. This is because both you and your spouse must be covered under the same Pre-65 Retiree Medical Program option.

Pre-65 Retiree Medical Program HMO information is available from YBR. HMOs offer a network of doctors and other medical care providers and HMO benefits include prescription drug card and mental health/substance abuse benefits. Usually, there are no claim forms to file. Your HMO primary physician or referral health care provider takes care of most paperwork for you. If you enroll in an HMO, you will receive an HMO membership booklet explaining benefits in full.

If you turn 65 while covered under an HMO option that offers BNSF sponsored Medicare+Choice, you will be enrolled in the BNSF sponsored HMO's Medicare+Choice product automatically. You will be mailed the BNSF sponsored Medicare+Choice HMO materials automatically three months prior to your 65th birthday. If there is no BNSF sponsored Medicare+Choice HMO available in your area, you need to contact YBR to arrange a transfer to the Post-65 Retiree Indemnity Medical Program, effective the first day of the month in which you attain age 65.

If you are enrolled in this Pre-65 Retiree Medical Program option when you turn age 65, you will receive information on both the Post-65 Indemnity Medical Program and the BNSF sponsored Medicare+Choice HMOs (if a Medicare+Choice HMO is available in your area). If you elect the BNSF sponsored Medicare+Choice HMO coverage and your spouse is age 65, your spouse must be covered under the same HMO option. If you have dependent children who are covered, they will be enrolled in a standard HMO offered by the same HMO that provides the Medicare+Choice option. **Remember, your spouse and all of your dependents must be enrolled in the same Pre-65 Retiree Medical Program option you choose.**

Cost of Pre-65 Retiree Coverage

BNSF shares the cost of medical coverage with you. If you retired after 1997, your portion of the cost is based on a "point scale". Points are determined by adding your age at retirement, plus your years of BNSF service in excess of 20 (or service after age 40 if you commenced employment prior to age 20). Points are grouped into three ranges:

- 70 or more points;
- 65 to 69 points; and
- Less than 65 points.

Retiree's share of the cost of coverage varies by range with the retiree's share being the least for those with 70 or more points and the most for those with less than 60 points.

The following examples illustrate how the point scale applies.

Example 1. If you retired at age 63 with 25 years of service, you would have 88 points minus 20, for a total of 68 points. You will pay more than someone with 70 points, but less than someone with 64 points.

Example 2. If you retired at age 58 with 19 years of service, you would have 57 points (77 minus 20). Your cost for coverage will be more than the other groups.

BNSF reserves the right to change the rates you are required to contribute for Pre-65 Retiree Medical Program coverage, depending on the overall experience of the Pre-65 Retiree Medical Program. You will be notified of any changes prior to their effective date.

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 86 - 91 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 the BNSF Pre-65 Retiree Medical Program terms and to make both initial claim determinations and final claim review decisions on ERISA appeals to the Claims Administrator for the various program options. 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 Retiree 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 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

BCBS PPO

No 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:

• Retiree'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.

CIGNA Network

No claim forms are necessary when you or a dependent uses a CIGNA Network provider in the region in which you live. However, at the start of each calendar year, the Claims Administrator may ask you to complete a claim form to update personal data.

Certain services require prior authorization in order to be covered. You or your authorized representative (typically, your health care provider) must request the medical necessity determination.

CIGNA PPO

No claim forms are necessary when you or a dependent uses a CIGNA 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 CIGNA 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:

- Retiree's name and Social Security number;
- 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.

Timeframe for Deciding Initial Benefit Claims (Including Medical Necessity Determinations)

Pre-Service Claims --The Claims Administrator will notify you or your representative of the determination within 15 days after receipt of the claim (or request). 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 claim, 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. Or, when services or benefits are determined to be not medically necessary you or your representative will receive a written description of the adverse determination. 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 or notice of an adverse benefit determination 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 Claims Administrator used or relied on internal guidelines, protocols, or other criteria, the letter will specify the criterion; and a copy of such rule, guideline, protocol or other criteria, and reasonable access to relevant documents, records and other information relevant to the Claim will be provided free of charge on request.

If your Primary Care Physician denies or limits a treatment or benefit under the **CIGNA Network** option, or if the Primary Care Physician denies a request for a referral for medical services or supplies, or to a medical specialist, you can consider your claim denied under the CIGNA Network option. Likewise, if a CIGNA Network provider other than the Primary Care Physician denies a request for services covered under the CIGNA Network option, whether the denial is for full or partial services, you can consider your claim denied under the CIGNA Network option.

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 have elected one of the **BCBS PPO** option and are appealing a denial of a mental illness or substance abuse benefit under the Program, there are special procedures. You will find those procedures in the Mental Health and Substance Abuse section of this SPD that relates to BCBS PPO Program Benefits. See page 27.*

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

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

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

- **For BCBS Program Options:**

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

- **For CIGNA Network Program Option:**

Your request for an appeal should be addressed to the address listed on your Benefit Identification card, explanation of benefits, or claim form.

- **For CIGNA PPO Program Option:**

  CIGNA Healthcare
  Claims Office
  P.O. Box 2546
  Sherman, Texas 75091-2546

¾ Special Rules for Mental Health and Substance Abuse Claims under the CIGNA Network AND CIGNA PPO Program options:
If there is a denial of mental health or substance abuse benefits under the CIGNA Network or CIGNA PPO option, you should address your request for an appeal to the following:

  CIGNA Behavioral Care
  11095 Viking Drive, Suite 350
  Eden Prairie, Minnesota 55344

If you have an urgent or emergency appeal, call CIGNA Behavioral Care at 1-800-283-6226

Outpatient Prescription Drug Benefit Claims
Caremark, Inc. is the Claims administrator for the Outpatient Prescription Drug Benefit. If there is a denial of an outpatient prescription drug benefit, you should address your request for an appeal to the following:

  Caremark, Inc.
  2211 Sanders Road
  Northbrook, Illinois 60062

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 100 of this SPD.

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 the Claims Administrator (BCBS or CIGNA, depending on the program option you elect) will not interfere with your relationship with any health care provider.

The Claims Administrator does not furnish health care services. The Claims Administrator 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. The Claims Administrator 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 the Claims Administrator. Any contractual relationship between the Claims Administrator 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 your Employer 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 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 Santa Fe Pacific 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, 2500 Lou Menk Drive, Fort Worth, Texas 76131, (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 all Pre-65 Retiree Medical Program options, except the HMO option, are self-insured by BNSF. Benefits under the HMO option are insured by the relevant HMO. Please review your HMO materials for additional details.

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.

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 BNSF Railway Company
2500 Lou Menk Drive
Fort Worth, Texas 76131
800-234-1283

The agent for service of legal process is:

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

The Burlington Northern Santa Fe Employee Benefits Committee (the "Committee") is the Program Administrator. The Named Fiduciary under the Program option you chose is listed on page 97 of this SPD. The Program Administrator has delegated the discretionary authority to interpret Program provisions relating to the payment of benefits to Claims Administrator for the Program option you elect 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

BCBS PPO Base and PPO Plus Options (including out-of-network claims)

Blue Cross and Blue Shield of Illinois
Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690
Phone: 1-888-399-5945

Claims Administrator and Claim Appeal Coordinator for Mental Health and Substance Abuse Benefits:

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

CIGNA Network Option

CIGNA HealthCare
Please see the reverse side of your CIGNA Network Identification card for the location address.
Phone: 1-800-244-6224

Claims Administrator and Claim Appeal Coordinator for Mental Health and Substance Abuse Benefits:

CIGNA Behavioral Care
11095 Viking Drive, Suite 350
Eden Prairie, Minnesota 55344
Phone: 1-800-291-6012

CIGNA PPO Option (including out-of-network claims)

CIGNA Health Care
P.O. Box 2546
Sherman, TX 75091-2546
Phone: 1-800-244-6224

Claims Administrator and Claim Appeal Coordinator for Mental Health and Substance Abuse Benefits:

CIGNA Behavioral Care
11095 Viking Drive, Suite 350
Eden Prairie, Minnesota 55344
Phone: 1-800-291-6012

Outpatient Prescription Drug Benefit

Caremark, Inc.
2211 Sanders Road
Northbrook, IL 60062

Named Fiduciary

Blue Cross and Blue Shield is the Named Fiduciary under ERISA for all ERISA appeals regarding Blue Cross and Blue Shield PPO Option Program benefit matters.

CIGNA is the Named Fiduciary under ERISA for all ERISA appeals regarding CIGNA Network and CIGNA PPO Option Program benefit matters.

The BNSF Employee Benefits Committee retains the discretionary authority to determine eligibility and enrollment rights under the Program.

COBRA Administrator

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

Program Year

The Program Year is the calendar year.

Special Arrangements

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.

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 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 Employee Benefits Security Administration.

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

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

Continue Medical Program Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the 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 86) 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The next page lists the EBSA area offices.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Who to Call About Your Benefits

For questions regarding the enrollment process or your Pre-65 Retiree benefits, call YBR Customer Care Representatives at 1-877-847-2436.

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

For questions regarding the services under the CIGNA Network option, call Member Services at 1-800-244-6224.

For questions regarding the services under the CIGNA PPO option, call Member Services at 1-800-244-6224.

For questions regarding your prescription benefits call Caremark at 1-800-378-7559.

This SPD is only a summary of the BNSF Pre -65 Retiree Medical Program options for Santa Fe Pacific Pre-65 Retirees. 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.