

**Railroad Employees
National Early Retirement
Major Medical Benefit Plan
GA-46000**



As Amended Through August 1, 2016

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I

Important Notice to Eligible Retirees

This booklet, dated August 1, 2016, describes the Benefits provided for U.S. residents under The Railroad Employees National Early Retirement Major Medical Benefit Plan ("Plan"). The Plan's Benefits are a Major Medical Benefit and a Managed Pharmacy Services Benefit. These Benefits are not insured. They are payable directly by the Plan.

UnitedHealthcare administers the Major Medical Benefit. Express Scripts administers the Managed Pharmacy Services Benefit.

You will notice that some of the terms used in your booklet are in bold print. These terms have special meanings under the Plan that are set forth in the "Definitions" section of this booklet.

COVERAGE REGISTRATION

As soon as possible following your retirement, complete the Retiree and Dependent Information Form found in the center of this booklet and mail it to the address indicated. If you are an **Eligible Retiree**, this will establish an official record of your eligibility for coverage under the Plan, and UnitedHealthcare will mail you an Identification Card.

NOTICE TO ALL PLAN PARTICIPANTS:

If a member or health care provider receives a payment from the Plan based on fraud or intentional misstatement, the Plan has the right to apply procedures as designed by the company administering benefits under the Plan to address instances of fraud or intentional misstatement. If a company administering benefits under the Plan decides to seek recoupment of a benefit payment made based on a member's fraud or intentional misstatement, the affected member will receive advance notice of at least

thirty (30) days. The affected member has the right to seek a review of a recoupment determination in accordance with the appeal procedures established by the relevant company administering benefits under the Plan and any appeal rights as may be set forth under ERISA.

* * * *

The Plan is intended to comply with the Health Insurance Portability and Accountability Act (HIPAA) privacy and security provisions. The Plan has a policy and procedures in place that comply with these provisions. You will receive a Notice of Privacy Practices from the Plan in accordance with the requirements of HIPAA. You will be notified of the availability of the Notice and how to get a copy every three years. If you need more information about your privacy and security rights or if you lose your copy of your Notice and would like another copy, please contact UnitedHealthcare at 1-800-842-5252. An electronic version of the Notice is also available at www.yourtracktohealth.com.

II Highlights

Here is a brief outline of the Benefits for U.S. residents provided by your Plan. A more elaborate summary of the Plan provisions, including limitations, exclusions and other details, appears in the body of this booklet.

MAJOR MEDICAL BENEFIT

Maximum Benefit per Lifetime	\$151,600, except that for Covered Health Services received prior to January 1, 2016, the Maximum Lifetime Benefit is \$145,800. The current \$151,600 maximum will be adjusted annually to reflect the increase, if any, in the medical cost components of the Consumer Price Index.
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Deductible per Individual per Calendar Year	\$100
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Eligible Expenses Payable After Deductible is Satisfied	80%*
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* 65% for **Mental Health Care** while not confined as an in-patient in a **Hospital** or for counseling services in connection with a terminal illness.

These Benefits may be reduced if applicable Care Coordination procedures are not followed. See pages 21 through 23.

MANAGED PHARMACY SERVICES BENEFIT

PRESCRIPTION DRUG CARD PROGRAM (supply of 21 days or less)

In-Network Pharmacy

Co-payment per Generic Drug Prescription	\$2
Co-payment per Brand Name Drug Prescription Ordered by your Physician to be “Dispensed as Written” or Where There is no Equivalent Generic Drug	\$6
Co-payment per Brand Name Drug Prescription Where There is a Generic Equivalent and Brand Name Was Not Ordered by your Physician to be “Dispensed As Written”	\$6 plus the difference in cost between the equivalent Generic Drug and the Brand Name Drug dispensed
Eligible Expenses Payable After Co-payment is Satisfied	100%
Out-of-Network Pharmacy	
Eligible Expenses Payable	75%

NOTE: If you buy a supply of Prescription Drugs for a period in excess of 21 days at an In-Network or Out-of-Network Pharmacy, you will receive no Benefits under the Plan.

HOME DELIVERY PRESCRIPTION DRUG PROGRAM (supply of 22 to 90 days)

Co-payment per Prescription	\$5
Eligible Expenses Payable After Co-payment is Satisfied	100%

III

Eligibility and Coverage

WHO IS ELIGIBLE FOR COVERAGE

Eligible Retirees

You are an **Eligible Retiree** and therefore eligible for coverage if you:

- were employed by a participating employer,
- were represented by a participating railway labor organization, and
- are either an **Age Annuitant** or a **Disabled Person** as defined below.

These requirements are very important. Read them with care. If you are uncertain of whether you meet them, call UnitedHealthcare's toll-free telephone number, 1-800-842-5252.

Eligible Retirees of hospital association railroads, who must look to their hospital association for their health care benefits, have Benefits under this Plan only for their Dependents.

Age Annuitant

You are an **Age Annuitant** if you have applied for a "60/30" annuity under the Railroad Retirement Act of 1974, as amended, and you meet both the following requirements:

- You applied for the annuity either on or after the date you reached age 60 or during the three months before your 60th birthday if you continued working into, or received vacation pay during, the month prior to the month in which your 60th birthday occurred, and

- You were covered for employee and dependents health benefits, or only for dependents health benefits, under The Railroad Employees National Health and Welfare Plan or The National Railway Carriers and United Transportation Union Health and Welfare Plan (or under any other group health plan or arrangement designated for this purpose by the National Carriers' Conference Committee), other than by reason of **COBRA**, on the day immediately before the date you applied for the annuity.

Disabled Person

You are a **Disabled Person** if you meet all of the following requirements:

- You had a current connection with the railroad industry on the date immediately before the earliest date on which a disability annuity for you under the Railroad Retirement Act of 1974, as amended, could have first become effective if you had applied for one.
- You have applied for a disability annuity to which you are entitled under the Railroad Retirement Act of 1974, as amended. If you have not applied for the disability annuity, you will nonetheless be considered to have met this requirement if:
 - You are receiving sickness benefits under the Railroad Unemployment Insurance Act. However, when these sickness benefits end, application for the annuity must be made in order for you to continue to be included as a **Disabled Person** under this Plan. Application must be made for the annuity within 60 days after the end of the last registration period in which you receive the sickness benefits, or
 - You are receiving a "60/30" annuity under the Railroad Retirement Act of 1974, as amended.
- You were covered for employee and dependents health benefits, or only for employee health benefits, under The Railroad Employees National Health and Welfare

Plan or The National Railway Carriers and United Transportation Union Health and Welfare Plan (or under any other group health plan or arrangement designated for this purpose by the National Carriers' Conference Committee), other than by reason of **COBRA**, on the day immediately before the latest of the following dates:

- The date you reached age 60.
- The date you became disabled to the extent that the disability is the only reason you are unable to work in your regular occupation or in any regular employment.
- The date your railroad service plus your current period of disability equals 30 years.

If you were employed by a hospital association railroad and had to look to the hospital association for your health care benefits while you were in active service, you were not covered for employee health benefits under The Railroad Employees National Health and Welfare Plan or The National Railway Carriers and United Transportation Union Health and Welfare Plan. Even so, for the purpose of determining whether you qualify as a **Disabled Person**, you will be considered as having the same coverage for employee health benefits under The Railroad Employees National Health and Welfare Plan or The National Railway Carriers and United Transportation Union Health and Welfare Plan that you would have had had you been employed by a non-hospital association railroad when you ceased work.

Eligible Dependents

Your **Eligible Dependents** are:

- Your spouse.
- Your unmarried children under 19.
- Your unmarried children between 19 and 25 who:

- are registered students in regular full-time attendance at school, and
- are dependent for care and support mainly upon you and wholly, in the aggregate, upon themselves, you, your spouse, and scholarships and the like, and
- have their legal residence with you.
- Your unmarried children 19 or over who:
 - are dependent for care and support mainly upon you and wholly, in the aggregate, upon you, your spouse, and governmental disability benefits and the like, and
 - have a permanent physical or mental condition that began prior to age 19, and
 - are unable to engage in any regular employment, and
 - have their legal residence with you.
- Your children who are Alternate Recipients under a **Qualified Medical Child Support Order**.

Children include:

- natural children,
- stepchildren,
- adopted children (including children placed with you for adoption), and
- other children related to you by blood or marriage, provided the children have their legal residence with you and are dependent for care and support mainly upon you and wholly, in the aggregate, upon themselves, you, your spouse, scholarships and the like, and governmental disability benefits and the like.

WHEN COVERAGE STARTS

You and your **Eligible Dependents** will be covered under the Plan on the date you qualify as an **Age Annuitant** or **Disabled Person**, except:

- You will not be covered if a hospital association has made a commitment to the railroad by which you were employed to provide you with benefits similar to those under the Plan.
- You will not be covered while you are eligible for employee health benefits under The Railroad Employees National Health and Welfare Plan or The National Railway Carriers and United Transportation Union Health and Welfare Plan (or under any other group health plan or arrangement designated for this purpose by the National Carriers' Conference Committee).
- An **Eligible Dependent** of yours will not be covered while you are eligible for dependent health benefits under The Railroad Employees National Health and Welfare Plan or The National Railway Carriers and United Transportation Union Health and Welfare Plan (or under any other group health plan or arrangement designated for this purpose by the National Carriers' Conference Committee).

WHEN COVERAGE STOPS

Your coverage ends on the earliest of the following:

- the date you become a **Person Eligible Under Medicare**;
- the date your Railroad Retirement Annuity terminates;
- the date the railroad by which you were employed ceases participation in the Plan with respect to the class in which you were included while active; or
- the date the railroad by which you were employed ceases participation in the Plan due to failure to make the required contributions or for any other reason.

All coverage ends for your **Eligible Dependents** on the earliest of the following:

- the date you become a **Person Eligible Under Medicare** due to age, or the date you would have become eligible due to age if you should die or become disabled before such date;
- the date your Railroad Retirement Annuity terminates for any reason except your death;
- the date the railroad by which you were employed ceases participation in the Plan with respect to the class in which you were included while active; or
- the date the railroad by which you were employed ceases participation in the Plan due to failure to make the required contributions or for any other reason.

Coverage for an individual dependent stops sooner upon the occurrence of one of the following events:

- the dependent becomes a **Person Eligible Under Medicare**;
- a dependent stops being an **Eligible Dependent**; or

- when a surviving spouse remarries.

Benefits After Coverage Ends

If coverage for you or your **Eligible Dependent** ends and that person is disabled on the date coverage ends, the Plan's benefits will continue to be payable subject to the following conditions:

- Benefits are payable only for **Eligible Expenses** incurred with respect to
 - your or your **Eligible Dependent's** injury or sickness causing the disability, or
 - your or your dependent wife's pregnancy causing the disability.
- The disability must be continuous from the date coverage ends to the date each expense is incurred.
- Benefits are payable for expenses incurred in the calendar year in which coverage ends and for expenses incurred during the next calendar year.
- Benefits are not payable for any expenses that are payable under any other group insurance policy or group plan.
- Benefits are not payable on account of expenses incurred by any person on or after the date he/she becomes a **Person Eligible Under Medicare**.

Dependent Spouses Covered as Employees Under a Hospital Association Plan

Benefits under this Plan are limited with respect to spouses who are covered under this Plan as **Eligible Dependents**, and who are also early retirees who must look to a hospital association for early retiree health care benefits. Benefits under this Plan will be payable for such a spouse only

- for any covered injury or sickness, subject to the following conditions:
 - benefits under this Plan are payable only to the extent that they exceed the benefits under the hospital association plan; and if the hospital association plan benefits are decreased or eliminated, this determination will be made as if no such decrease in or elimination of the hospital association plan benefits had been made;
 - he or she is a member of the hospital association plan; and
 - non-hospital association facilities or services are not used when it is possible to use hospital association facilities or services.

If a spouse who is an **Eligible Dependent** is also an employee eligible for coverage under The Railroad Employees National Health and Welfare Plan or the National Railway Carriers and United Transportation Union Health and Welfare Plan who must look to a hospital association for employee health care benefits, benefits will be payable under this Plan with respect to such spouse only to the extent that the **Eligible Expenses** for which such benefits are payable exceed the benefits under the hospital association plan.

The following conditions apply:

- the dependent spouse must be a member of the hospital association plan.
- non-hospital association facilities or services must not be used when it is possible to use hospital association facilities or services.
- if any hospital association plan benefits are decreased or eliminated, benefits under this Plan, if any, will be determined as if there had been no decrease in or elimination of benefits under the hospital association plan.

Dependents Covered Under Another Railroad Health and Welfare Plan

If benefits are payable under **Another Railroad Health and Welfare Plan** for a person who is a dependent not only of an employee or retiree covered by that plan but also of an **Eligible Retiree** covered by this Plan, and that dependent is covered under this Plan as an **Eligible Dependent**, Dependents Health Care Benefits will be payable under this Plan only

- if the **Eligible Retiree** covered under this Plan has a birthday earlier in the calendar year than the employee or retiree covered by the other Plan, and
- in all other cases, only to the extent that payments under both Plans do not exceed the benefits that would have been paid under this Plan alone.

OPTIONAL CONTINUATION COVERAGE UNDER COBRA

This part of your booklet contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **The material in this section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your Plan coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their Plan coverage. What follows is only a summary of your COBRA continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact UnitedHealthcare toll free at 1-800-842-5252.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your former employer, and that bankruptcy results in your loss of coverage as a retired employee under the Plan, you will become a qualified beneficiary with respect to the bankruptcy. Your spouse and dependent children will also become qualified beneficiaries if bankruptcy of your former

employer results in the loss of their coverage under the Plan

If you are the spouse of an **Eligible Retiree**, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-retiree dies;
- The parent-retiree becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after UnitedHealthcare has been notified that a qualifying event has occurred. When the qualifying event is the death of the employee, commencement of a proceeding in bankruptcy with respect to your former employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify UnitedHealthcare of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify UnitedHealthcare within 60 days after the qualifying event occurs. The notice must be in writing and must be sent to:

Railroad Enrollment Services
Railroad Administration (COBRA)
P.O. Box 30791
Salt Lake City, UT 84130-0791

How is COBRA Coverage Provided?

Once UnitedHealthcare 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. Covered retirees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of the coverage you lost as a result of the qualifying event. When the qualifying event is the death of the employee, the employee's becoming entitled 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 You Have Questions

Questions about your Plan 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 Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep UnitedHealthcare 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 UnitedHealthcare.

Contact Information

Information about the Plan and COBRA continuation coverage can be obtained on request by calling UnitedHealthcare toll free at 1-800-842-5252 or by writing Railroad Enrollment Services, Railroad Administration (COBRA), P.O. Box 30791, Salt Lake City, UT 84130-0791.

IV

Major Medical Benefit

The Major Medical Benefit pays a percentage of **Eligible Expenses** (in excess of the deductible) for **Covered Health Services**. These **Expenses** must be incurred by you or your **Eligible Dependent** while covered by the Plan. The general rules that apply in determining whether or not an expense is an **Eligible Expense** for a **Covered Health Service** are explained at pages 25 through 26 of this booklet.

To receive the highest benefit level, you must comply with Care Coordination requirements (see Care Coordination on pages 21 through 23).

Deductible

The amount of the deductible is \$100. It applies separately to each **Covered Family Member** each calendar year.

Percentage of **Eligible Expenses** Payable

The Major Medical Benefit pays:

- 80% of the **Eligible Expenses**, except
- 65% of **Eligible Expenses** in connection with **Mental Health Care** while not confined as an inpatient in a **Hospital** or for counseling services in connection with a terminal illness.

If a required notice to Care Coordination is not given or if Care Coordination determines that, although the service or supply is a **Covered Health Service**, it is not **Medically Appropriate**, the Major Medical Benefit pays:

- 40% of **Eligible Expenses** in connection with **Mental Health Care** while confined as an inpatient in a **Hospital**, or in connection with **Substance Abuse Care** wherever the service is rendered,

- 33% of **Eligible Expenses** in connection with **Mental Health Care** while not confined as an inpatient in a **Hospital**, or
- 64% of **Eligible Expenses** in connection with any other sickness or injury.

Prescription Drugs Are Not Covered by this Benefit

The Major Medical Benefit does not cover **Prescription Drugs** obtained as part of outpatient care. The Plan does cover those **Prescription Drugs**, however, to the extent stated in the description of the Managed Pharmacy Services Benefit (see pages 39 through 47).

Maximum Benefit

The lifetime Maximum Benefit payable for you or any **Eligible Dependent** for **Covered Health Services** is \$151,600, except that for **Covered Health Services** received prior to January 1, 2016, the lifetime Maximum Benefit is \$145,800. The lifetime Maximum Benefit will be adjusted annually to reflect the increase, if any, in the medical cost components of the Consumer Price Index.

Special Arrangements with Providers

The Plan enjoys arrangements with various health care providers pursuant to which those providers' charges for **Eligible Expenses** are discounted. These discounts are made available to **Covered Family Members** as a result of direct arrangements with the providers through UnitedHealthcare and indirect or supplemental arrangements with providers through the UnitedHealthcare Supplemental Discount Program.

Many of the providers that have such direct arrangements with UnitedHealthcare that are applicable to the **Major Medical Benefit** are called **Preferred Providers**. Providers that have indirect or supplemental arrangements with the UnitedHealthcare Supplemental Discount Program are called UnitedHealthcare Supplemental Discount Program Providers.

If **Preferred Providers** or UnitedHealthcare Supplemental Discount Program Providers are used for services under the **Major Medical Benefit**, the amount of **Eligible Expenses** for which you are responsible will generally be less than if other providers are used. The percentage of **Eligible Expenses** payable remains the same whether or not **Preferred Providers** or UnitedHealthcare Supplemental Discount Program Providers are used. However, because the **Eligible Expenses** may be less when **Preferred Providers** or UnitedHealthcare Supplemental Discount Program Providers are used, the portion that you owe will be less.

You will receive an Identification Card showing that you and your **Eligible Dependents** are entitled to these discounts where available from **Preferred Providers** or UnitedHealthcare Supplemental Discount Program Providers. This Identification Card must be shown every time health care services are given. This is how the provider knows that you or your **Eligible Dependent** is covered under a **Preferred Provider** or UnitedHealthcare Supplemental Discount Program Providers plan. Otherwise, you could be billed for the provider's normal charge.

Call UnitedHealthcare at 1-800-842-5252 to get a directory of **Preferred Providers** or visit their website at www.myuhc.com.

Preferred Providers are responsible for filing your claims directly with UnitedHealthcare. You do not need to submit claims for **Preferred Provider** services or supplies.

You must submit claims for services and supplies rendered by other providers, including UnitedHealthcare Supplemental Discount Program Providers, unless the provider undertakes to do so for you. See pages 76 through 78 of this booklet.

If a **Preferred Provider** bills you for any part of the discount amount, call UnitedHealthcare at 1-800-842-5252 for assistance.

Care Coordination

The Care Coordination program is designed to encourage an efficient system of care for **Covered Family Members** by identifying possible unmet covered health care needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. The Care Coordination activities are not a substitute for the medical judgment of your **Physician**, however, and the ultimate decisions as to what care you actually receive must be made by you and your **Physician**.

Care Coordination is triggered when UnitedHealthcare receives notification of an upcoming treatment or service. The notification process serves as a gateway to Care Coordination activities.

When to Notify Care Coordination

Care Coordination must be notified as soon as possible after you know that you require any of the services or supplies shown below:

- Inpatient admission to a **Hospital, Birth Center** or **Skilled Nursing Facility**.
- Home health care.
- **Hospice** care.
- Durable medical equipment (over \$1,000).
- Reconstructive procedures.
- Dental services rendered as a result of an accident.

With regard to organ/tissue transplants, Care Coordination must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation of a transplant.

- The donor search.
- The organ procurement/tissue harvest.
- The transplant procedure.

For an inpatient confinement which is the result of an **Emergency**, you (or your representative or your **Physician**) must call Care Coordination within one day (excluding weekends and holidays) from the date the confinement begins.

You should notify Care Coordination promptly after you become aware that you are pregnant. You are required to notify Care Coordination, however, only if and when the inpatient care for the mother or child is expected to continue beyond:

- 48 hours following a normal delivery, or
- 96 hours following a Caesarean section.

The notice you give must be given in sufficient time to allow Care Coordination to complete its review before the services are rendered. If Care Coordination does not receive sufficient advance notice, it may not be able to complete its review and determine, before you incur expenses, if the service is a **Covered Health Service** and, if so, if it is **Medically Appropriate**.

Remember: This notice obligation is your responsibility. It is not the responsibility of your Physician, your Hospital or any other provider.

How to Notify Care Coordination

Care Coordination is notified by calling toll-free 1-800-842-4555 Monday through Friday, except for State and Federal holidays. The hours of operation are 8:00 a.m. to 7:00 p.m. local time. However, you can call Care Coordination at any time, day or night. If you call outside the hours of operation, you may leave a message with your telephone number on an answering machine, and

Care Coordination will return your call within one working day.

What Happens After You Give The Required Notice?

Care Coordination reviews the services for which you have given it notice and determines whether they are **Covered Health Services** and, if so, whether they are **Medically Appropriate**.

*The ultimate decision on your medical care must be made by you and your **Physician**. Care Coordination review only determines whether the service or supply is a **Covered Health Service** and, if so, whether it is **Medically Appropriate** for purposes of deciding what, if any, amounts are payable with respect to the service or supply under the Plan.*

Effects on Benefits

- Benefits are reduced if you do not give the required notice or if Care Coordination determines that, although the service or supply is a **Covered Health Service**, it is not **Medically Appropriate**. In either case, the benefit will be reduced to the applicable percentage shown on pages 18 through 19.
- No benefits are payable if Care Coordination determines that the service or supply is not a **Covered Health Service**.

If Care Coordination determines that a service is not a **Covered Health Service**, or that is it not **Medically Appropriate**, you or your **Physician** can appeal that determination. The appeal procedure is described at pages 83 through 92 of this booklet.

Case Management Services

Care Coordination also provides case management services in connection with your Major Medical Benefit. These services focus on severe illnesses and injuries which could result in long-term hospital confinements.

Care Coordination will determine whether the services of case management are appropriate in your case.

Through the case management service, benefits for alternative treatment may be offered to you or your **Eligible Dependent** when such alternative treatment is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and **Physician**.

Disease Management Services

Disease management services focus on providing information about certain chronic medical conditions, such as heart failure, coronary artery disease, diabetes, or asthma, and the ways these conditions can be treated or managed. If you have been diagnosed with a chronic medical condition, UnitedHealthcare may contact you to discuss this program. Or you can call 1-800-842-5685 from 8:00 a.m. until 7:00 p.m., to learn whether you are eligible to participate in a disease management program. The company's working days are Monday through Friday, excluding State and Federal Holidays. Participation is voluntary, and there is no charge to **Covered Family Members** for these services.

Through disease management services, benefits for alternative treatment may be offered to you or your **Eligible Dependent** when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and **Physician**.

Telephonic Access to Nurses and Counselors

This program provides a toll-free telephone service that puts you in immediate contact with a registered nurse any time, 24 hours a day, seven days a week. These nurses can provide health information for routine or urgent health concerns, such as a recent diagnosis, a minor sickness or injury, or other health-related topics. You can also listen to pre-recorded messages on a variety of medical topics. This service is available to **Covered Family Members** at no charge. To use it, you can call 1-866-735-5685.

Through this service, you may learn about benefits for alternative treatment for you or your **Eligible Dependent** when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and **Physician**.

Wellness Programs

These programs provide information on health issues and assist with smoking cessation and achieving and maintaining a healthy weight. These services are available to **Covered Family Members** at no charge. To learn more information about these programs, you can call the Wellness Program at 1-866-735-5685 from 8am to 7pm.

Treatment Decision Support Program

UnitedHealthcare will, at your request and at no cost to you, provide you and your **Eligible Dependents** with access to enhanced one-on-one coaching for services related to potential procedures for conditions such as back pain, knee/hip replacement, benign prostate disease, prostate cancer, benign uterine conditions, hysterectomy, breast cancer, coronary artery disease and bariatric surgery.

ELIGIBLE EXPENSES AND COVERED HEALTH SERVICES

Eligible Expenses are the actual cost to you of the **Reasonable Charges** (defined on page 72) for **Covered Health Services**.

A **Covered Health Service** is a service or supply that meets all of the following criteria:

- It is needed because of sickness, injury or pregnancy.
- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrates that the service or supply has a beneficial effect on health outcomes and is based on trials that meet the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- It is a service or supply that is described under the heading “List of Covered Health Services” on page 27 of this booklet and is not excluded under *General Exclusions and Limitations* (pages 48 through 55).
- It is provided to a **Covered Family Member** while the Plan is in effect and prior to the date that any of the individual termination conditions set forth in this booklet apply to the patient.

A service or supply is not a **Covered Health Service** just because it is furnished or ordered by your provider. The services and supplies you receive will be reviewed by UnitedHealthcare to determine if they are **Covered Health Services**. A determination that a service or supply is not a **Covered Health Service** may apply to the entire service or supply or to any part of the service or supply.

If you have any question as to whether services or supplies ordered or recommended by your health care provider are **Covered Health Services**, you may call for assistance toll-free at 1-800-842-5252.

List of Covered Health Services

Ambulatory Surgical Center Services

Services given within 72 hours before or after a surgical procedure. The services have to be given in connection with the procedure.

Anesthetics

Birth Center Services

Chemotherapy

Durable Medical Equipment

Durable Medical Equipment means equipment that meets all of the following criteria:

- It is for repeated use and is not consumable or disposable.
- It is used primarily for a medical purpose.
- It is appropriate for use in the home.

Some examples of durable medical equipment are:

- Appliances that replace a lost body organ or part or help an impaired one to work.
- Orthotic devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.
- Monitoring devices.

*Care Coordination must be contacted for any purchase or rental costs which exceed \$1,000. Care Coordination will determine whether the purchase or rental of the equipment is **Medically Appropriate**.*

Home Health Care Agency Services

- Part-time or intermittent nursing care rendered by or supervised by a registered nurse.
- Part-time or intermittent care by a home health aide.
- Physical therapy, occupational therapy, and speech therapy each with limits as described below under the headings “Physical Therapy,” “Occupational Therapy,” and “Speech Therapy,” respectively.
- **Prescription Drugs.**
- Medical Supplies.
- X-rays and laboratory tests.

Hospice Care Services

Up to a maximum payment of \$3,000 for each Course of Care for room, board, care and treatment charged by the **Hospice**.

Up to a maximum payment of \$1,000 for each Course of Care for:

- Counseling for the patient and the patient's Immediate Family. Services must be given by a licensed **Social Worker** or a licensed pastoral counselor.
- Bereavement counseling up to 15 visits for the patient's Immediate Family. Services must be given by a licensed **Social Worker** or a licensed

pastoral counselor and given within six months after the patient's death.

The **Physician** must certify that the patient is terminally ill with 6 months or less to live.

"Immediate Family" means you or any member of your family who is covered under this Plan.

"Course of Care" means all services given to the patient and the patient's Immediate Family in connection with the terminal illness of the patient.

Services provided by a licensed pastoral counselor to a member of his/her congregation in the course of his/her normal duties as a pastor or minister is not a **Covered Health Service**.

Hospital Services

Services and supplies provided by a **Hospital** on an inpatient or outpatient basis.

If charges are made for a private room, **Eligible Expenses** will be limited to the **Hospital's** average daily charge for a semi-private room.

*The Plan does not, and generally may not under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by Caesarean section, or require that a provider obtain authorization from the Plan, from Care Coordination, or through any other utilization management procedure, for prescribing a length of stay not in excess of the above periods. However, the Plan may pay for a shorter stay if the attending provider (e.g., your **Physician, Nurse-Midwife**, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, the Plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.*

Infertility Treatment

Diagnosis and treatment of infertility, including surgery and drug therapy. This does not include procedures or services to facilitate a pregnancy, such as, but not limited to, in vitro fertilization, embryo transfer, artificial insemination and immunotherapy for infertility.

Medical Supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood derivatives only if not donated or replaced.

Nursing Services

Services of a trained nurse or a **Nurse-Midwife**.

Occupational Therapy

Services of a licensed occupational therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a **Physician**.
- The therapy must be given in accordance with a written treatment plan approved by a **Physician**. The therapist must submit progress reports to the **Physician** at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement in the **Covered Family Member's** condition.

Organ/Tissue Transplants

- Donor Charges

In the case of an organ or tissue transplant, no services or supplies for the donor are considered **Covered Health Services** unless the recipient is a **Covered Family Member**. If the recipient is not a **Covered Family Member**, no benefits are payable for donor charges.

The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a **Covered Health Service** UNLESS the search is made in connection with a transplant procedure arranged by a **Transplant Facility**.

- **Qualified Procedures**

If a Qualified Procedure, listed below, is **Medically Appropriate** and performed at a **Transplant Facility**, the "Medical Care and Treatment" and "Transportation and Lodging" provisions set forth below apply:

- Heart Transplants.
- Lung transplants.
- Heart/Lung transplants.
- Liver transplants.
- Kidney transplants.
- Pancreas transplants.
- Kidney/Pancreas transplants.
- Bone Marrow/Stem Cell transplants.
- Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a **Transplant Facility**.
- Medical Care and Treatment
 - The following services provided in connection with the transplant are **Covered Health Services**:
 - Pre-transplant evaluation for one of the procedures listed above.
 - Organ acquisition and procurement.
 - Hospital and Physician fees.
 - Transplant procedures.
 - Follow-up care for a period up to one year after the transplant.
 - Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of \$25,000 is payable for all charges made in connection with the search.

- **Transportation and Lodging**

Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people.

Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

If the **Covered Family Member** who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the \$100 per diem rate.

There is a combined overall lifetime maximum of \$10,000 per **Covered Family Member** for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.

If you or your **Eligible Dependents** receive reimbursement for meals associated with this Transportation and Lodging benefit that are not part of inpatient care, federal tax rules require that such reimbursements be reported as taxable income to the **Eligible Retiree**. You will receive

appropriate notification of any such taxable amounts paid to you.

Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a **Physician**.
- The therapy must be given in accordance with a written treatment plan approved by a **Physician**.
- The therapist must submit progress reports to the **Physician** at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement in the **Covered Family Member's** condition.

Physicians' Services

- **Medical Care** and Treatment
 - **Hospital**, office and home visits.
 - **Emergency** room services.
- Surgery
 - Surgical procedures to treat a sickness, injury or pregnancy.
 - Reconstructive Surgery:
 - Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of a birth defect, a sickness or an accidental injury.

- Reconstructive breast surgery in connection with a mastectomy as follows:
 - all stages of 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 physical complications of mastectomy, including lymphedemas (some-times referred to as swelling associated with the removal of lymph nodes);

in a manner determined in consultation with the attending **Physician** and the patient.

- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to sickness or accidental injury.
- Cosmetic procedures are excluded from coverage, except for surgeries for injuries sustained while or before the patient is covered by the Plan. Procedures that correct a physical anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a **Covered Family Member** may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.
- Assistant Surgeon Services
 - **Eligible Expenses** for assistant surgeon services are limited to 1/5 of the amount of **Eligible Expenses** for the surgeon's charge

for the surgery. An assistant surgeon must be a **Physician**. Surgical assistant's services are covered at the same or lesser rate.

- **Multiple Surgical Procedures**

Multiple surgical procedures means more than one surgical procedure performed during the same operative session. **Eligible Expenses** for multiple surgical procedures are limited as follows:

- **Eligible Expenses** for a secondary procedure limited to 50% of the **Eligible Expenses** that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
- **Eligible Expenses** for any subsequent procedure are limited to 50% of the **Eligible Expenses** that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

Prescription Drugs

Prescription Drugs other than those obtained from a retail pharmacy or by home delivery.

Prescription Contraceptive Devices

Prescription Contraceptive Devices approved by the U.S. Food and Drug Administration.

Radiation Therapy

Skilled Nursing Facility Care After Hospital Confinement

Services and supplies up to 31 days of confinement following each **Hospital** confinement.

Separate confinements for the same cause are considered to be one confinement, unless separated by 14 or more days.

If charges are made for a private room, **Eligible Expenses** will be limited to the **Skilled Nursing Facility's** daily charge for a semi-private room.

Speech Therapy

Services given to restore speech. The speech must have been lost or impaired due to:

- Removal of vocal chords, or
- Cerebral thrombosis (cerebral vascular accident), or
- Brain damage due to injury or organic brain lesion (aphasia).

The therapy must be expected to result in significant, objective, measurable physical improvement in the **Covered Family Member's** condition.

Spinal Manipulations

Services of a **Physician** given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

No benefits are available for any type of therapy, service or supply, including, but not limited to, spinal manipulations by a chiropractor or other **Physician** once the therapy, service or supply ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Transportation Services

Transportation services must be to or from a **Facility** in your local area. If there is no local **Facility** equipped to provide the care needed, transportation service to the

nearest **Facility** outside your local area qualified to give the required treatment is covered.

X-ray and Laboratory Tests

*Exclusions that apply to this Major Medical Benefit are set forth under the heading **General Exclusions and Limitations** at pages 48 through 55. Also, your benefit may be reduced if you or your **Eligible Dependent** has health benefits under another plan. These benefit reductions are described under the heading **Coordination of Benefits** at pages 56 through 60. Other limitations, with respect to Dependent Health Care Benefits, are described on pages 11 through 13.*

V Managed Pharmacy Services Benefit

The Managed Pharmacy Services Benefit covers **Prescription Drugs** that are **Medically Necessary** and that are given for the treatment or prevention of an injury, sickness or pregnancy. There is no deductible applicable to this Benefit. Nor does anything you pay under this Benefit count against the lifetime maximum under the Plan's Major Medical Benefit.

Prescription Drug Card Program

This program, administered by Express Scripts, pays for outpatient **Prescription Drugs** filled at either an In-Network Pharmacy or Out-of-Network Pharmacy. The prescription drug identification card that you will receive under this Benefit may be used only at In-Network Pharmacies.

In-Network Pharmacy

An In-Network Pharmacy is any pharmacy that participates in the Express Scripts retail network. For more information on which pharmacies participate in the Express Scripts retail network, visit www.express-scripts.com to use the on-line pharmacy locator or call customer service at 1-800-842-0070.

In-Network Pharmacies fill prescriptions for supplies of up to 21 days. In-Network Pharmacies dispense **Generic Drugs** whenever possible. They also dispense **Brand Name Drugs**.

Generic Drugs

If a **Generic Drug** is dispensed, you pay only a \$2 Co-payment.

Brand Name Drugs

If a **Brand Name Drug** is dispensed for either of the following reasons, you pay only a \$6 Co-payment:

- The **Brand Name Drug** is ordered by your **Physician** by writing “Dispense as Written” on the prescription.
- The **Brand Name Drug** is dispensed because there is no equivalent **Generic Drug**.

If a **Brand Name Drug** is dispensed instead of an equivalent **Generic Drug** for any reason other than those set forth above, you must pay:

- the \$6 Co-payment, and
- the difference in cost between the **Generic Drug** and the **Brand Name Drug**.

Any co-payments applicable to the Prescription Drug Card program and any difference in cost between a **Generic Drug** and **Brand Name Drug** are not **Eligible Expenses** under the Major Medical Benefit of the Plan.

Out-of-Network Pharmacy

An Out-of-Network Pharmacy is any pharmacy that does not participate in the Express Scripts retail network. If you go to an Out-of-Network Pharmacy you must pay the entire cost of each prescription at the time it is filled. Then you must submit a claim.

The Plan will pay 75% of the cost you pay for up to a 21-day supply of the **Prescription Drug** that you buy at an Out-of-Network Pharmacy.

If you buy a supply of Prescription Drugs for a period in excess of 21 days at an In-Network or Out-of-Network Pharmacy, you will receive no benefits under the Plan.

Mail Order Prescription Drug Program

Under the Mail Order Prescription Drug program, administered by Express Scripts, you may obtain **Prescription Drugs** by mail.

The **Prescription Drug** must be prescribed for you or one of your **Eligible Dependents**. You or your **Eligible Dependent** must be covered under the Plan when the prescription is received by Express Scripts. If you or your **Eligible Dependent** is not covered under the Plan when a new prescription is received by Express Scripts, this Mail Order Prescription Drug Program will still apply, but only if the following two conditions are met:

- The new prescription was prescribed while you or your **Eligible Dependent** was covered under the Plan, and
- Express Scripts received the prescription before the end of the calendar month following the month coverage was lost.

Generic Drugs, if available, will be dispensed unless the written prescription otherwise requires.

You must pay a co-payment of \$5 for each prescription filled by Express Scripts. The co-payment is not an **Eligible Expense** under the Major Medical Benefit of the Plan.

Obtaining Your Mail Order Drugs

Mail your original prescription (no copies) or refill slip with the order form in the postage-paid envelope provided by Express Scripts, along with a check or money order for \$5 for each prescription or refill submitted. If you prefer to pay for all of your orders by credit card, you can join Express Scripts's automatic payment program by enrolling online at www.express-scripts.com or by calling 1-800-948-8779.

Complete the information required on the order form. If you are submitting your first prescription, complete the Health Assessment Questionnaire as well.

The prescription must be written for a minimum 22-day supply of the drug and for no greater than the lesser of a 90-day supply, the supply the dispensing pharmacist deems appropriate in the exercise of his/her professional judgment, the quantity recommended by the manufacturer, and the maximum quantity permitted by applicable law.

If you need order forms or Health Assessment Questionnaires, or if you have any questions on how to submit an order, visit www.express-scripts.com or call 1-800-842-0070.

Limitations Under the Managed Pharmacy Services Benefit

Managed Pharmacy Services Benefits for any prescription filled at an In-Network or Out-of-Network Pharmacy are limited to a 21-day supply of the drug. An In-Network Pharmacy will not fill a prescription for more than a 21-day supply. ***The Managed Pharmacy Services Benefit pays nothing at all for any prescription filled at an In-Network or Out-of-Network Pharmacy for more than a 21-day supply of the drug.*** Benefits for supplies of **Prescription Drugs** for more than 21 days are available under the Managed Pharmacy Services Benefit only if the supply is ordered by mail, and then are limited to the quantities described above under the heading "Obtaining Your Mail Order Drugs."

If a prescription so provides, however, it may be refilled, except that any request for a refill that is made more than one year after the latest prescription was written will not be granted. Any refills that remain on a prescription expire one year after the original prescription was written.

You may obtain medicines (other than **Prescription Drugs**) under the Mail Order Prescription Drug program (if available from Express Scripts by Mail Pharmacy Service), but not under the Prescription Drug Card program or the Major Medical Benefit of the Plan. Such medicines must be prescribed for you by a **Physician** and be **Medically Necessary**.

Not Covered

This Benefit does not cover any expenses for the following drugs whether they are purchased from an In-Network Pharmacy, Out-of-Network Pharmacy or by mail.

- Drugs given other than for:
 - the treatment of an injury,
 - the treatment of a sickness,
 - the treatment of a pregnancy,
 - with respect to female retirees and the wives of male retirees, prevention of a pregnancy.
- Drugs which are not **Medically Necessary**.
- Drugs given in connection with a service or supply which is not a **Covered Health Service**.
- Drugs that are considered investigational because they do not meet generally accepted standards of medical practice in the United States.
- Drugs to treat infertility or vitamin supplements, except when **Medically Necessary** and ordered under the Mail Order Prescription Drug program. Please note that drug therapy for infertility is a **Covered Health Service** under the Major Medical Benefit.
- Nicotine suppressants, except for **180 days** of treatment per lifetime under the Mail Order Prescription Drug program.
- Allergy serum, immunization agents and biological sera.
- Prescribed devices or supplies of any type including colostomy supplies and contraceptive devices. Please note that prescription contraceptive devices are

Covered Health Services under the Major Medical Benefit.

- Drugs given by a **Physician** either in his or her office or as part of a home health care visit.
- Drugs given by a **Hospital** (including take-home drugs), **Skilled Nursing Facility**, **Home Health Care Agency**, or similar place that is not a pharmacy, but has its own drug dispensary.
- Injectables other than insulin, unless they are ordered under the Mail Order Prescription Drug program.

Rx Clinical Management Rules/Programs

RationalMed®

As part of the Managed Pharmacy Services Benefit, your Physicians and your **Eligible Dependents' Physicians** may receive information about **Prescription Drugs** through the RationalMed program. RationalMed drives improved clinical outcomes by detecting critical errors and gaps in care across the Managed Pharmacy Services Benefit population. By integrating patient medical, pharmacy and lab data, RationalMed can rapidly identify health and safety issues and effect greater changes in therapy or treatment across all disease states. These actions could help prevent unnecessary and costly hospitalization and adverse effects, and also address gaps in essential care. Using thousands of continuously updated evidence based clinical rules, RationalMed identifies important safety risks.

There is no charge to you for information provided through the RationalMed program. Through the RationalMed program, benefits for alternative treatment may be offered to you or your **Eligible Dependents** when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and **Physician**.

The following programs apply to (1) individuals who were covered under the National Railway Carriers and United Transportation Union (NRC/UTU) Health and Welfare Plan and became Eligible Retirees and Eligible Dependents on or

after January 1, 2012, and (2) individuals who were covered under The Railroad Employees National Health and Welfare Plan and became Eligible Retirees and Eligible Dependents on or after July 1, 2012:

Coverage Approval (also known as Prior Authorization)

For certain medications, Express Scripts must review the prescription with your **Physician** to determine whether the medication meets the requirements for coverage. For example, *Retin-A*® may be covered for acne, but not for cosmetic purposes.

- The coverage review uses **MPSB** rules based on U.S. Food and Drug Administration-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective. If coverage is approved, you will pay the appropriate co-payments.
- The coverage review for certain medications helps assure that coverage is provided to those participants for whom the medication is safe, effective and appropriate.

Quantity/Dose Duration Program

Certain medications are authorized for coverage in a limited quantity within a specified time period. This program evaluates the quantity and dosing of a medication over a specific timeframe and alerts the pharmacist to the need for a coverage review when the quantity or dose exceeds the covered amount.

Step Therapy Program

For certain medications, this program requires that you first try one or more specified drugs to treat a particular condition before the **MPSB** will cover another (usually more expensive) drug that your doctor may have prescribed. Step therapy is intended to reduce costs for you and the Plan by encouraging the use of alternative

medications that are equally effective when compared to the usually more expensive prescribed medications.

Personalized Medicine Program

This program makes genetic testing available to you to optimize prescription drug therapies for certain conditions.

- The conditions, medications, and testing covered by the program will change periodically as new genetic tests become available and are included in the program.
- The most up to date information on the conditions and drugs covered by the program can be accessed online at or by calling Express Scripts Member Services.
- For participants who qualify based on Express Scripts specific criteria, the Personalized Medicine Program will include access to certain specified genetic tests administered and analyzed by one of several designated clinical laboratories, and a clinical program that includes consultation with the prescribing doctor about the test results by a representative of Express Scripts trained specifically in genetic testing.
- The results of the genetic tests are for informational purposes only. Any dosing or medication changes remain the sole discretion of the participant's doctor.
- Participation is voluntary and if you decide to participate, Express Scripts will manage your coverage under the program.
- Results are confidential and shared with you and your **Physician** only.
- Please contact the Express Scripts at 1-800-842-0070 for more information.

*Exclusions applicable to this Managed Pharmacy Services Benefit are set forth under the heading **General Exclusions and Limitations** on pages 48 through 55. Also, your benefits may be reduced if you or your **Eligible Dependent** has health benefits under another plan. These benefit reductions are described under the heading **Coordination of Benefits** on pages 56 through 60. Other limitations, principally with respect to Benefits for your **Eligible Dependents**, are described on pages 11 through 13.*

VI

General Exclusions and Limitations

This Plan does not cover any expenses – even if they are **Eligible Expenses** – incurred for services, supplies, care or treatment relating to, arising out of, or given in connection with, the following:

- **Another Railroad Health and Welfare Plan** – services and supplies for which an **Eligible Dependent** is entitled to benefits as an employee in connection with **Another Railroad Health and Welfare Plan**, except as stated on page 13.
- Completion of claim forms or missed appointments.
- Cosmetic/Reconstructive Surgery or treatment, except as specified on pages 34 through 35 of this booklet, including but not limited to:
 - Abdominoplasty.
 - Breast reduction surgery.
 - Liposuction
 - Rhytidectomy
 - Cosmetic Services – such as, but not limited, to wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury), hair transplants, hair weaving, or any drug if such drug is used in connection with baldness.
 - Counseling Services, Treatment, or Education Services such as, but not limited to:

- Services given by a pastoral counselor, except as specified under “Hospice Care Services” on pages 28 through 29.
- Educational rehabilitation, or treatment of learning disabilities, regardless of the setting in which such services are provided.
- Treatment for personal or professional growth, development, or training or professional certification.
- Evaluation, consultation, or therapy for educational or professional training or for investigational purposes relating to employment.
- Examinations, testing, evaluations or treatment which may be required solely for purposes of obtaining or maintaining employment or insurance or pursuant to judicial order or administrative proceedings.
- Academic education during residential treatment.
- Therapies such as Erhard/The Forum, primal therapy, aversion therapy, bioenergetic therapy, crystal healing therapy.
- Counseling services and/or treatment related to such problems as financial, marital or occupational difficulties, adult anti-social behavior or parent-child relationships.
- Non-abstinence based or nutritionally based chemical dependency treatment.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Sensitivity training, educational training therapy or treatment for an education requirement.

- **Custodial Care**
- Dental Implants.
- Dental Services - care of and treatment to the teeth, gums or supporting structures, except for:
 - **Hospital**, radiology and pathology services while confined as an inpatient in a **Hospital** for dental surgery or within 72 hours of dental surgery, and
 - full or partial dentures, fixed bridgework, or repair to natural teeth, if needed because of injury to natural teeth.
- Dependents:
 - a dependent child's pregnancy or the resulting childbirth, abortion or miscarriage;
 - a dependent child's expenses if the child is receiving benefits for the same expenses as an employee under The Railroad Employees National Health and Welfare Plan or The National Railway Carriers and United Transportation Union Health and Welfare Plan; and
 - a dependent's work related injury or sickness - services or supplies for which your **Eligible Dependent** is entitled to indemnity under any workers' compensation or similar law.
- Donor Expenses – expenses incurred by an organ donor except as provided under the description of "Organ/Tissue Transplants" (see page 31); services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a **Covered Family Member** under this Plan and is undergoing a covered transplant.
- Ecological or environmental medicine, diagnosis and/or treatment, such as, but not limited to:

- chelation therapy, except to treat heavy metal poisoning,
- chemical analysis of hair or nails,
- gastrogram,
- Heidelberg capsule,
- cytotoxic, sublingual or wrinkle allergy testing,
- environmental chemical screening for toxins, and allergens.
- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as **Covered Health Services**.
- Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time a determination regarding coverage in a particular case is made under the Plan are:
 - not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use;
 - or
 - subject to review and approval by any institutional review board for the proposed use;
 - or
 - the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set

forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If a **Covered Family Member** has a “life-threatening” sickness or condition (one which is likely to cause death within one year of the request for treatment) UnitedHealthcare may determine that an experimental, investigational or unproven service meets the definition of a **Covered Health Service** for the sickness or condition. For this to take place, UnitedHealthcare must determine that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

- Family Members - services, supplies, care or treatment given by one of the following members of your family:
 - Your spouse.
 - The child, brother, sister, parent or grandparent of either you or your spouse.
- Government Hospital - treatment in a United States government or agency hospital. However, if the United States government or one of its agencies is authorized by law to charge the Plan for the services provided, then this exclusion will not apply.
- Hearing Services - ear examinations, hearing aids or cochlear implants for diagnosis or treatment of hearing loss, except to the extent needed for repair of damages caused by bodily injury.
- Herbal medicine, holistic or homeopathic care, including drugs.
- **Hospital Special Care Areas** - charges made by a **Hospital** for confinement in a special area of the **Hospital** which provides non-acute care, by whatever name called, including but not limited to the type of care given by the facilities listed below. If that type of facility is otherwise covered under this Plan, then benefits for that covered facility which is part of a **Hospital**, as defined, are payable at the coverage level

for that facility, not at the coverage level for a **Hospital**.

- Adult or child day care center.
- **Ambulatory Surgical Center**.
- **Birth Center**.
- Half-way house.
- **Hospice**.
- **Skilled Nursing Facility**.
- Vocational rehabilitation center.
- Any other area of a **Hospital** which renders services on an inpatient basis for other than acute care of sick, injured or pregnant persons.
- **Medicare**
 - services and supplies received while you or your **Eligible Dependent** is a **Person Eligible Under Medicare** if benefits are provided for such expenses under **Medicare**, except to the extent necessary so that the sum of the benefits payable under this Plan and under **Medicare** equal the benefits which would have been payable under the Plan alone.
 - services and supplies which are partially or wholly covered under **Medicare** during any period of time for which you or your spouse has rejected this Plan as primary provider of health benefits.
- No Legal Obligation - services and supplies for which the **Covered Family Member** is not legally required to pay.
- On-duty Injury - bodily injuries incurred while on duty for an employer unless such injury was incurred while you were covered as an employee under The Railroad

Employees National Health and Welfare Plan or The National Railway Carriers and United Transportation Union Health and Welfare Plan (or under any other group health plan or arrangement designated for this purpose by the National Carriers' Conference Committee).

- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.
- Pregnancy Facilitation or Prevention
 - Charges for procedures which facilitate a pregnancy but do not treat the cause of infertility, such as in vitro fertilization, artificial insemination, embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer and tubal ovum transfer.
 - Sterilization procedures, except to avoid a life-threatening condition.
 - Reversal of sterilization.
- Preventive care, including newborn well baby care.
- Private duty nursing services while confined in a **Facility**.
- Routine foot care, including, but not limited to, nail cutting and trimming and removal of corns and calluses, except when required for the prevention of complications due to diabetes or severe systemic disease.
- Services given by volunteers or persons who do not normally charge for their services.
- Services or supplies which are not **Covered Health Services**, including any confinement or treatment given

in connection with a service or supply which is not a **Covered Health Service**.

- Services or supplies received before a Retiree or his or her Dependent becomes covered under this Plan.
- Sex-change surgery.
- Speech therapy, except as set forth under the heading “Speech Therapy” on pages 36 and 37 of this booklet.
- Stand-by services required by a **Physician**.
- Tobacco dependency (except as may be offered to **Covered Family Members** through a wellness program as described on page 25).
- Treatment or consultations provided via telephone.
- Vision Services
 - Services for a surgical procedure to correct refraction errors of the eye, except for radial keratotomy, including any confinement, treatment, services, or supplies given in connection with or related to the surgery.
 - Eye examinations, glasses or contact lenses for diagnosis or treatment of refractive errors except to the extent needed for repair of damages caused by bodily injury.
- War, declared or undeclared, international armed conflict.
- Weight reduction or control including but not limited to: nutritional counseling, membership costs for health clubs, weight loss clinics and similar programs, special foods, food supplements, liquid diets, diet plans or any related products (except as may be offered to **Covered Family Members** through a wellness program as described on page 25).

VII Coordination of Benefits

This section of your booklet describes how the Benefits payable under this Plan will be coordinated with similar benefits payable under other plans.

You or any **Eligible Dependent** may be covered under another group health plan. It may be sponsored by another employer who makes contributions or payroll deductions for it. The other plan could also be a government or tax-supported program.

Coordination of Benefits does not apply to:

- **Another Railroad Health and Welfare Plan**, except as set forth under the heading “Dependents Covered Under Another Railroad Health and Welfare Plan” on page 13 of this booklet.
- an individual health insurance policy which a person may purchase with his/her own funds, or
- health benefit plans paid for through payroll deductions unless the plan is an employer-sponsored plan.

How Does Coordination Work?

One of the plans involved will pay benefits first. (Such plan is primary.) The other plans will pay benefits next. (These plans are secondary.)

If this Plan is primary, it will pay benefits as if it were the only plan involved. Benefits under this Plan will not be reduced because benefits are payable under other plans.

If this Plan is secondary, the benefits it pays will be reduced because of benefits payable by other plans primary to this Plan. The amount of benefits this Plan

would have paid without this provision will be determined first. Then the amount of benefits payable by other plans primary to this Plan for the same charges will be subtracted from this amount. This Plan will pay the difference, if any.

Which Plan is Primary?

There are rules to find out which plan is primary and which plans are secondary when benefits are payable under more than one plan. The rules that usually apply are as follows:

- A plan which has no coordination of benefits provision will be primary to a plan which does have such a provision.
- A plan which covers the person as an employee or retiree will be primary to a plan which covers the same person as a dependent.
- If a person is covered as a dependent under two or more plans, then the plan which covers that person as a dependent of the person whose birthday is earlier in the calendar year will be primary to a plan which covers that person as a dependent of a person whose birthday is later in the calendar year.
- If the **Eligible Retiree** under this Plan is also covered as an active employee under another plan, then this Plan will be secondary.
- If a determination of which plan is primary cannot be made by any of the above rules, then the plan which has covered the person for the longest time will be primary to all other plans.
- If the birthday rule above would apply except that the other plan does not have the same rule based on birthday then the rule in the other plan will determine which plan is primary.

- If the birthday rule above would apply except that the person is covered as a dependent under two or more plans of divorced or separated parents, then the rule that applies depends upon whether there is a court order giving one parent financial responsibility for the medical, dental or other health expenses of the dependent child.
- If there is no court decree, the plan of the parent with custody will be primary to the plan of the parent without custody. Further, if the parent with custody has remarried, the order of payment will be as follows:
 - The plan of the parent with custody will pay benefits first.
 - The plan of the step-parent with custody will pay benefits next.
 - The plan of the parent without custody will pay benefits.
- If there is a court decree, then the plan of the parent with financial responsibility will be primary to any other plan.
- You will have to give information about any other plans when you file a claim.

If Both Wife and Husband are Covered Under This Plan

If a husband or wife is covered under this Plan both as an **Eligible Retiree** and as an **Eligible Dependent**, then this Plan will be treated as two separate plans, and the rules previously stated will be used to determine which plan is primary and which plan is secondary.

If a person is covered under this plan as an **Eligible Dependent** of two **Eligible Retirees**, the **Eligible Dependent** benefits will be paid on behalf of each **Eligible Retiree** as if there were two separate plans, and the rules previously

stated will be used to determine which plan is primary and which plan is secondary.

For the secondary plan, benefits will be determined under what is commonly known as a “make whole” Coordination of Benefits approach, namely:

- First determine the **Eligible Expenses**.
- Then subtract the amount paid by the primary plan.
- The secondary plan pays the difference, provided the difference is no more than the amount that would have been paid without this provision.

If Husband or Wife is Covered Under The Railroad Employees National Health and Welfare Plan, The National Railway Carriers and United Transportation Union Health and Welfare Plan (or Under Another Group Health Plan Designated For This Purpose by the National Carriers’ Conference Committee)

The rules previously stated will determine which plan is primary and which plan is secondary.

For the secondary plan, benefits will be determined under the “make whole” approach as follows:

- First determine the **Eligible Expenses**.
- Then subtract the amount paid by the primary plan.
- The secondary plan pays the difference, provided the difference is no more than the amount that would have been paid without this provision.

Coordination of Benefits Under the Managed Pharmacy Services Benefit

If you or your **Eligible Dependent** has primary coverage for **Prescription Drugs** under another health plan you must follow the procedures shown below in seeking benefits under the Prescription Drug Card program portion of the Managed Pharmacy Services Benefit for prescriptions up

to a 21-day supply (there is no benefit under this program if the prescription supply exceeds 21 days):

- You must pay the full price of the prescription at the pharmacy whether it is an In-Network Pharmacy or an Out-of-Network Pharmacy.
- You must submit the claim to your or your **Eligible Dependent's** primary medical plan.
- You must attach the Explanation of Benefits form received from the primary medical plan and a copy of the itemized receipt to Express Scripts's Coordination of Benefits (COB) claim form and return them to Express Scripts. You can request Express Scripts COB claim forms online at www.express-scripts.com or by calling 1-800-842-0070 to request a form. The forms show the address to which you should mail these papers.

You will be reimbursed for the difference, if any, between what the primary medical plan paid and 75% of the **Eligible Expenses** for the drug. Remember, there is no benefit if you buy a supply of **Prescription Drugs** at either an In-Network Pharmacy or an Out-of-Network Pharmacy for a period in excess of 21 days.

The provisions "If Both Wife and Husband are Covered Under this Plan" (see page 57) and "If Husband or Wife is Covered Under The Railroad Employees National Health and Welfare Plan, The National Railway Carriers and United Transportation Union Health and Welfare Plan (or Under Another Group Health Plan Designated For This Purpose by the National Carriers' Conference Committee)" (see page 59 of this booklet) do not apply to the coordination of benefits under the Prescription Drug Card program.

There is no coordination of benefits provision applicable to the Mail Order Prescription Drug program. This means that benefits under the Mail Order Prescription Drug Program will be paid as if there were no other coverage.

VIII Definitions

These definitions apply when the following terms are used in this booklet.

Age Annuitant

See pages 5 through 6 for the definition of **Age Annuitant**.

Ambulatory Surgical Center

A specialized facility which is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an **Ambulatory Surgical Center** by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.
- Where licensing is not required, it meets all of the following requirements:
 - It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) and permits a surgical procedure to be performed only by a **Physician** who, at the time the procedure is performed, is privileged to perform the procedure in at least one **Hospital** in the area.
 - It provides at least one operating room and at least one post-anesthesia recovery room.
 - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
 - It has trained personnel and necessary equipment to handle emergency situations.

- It has immediate access to a blood bank or blood supplies.
- It provides the full-time services of one or more registered nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room.

Another Railroad Health and Welfare Plan

A health and welfare plan established pursuant to agreement between a railroad or railroads and a labor organization or labor organizations other than this Plan, The Railroad Employees National Health and Welfare Plan, The National Railway Carriers and United Transportation Union Health and Welfare Plan and any other plan or arrangement designated by the National Carriers' Conference Committee as excluded from this definition. Also, a hospital association is not **Another Railroad Health and Welfare Plan**.

Birth Center

A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which the facility is located.
- Where licensing is not required, it meets all of the following requirements:
 - It is operated and equipped in accordance with any applicable state law.
 - It is equipped to perform routine diagnostic and laboratory examinations.
 - It has trained personnel and necessary equipment available to handle foreseeable **Emergencies**.

- It is operated under the full-time supervision of a doctor of medicine (M.D.) or registered nurse (R.N.).
- It maintains a written agreement with at least one **Hospital** in the area for immediate acceptance of patients who develop complications.
- It is expected to discharge or transfer patients within 24 hours following delivery.

Brand Name Drug

A **Prescription Drug** which is or was at one time under patent protection.

COBRA

Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Family Members

Eligible Retirees and their **Eligible Dependents** who are covered under the Plan.

Covered Health Services

Those services and supplies described under the heading "Eligible Expenses and Covered Health Services" on page 25 of this booklet.

Custodial Care

Care made up of services and supplies that meets one of the following conditions:

- Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
- Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

Care that meets one of the conditions above is **Custodial Care** regardless of any of the following:

- Who recommends, provides or directs the care.
- Where the care is provided.
- Whether or not the patient can be or is being trained to care for himself or herself.

Disabled Person

See pages 6 through 7 for the definition for **Disabled Person**.

Eligible Dependent

An individual described under the heading “Eligible Dependents” on pages 7 through 8 of this booklet.

Eligible Expenses

The actual cost to you of the **Reasonable Charges** for **Covered Health Services** or for **Prescription Drugs** that are covered under the Managed Pharmacy Services Benefit.

Eligible Retiree

An individual described under the heading “**Eligible Retiree**” on page 5 of this booklet.

Emergency

*For purposes of care other than **Mental Health Care** or **Substance Abuse Care**, the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:*

- The patient’s health would be placed in serious jeopardy.

- Bodily function would be seriously impaired.
- There would be serious dysfunction of a bodily organ or part.

*For purposes of **Mental Health Care** or **Substance Abuse Care**, a situation in which one or more of the following circumstances are present:*

- The patient is in imminent or potential danger to harm himself, herself, or others as a result of a sickness or injury covered as **Mental Health Care** or **Substance Abuse Care**;
- The patient shows symptoms (e.g. hallucinations, agitation, delusions, etc.) resulting in impairment in judgment, functioning and/or impulse control, severe enough to endanger the welfare of himself, herself, or others;
- There is an immediate need for **Mental Health Care** or **Substance Abuse Care** resulting from or in conjunction with a sickness or injury covered as **Mental Health Care** or **Substance Abuse Care**, such as an overdose, suicide attempt or detoxification.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

Facility

An **Ambulatory Surgical Center** or a **Hospital**.

Generic Drug

A **Prescription Drug** which is a multi-source drug which has never been under patent protection.

Home Health Care Agency

An agency or organization which provides a program of home health care and which fully meets one of the following three tests:

- It is approved under **Medicare**.
- It is established and operated in accordance with the applicable licensing and other laws.
- It meets all of the following tests:
 - It has the primary purpose of providing a home health care delivery system bringing supportive services to the home.
 - It has a full-time administrator.
 - Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available.

Hospice

An agency that provides counseling and incidental medical services for a terminally ill individual. The agency must meet all of the following tests:

- It is approved under any required state or governmental Certificate of Need.
- It provides 24 hour-a-day, 7 day-a-week service.
- It is under the direct supervision of a **Physician**.
- It has a social-service coordinator who is licensed in the area in which it is located.
- The main purpose of the agency is to provide **Hospice** services.

- It has a full-time administrator.
- It is established and operated in accordance with any applicable state laws.

A part of a **Hospital** that meets the criteria set forth above will be considered as a **Hospice** for the purpose of this Plan.

Hospital

An institution which is engaged primarily in providing **Medical Care** and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets one of the following three tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.
- It is approved by **Medicare** as a hospital.
- It meets all of the following criteria:
 - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of **Physicians**; and
 - It continuously provides on the premises 24 hour-a-day nursing service by or under the supervision of registered nurses; and
 - It is operated continuously with organized facilities for operative surgery on the premises.

Level of Care

The duration, frequency, location, intensity and/or magnitude of a treatment setting, treatment plan, or treatment modality, including, but not limited to:

- acute care facilities;
- less intensive inpatient or outpatient alternatives to acute care facilities such as residential treatment centers, group homes or structured outpatient programs;
- outpatient visits; or
- medication management.

Medical Care

Treatment of a sickness, injury or pregnancy when such sickness, injury or pregnancy:

- shows a clinically significant physiological syndrome or pattern;
- substantially or materially impairs a person's ability to function in one or more major life activities; and
- is identified under one of the specific code numbers listed in either the Diagnostic Statistical Manual V, published by the American Psychiatric Association, or published in the International Classification of Diseases, Tenth Edition, Clinical Modification, published by the United States Department of Health and Human Services, or the current, updated version of either publication, that have been accepted for inclusion as **Medical Care** by the Plan.

Medically Appropriate

A **Covered Health Service** which has been determined by UnitedHealthcare to be the appropriate **Level of Care** that can safely be provided for the specific covered individual's diagnosed condition in accordance with the professional and technical standards adopted by UnitedHealthcare.

Medically Necessary

A **Prescription Drug** which has been determined by Express Scripts with respect to the Managed Pharmacy Service Benefit, to be:

- a therapeutic response provided for and consistent with the symptoms or proper diagnosis and treatment for the specific covered individual's illness, disease or condition;
- prescribed in accordance with generally accepted principles of **Medical Care**, **Mental Health Care** or **Substance Abuse Care** practice in the U.S. at the time prescribed; and
 - safe and effective according to accepted clinical evidence generally recognized by **Medical Care**, **Mental Health Care**, or **Substance Abuse Care** professionals or publications; or
 - not primarily for the convenience of the covered individual, his/her family, or the provider.

Medicare

The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act.

Mental Health Care

Treatment of a sickness or injury when such sickness or injury:

- shows a clinically significant behavioral or psychological syndrome or pattern;
- substantially or materially impairs a person's ability to function in one or more major life activities; and
- is identified under one of the specific code numbers listed in either the Diagnostic Statistical Manual V, published by the American Psychiatric Association, or published in the International Classification of Diseases, Tenth Edition, Clinical Modification,

published by the United States Department of Health and Human Services, or the current, updated version of either publication, that have been accepted for inclusion as **Medical Care** by the Plan.

Some examples of services and supplies that do not fall within the definition of **Mental Health Care** are:

- Treatment of congenital and/or organic disorders, including, but not limited to Organic Brain Disease, Alzheimer's Disease, autism and mental retardation.
- Treatment for stress co-dependency, sexual addiction, and chronic pain when not part of **Mental Health Care**.
- Treatment for smoking cessation, weight reduction, obesity, stammering, or stuttering.

Nurse-Midwife

A person who is certified to practice as a **Nurse-Midwife** and who:

- is licensed as a registered nurse by the appropriate board of nursing having responsibility for such licensure under the laws of the jurisdiction where such person renders services, and
- has completed a program for the training of **Nurse-Midwives** approved by the appropriate regulatory authority having responsibility for such programs under the laws of the jurisdiction where such program is provided.

Person Eligible under Medicare

You or your **Eligible Dependent** if eligible to enroll under **Medicare**.

If you or your **Eligible Dependent** would have become a **Person Eligible Under Medicare** due to age but did not because you or the **Eligible Dependent** were not a citizen or resident of the United States, you or the **Eligible**

Dependent will nevertheless be regarded for purposes of this Plan as a **Person Eligible Under Medicare**.

If you or your **Eligible Dependent** become eligible under **Medicare** due to End Stage Renal Disease, you or your **Eligible Dependent** will not be considered to be a **Person Eligible Under Medicare** during the first 30 months of **Medicare** eligibility.

Physician

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Chiropody (D.S.C.).
- Doctor of Chiropractic (D.C.).
- Doctor of Dental Surgery (D.D.S.).
- Doctor of Medical Dentistry (D.M.D.).
- Doctor of Osteopathy (D.O.).
- Doctor of Podiatry (D.P.M.).
- Physician Assistant when operating under the direction of one of the above Doctors.

Preferred Provider

A provider who has agreed to negotiated charges for covered services under the Major Medical Benefit.

Prescription Drugs

The following will be considered **Prescription Drugs**:

- Federal Legend Drugs. These are all medical substances which the Federal Food, Drug and Cosmetic Act requires to be labeled "Caution -

Federal Law prohibits dispensing without prescription.”

- Drugs which require a prescription under State law but not under Federal law .
- Compound Drugs. These are drugs that have more than one ingredient. At least one of the ingredients has to be a Federal Legend Drug or a drug which requires a prescription under State law .
- Injectable insulin, when prescribed by a **Physician**.
- Needles and syringes, when prescribed by a **Physician**.

Qualified Medical Child Support Order

A medical child support order is defined in clause (B) of 29 U.S. Code §1169(a)(2) that meets the requirements of clause (A) of that provision, i.e., Section 1169(a)(2).

Reasonable Charge

For services rendered by a provider under a negotiated discount arrangement made available to the Plan through UnitedHealthcare or the UnitedHealthcare Supplemental Discount Program, an amount that does not, as determined by the entity through which the discount arrangement is made available to the Plan, exceed the negotiated amount.

For all other services, an amount measured and determined by UnitedHealthcare or the UnitedHealthcare Supplemental Discount Program by comparing the actual charge with the charges made, and/or with the amounts reimbursed to providers for charges made under a variety of methods, including but not limited to known provider reimbursement schedules, negotiated discount arrangements, and maximum allowables, for similar services and supplies provided to individuals of similar age, sex, circumstances and medical condition in the locality concerned.

In determining the **Reasonable Charge** for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

factors such as the following may be taken into account:

- the complexity;
- the degree of skill needed;
- the type or specialty of the provider;
- the range of services or supplies provided by a **Facility**; and
- the prevailing charge in other areas.

Skilled Nursing Facility

A facility approved by **Medicare** as a **Skilled Nursing Facility**.

If not approved by **Medicare**, a facility that meets all of the following tests:

- It is operated under the applicable licensing and other laws.
- It is under the supervision of a licensed **Physician** or registered nurse (R.N.) who is devoting full time to supervision.
- It is regularly engaged in providing room and board and continuously provides 24 hour-a-day skilled nursing care of sick and injured persons at the

patient's expense during the convalescent stage of an injury or sickness.

- It is authorized to administer medication to patients on the order of a **Physician**.
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

A part of a **Hospital** that meets the criteria set forth above will be considered as a **Skilled Nursing Facility** for the purposes of this Plan.

Social Worker

A person who specializes in clinical social work and is licensed or certified as a social worker by the appropriate authority.

Speech Therapist

A person who is licensed as a speech therapist.

Substance Abuse Care

Treatment of a sickness or injury when such sickness or injury:

- shows a clinically significant behavioral or psychological syndrome or pattern;
- substantially or materially impairs a person's ability to function in one or more major life activities; and
- is identified under one of the specific code numbers listed in either the Diagnostic Statistical Manual V, published by the American Psychiatric Association, or published in the International Classification of Diseases, Tenth Edition, Clinical Modification, published by the United States Department of Health and Human Services, or the current,

updated version of either publication, that have been accepted for inclusion as **Substance Abuse Care** by the Plan.

Transplant Facility

A **Hospital** that UnitedHealthcare specifically designates as a transplant facility. A **Transplant Facility** has entered into an agreement with UnitedHealthcare to render **Covered Health Services** for the treatment of specified diseases or conditions. A **Transplant Facility** may or may not be located within your geographic area. The fact that a **Hospital** is a network hospital does not mean that it is a **Transplant Facility**.

IX

Claim Information

HOW TO FILE A CLAIM FOR MAJOR MEDICAL BENEFITS

Necessary Pre-Approval

In order to receive full benefits for certain services, you must notify Care Coordination and obtain a determination, before you receive the services, as to whether they are Covered Health Services and, if so, whether they are **Medically Appropriate**. The services for which this pre-approval is required, and the process for requesting it, are described at pages 21 through 23 of this booklet.

Post-Service Claims for Reimbursement or Payment

If you receive services from **Preferred Providers**, they will file your medical claims for you. If you receive services from other providers, send your claims to:

UnitedHealthcare
P.O. Box 30985
Salt Lake City, UT 84130

In order for UnitedHealthcare to process your claims promptly, the following information is necessary:

- the name and UnitedHealthcare member identification number of the **Eligible Retiree**,
- the patient's name and relationship to the **Eligible Retiree**,
- The plan number assigned by UnitedHealthcare (GA-46000),
- the diagnosis,

- an itemized statement of the services rendered, and the charges for those services.

UnitedHealthcare does not provide claim forms specific to this Plan. UnitedHealthcare will accept standard claim forms generally accepted by medical benefits administrators.

**HOW TO FILE A CLAIM FOR
PRESCRIPTION DRUGS FILLED AT AN
OUT-OF-NETWORK PHARMACY**

If you fill your prescription at an Out-of-Network Pharmacy, you must file a claim form with Express Scripts. You can obtain a claim form by visiting www.express-scripts.com or calling 1-800-842-0700. You must complete the claim form and send it to Express Scripts at the address printed on the form.

You do not need to file a claim form when you fill your prescription at an In-Network Pharmacy.

TOLL-FREE TELEPHONE SERVICE

Toll-free service is available as follows:

UnitedHealthcare

Major Medical Benefit	1-800-842-5252
Member Services	1-800-842-4555
Care Coordination &	1-866-735-5685
Medical Management	1-866-735-5685
Disease Management	1-866-735-5685
Nurses/Counselors	
Wellness Programs	

Express Scripts

For the Prescription Drug Card Program	1-800-842-0070
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For the Mail Order Prescription Drug Benefit	1-800-842-0070
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PROOF OF LOSS

UnitedHealthcare may:

- require bills for **Hospital** confinement and other services as part of the proof of claim.
- examine you or your **Eligible Dependent** in connection with the claim.
- require proof of disability if:
 - you believe your child meets the requirements set forth for a disabled child in the definition of an **Eligible Dependent** (see pages 7 through 8), or
 - an **Eligible Dependent** is eligible for Benefits After Coverage Ends (see pages 10 through 13).
- require proof of student status if you believe your child meets the requirements for a student in the definition of an **Eligible Dependent** (see pages 7 through 8).
- require periodic information whether a spouse or child is employed and is covered under another plan (see **Coordination of Benefits** section beginning on page 56).

Proof must be furnished no later than 90 days after the loss for which the claim is made. If it is not reasonably possible to furnish the proof in this time it must be furnished at the earliest reasonably possible date.

Payment of Claims

Benefits are payable to or on behalf of the **Eligible Retiree** except that:

- If Major Medical Benefits have been assigned, they will be paid to the assignee and the **Eligible Retiree** will receive an Explanation of Benefits. Managed Pharmacy Services Benefits may not be assigned.

- With respect to a situation where it is administratively feasible to make payment to someone other than the **Eligible Retiree** and UnitedHealthcare with respect to Major Medical Benefits or Express Scripts, with respect to Managed Pharmacy Services Benefits has been informed:
- that the patient is a minor living with a custodial parent or guardian who is not the **Eligible Retiree**, or
- of a specific situation and UnitedHealthcare or Express Scripts, determines that it is otherwise appropriate to send the payment and Explanation of Benefits to someone other than the **Eligible Retiree**,

the Plan may but shall not be obligated to pay such other person.

- If the Plan has received and accepted a **Qualified Medical Child Support Order**, Benefits will be paid to or at the direction of a custodial parent.

Right of Reimbursement

If you or your **Eligible Dependent** incurs expenses as a result of bodily injury or sickness in circumstances giving rise to a right of recovery against a third party tortfeasor, other than your employer, any payment under the Plan is subject to the following conditions:

- The Plan, by virtue of payment of benefits, automatically acquires the right to be reimbursed by you, from any recovery you or your **Eligible Dependent** recovers from the third party tortfeasor for damages, all or part of which are recovered on account of the expenses incurred as a result of the bodily injury or sickness.
- The amount to be reimbursed by you out of such recovery shall equal but not exceed the amount of such benefits or the total recovery from the third party tortfeasor whichever is less, less the proportionate amount of legal fees and expenses incurred by you or your **Eligible Dependent** in

making recovery. Reimbursement shall be made from the first dollar of the amount determined pursuant to the preceding sentence, regardless of whether you are made whole for any losses you suffered as a result of the injury or sickness involved.

- The Plan, by virtue of payment of benefits, shall also be subrogated to and succeed to your, or your **Eligible Dependent's**, right of recovery against any third party tortfeasor, other than your employer, and in its discretion may exercise such right to the extent of such benefits paid.

PROCESSING OF CLAIMS AND BENEFIT DETERMINATIONS

If, in order to receive full benefits, you request required pre-approval from Care Coordination of services involving urgent care, you will receive verbal notification followed by a written or electronic Explanation of Benefits informing you of the determination made with regard to your request. For all other claims, you will receive a written or electronic Explanation of Benefits informing you of the benefit determination. The Explanation of Benefits will be written in a manner that can be understood by you. If the decision is adverse to you, the Explanation of Benefits will contain the reasons for the decision, references to specific Plan provisions that explain the decision, an explanation of any additional material or information that may be necessary and why that information is necessary, a description of the applicable appeal procedure and time limits (see below), including the expedited procedures for claims involving urgent care, and a statement about your rights to bring an action in court if the decision is still adverse to you once you complete the appeal process. The Explanation of Benefits will also include information about any rule, guideline, protocol, or similar criterion that was relied upon in making a decision adverse to you, or a statement that such information will be provided at no charge upon request. If a determination adverse to you is based on a judgment about medical necessity, experimental treatment, or a similar Plan exclusion or limitation, the Explanation of Benefits will include either an explanation of the scientific or clinical judgment involved or a statement that such an explanation will be provided to you at no charge upon request.

Urgent Care Claims

If you are requesting required pre-approval from Care Coordination for care or treatment in order to obtain full Major Medical Benefits, and if a delay in granting of your request could seriously jeopardize your life or health or your ability to regain maximum function, or if, in the opinion of a **Physician** who knows your medical condition, you are in severe pain that cannot be managed adequately without the care or treatment being sought, the following will apply:

- A health care professional with knowledge of your medical condition may act as your authorized representative for the purpose of your request.
- If your request was not made properly, you will be provided with verbal notification of the proper procedure for making the request as soon as possible, but no later than 24 hours from the receipt of your request.
- If your request is made properly and all necessary information is included, you will be provided with verbal notification of the determination made upon your request as soon as possible, but no later than 72 hours from the receipt of your request.
- If additional information is required to make a determination on your request, you will be provided with verbal notification of the additional information required to perfect your request as soon as possible, but no later than 24 hours from receipt of your request.
 - You will have 48 hours after receipt of this notification to provide the additional information.
 - You will then be provided with verbal notification of the determination on your request as soon as possible, but no later than 48 hours after the earlier of:
 - the receipt of the additional information; or
 - the end of the 48-hour period in which you have to provide the additional information.
- If an urgent care request for ongoing treatment was previously approved for a period of time or a number of treatments, and you request an extension of that treatment, you will be provided with verbal notification of the determination on your request as soon as possible, but no later than 24 hours from the receipt of your request, provided your request is made at least

24 hours before the termination of care. Otherwise, you will be provided with verbal notification of the determination no later than 72 hours from the receipt of your request.

- For all requests for required Care Coordination pre-approval of services involving urgent care, a written or electronic copy of the determination will be sent to you within 3 days following verbal notification.
- Your request will no longer be processed as involving urgent care if you go ahead and receive the care or treatment for which you seek pre-approval. Instead, your request will be processed as a post-service claim for reimbursement.

Non-Urgent Care Claims

Pre-Service

- If, in order to receive full Major Medical Benefits, you request required pre-approval from Care Coordination of care or treatment that does not involve urgent care, the following will apply:
 - If your request was not made properly, you will be notified verbally or in writing within 5 days from the receipt of your request of the proper procedure for making the request.
 - If your request is made properly, a notice of determination regarding your request will be sent to you no later than 15 days after receipt of your request. UnitedHealthcare may take an additional 15 days to make a determination if it determines that such an extension is necessary for reasons beyond its control and notifies you of this extension within 15 days from the receipt of your request. This notice will give you the reason for the extension and the date by which UnitedHealthcare's determination will be made.
 - If an extension is necessary because additional information is required to make the determination,

you will be notified of the specific information that is needed.

- You will have 45 days after receipt of this notice to provide the additional information.
- The period for making a determination on your request will be suspended until you either provide the necessary information or until the 45-day period for you to provide the information ends, whichever comes first.
- If a request to pre-approve ongoing treatment was previously approved by Care Coordination for a period of time or a number of treatments, and UnitedHealthcare wants to reduce or terminate the treatment, you will be notified promptly.
- Your request will no longer be processed as a pre-service request if you go ahead and receive the care or treatment for which you seek pre-approval. Instead, your request will be processed as a post-service claim for reimbursement.

Post-Service

When you seek reimbursement for or payment of statements for care or treatment that you have already received, your claim will be handled as follows:

- You will ordinarily be notified as to whether your claim has been denied no later than 30 days after the receipt of your claim.
- UnitedHealthcare or, for claims for prescriptions filled Out-of-Network under the Managed Pharmacy Services Benefit, Express Scripts, may take an additional 15 days to make a benefit determination if it determines that such an extension is necessary due to matters beyond its control and notifies you of this extension within 30 days from the receipt of your claim. This notice will give you the reason for the extension and the date by which the benefit determination will be made.

- If additional information is required to make a benefit determination, the notice will state this and identify the additional information required.
- You have 45 days after receipt of this notice to provide the additional information.
- The period for making a benefit determination on your claim will be suspended until you either provide the necessary information or until the 45-day period for you to provide the information ends, whichever comes first.

Informal Inquiries Following Claim Denials

If your request for required pre-approval or for reimbursement for or payment for care or treatment you have already received (a "claim") has been denied in full or in part and you have questions about the reasons for the denial or you disagree with the reasons, you may make an informal inquiry by telephone about the reasons for the denial to:

- UnitedHealthcare with respect to the Major Medical Benefit.
- Express Scripts with respect to the Managed Pharmacy Services Benefit.

The Explanation of Benefits that you receive denying your claim in whole or in part will set forth the name and telephone number of the appropriate office to contact if you would like to make an informal inquiry concerning your claim for benefits. You are not required to make an informal inquiry before you initiate any formal appeal, but an informal inquiry could lead you to understand better the reasons for the claim denial, or it could result in a change in the way your claim is handled. Informal inquiries concerning claim denials must be made within 60 days after you receive your Explanation of Benefits and will be addressed promptly.

Formal Appeals of Claim Denials

If you are dissatisfied with the handling of your claim following informal inquiry, or even if you do not make an informal inquiry, you may make a formal written appeal to:

- UnitedHealthcare with respect to the Major Medical Benefit.
- Express Scripts with respect to the Managed Pharmacy Services Benefit.

Your Explanation of Benefits will include information explaining how to initiate this formal appeal and the name and address of the office to which the formal appeal should be sent. All formal appeals must be initiated by a written request for a formal appeal, unless you are appealing from a failure to grant your request for Care Coordination pre-approval of urgent care, in which case you may initiate your appeal verbally. Your request for a formal appeal must be submitted within one hundred eighty (180) days after you receive your Explanation of Benefits or, if you make a timely informal telephone inquiry concerning the denial of your claim, within one hundred eighty (180) days after you make that informal inquiry.

You may submit additional information with your written request for formal appeal. You may also submit issues and comments in writing. You are also entitled, upon request and at no charge, to receive access to and copies of all documents, records, and other information relevant to your claim, although in some cases approval may be needed for the release of confidential information such as medical records. The decision made on your appeal will take into account all comments, documents, records, and other information you submit relating to your claim, regardless of whether the information was submitted or considered as part of the initial determination on your claim.

The Plan has engaged an independent review agency, MCMC, LLC. to handle certain further appeals. If you are dissatisfied with the results of any initial appeal of your

claim denial to UnitedHealthcare, you may file an additional appeal with MCMC. Your request for an appeal to MCMC must be submitted within ninety (90) days after you receive the results from your initial appeal, and the process for filing an appeal to MCMC will be included with the results from your initial appeal.

With respect to the Managed Pharmacy Services Benefit, if you are dissatisfied with the results of any initial appeal of you claim denial to Express Scripts, you may file an additional appeal with Express Scripts. Your request for an appeal to Express Scripts must be submitted within ninety (90) days after you receive the results from your initial appeal, and the process for filing an appeal to Express Scripts will be included with the results from your initial appeal.

All decisions following formal appeals will be made without any deference to the initial decision on your claim. The individual who decides your formal appeal will not be the same person who initially decided your claim, nor a subordinate of that person. If the benefits decision under review is based on a medical judgment, the individuals reviewing your appeal will consult with a health care professional who has appropriate training and experience. That health care professional will not be a person who was consulted in connection with the initial decision on your claim nor a subordinate of a person consulted on the initial decision.

You will be notified of the decision on your formal appeal in writing or electronically (except as noted below). The written or electronic notice will specify the reasons for the decision and will be written in a manner calculated to be understood by you, and will contain a reference to specific plan provisions relevant to the decision, as well as a statement that you may receive, upon request and at no charge, reasonable access to and copies of documents and information relevant to your claim for benefits. The notice will also include a description of your right to bring an action under ERISA section 502(a), along with any rule, guideline, or protocol relied on in deciding your appeal, or an offer to provide such rule, guideline or protocol at no charge upon request. The notice will also identify any medical experts whose advice was obtained on behalf of

the Plan in connection with your claim, even if the advice was not relied on in making a benefit decision. A decision on your formal appeal will be final, except that you may appeal that decision to a court (see below).

Urgent Care Appeals

Your appeal may require prompt action if you are appealing from the denial of your request for required pre-approval by Care Coordination for care or treatment, and if a delay in the approval of benefits for that care or treatment could seriously jeopardize your life or health or your ability to regain maximum function, or if, in the opinion of a **Physician** who knows your condition, you are in severe pain that cannot be managed adequately without the care or treatment being sought. In these situations:

- Your appeal need not be in writing. You or your **Physician** can request a review by telephone. All necessary information, including the decision, will be transmitted verbally, by telephone, by facsimile, or by similar means.
- You will be notified verbally as soon as possible, but no later than 72 hours from receipt of your appeal.
- Your appeal will no longer be processed as an appeal from denial of a request for pre-approval by Care Coordination for urgent care or treatment if you go ahead and receive the care or treatment for which you seek pre-approval. Instead, your appeal will be processed as one involving a post-service claim for reimbursement.

Non-Urgent Care Appeals

Pre-Service

If you are appealing from the denial of your request for required pre-approval by Care Coordination for non-urgent care or treatment, or from the termination or reduction of benefits for non-urgent care or treatment, your appeal will be handled as follows:

- A decision following the review of your appeal by UnitedHealthcare or Express Scripts will be sent to you within 15 days from the day your appeal of the denial is received.
- If you file a further appeal with MCMC or with Express Scripts, a decision will be sent to you within 15 days from the day your appeal is received by MCMC or Express Scripts.
- Your appeal will no longer be processed as appealing from denial of a request for required pre-approval by Care Coordination for non-urgent care or treatment if you go ahead and receive the care or treatment for which you seek pre-approval. Instead, your appeal will be processed as one involving a post-service claim for reimbursement.

Post-Service

If you are appealing from the denial of benefits for care or treatment that you have already received, your appeal will be handled as follows:

- A decision following the review of your appeal by UnitedHealthcare or Express Scripts will be sent to you within 30 days after your appeal of the denial is received.
- If you file a further appeal with MCMC or with Express Scripts, its decision will be sent to you within 30 days after your appeal is received by MCMC or Express Scripts.

Judicial Actions

You must exhaust the appeals process described in this booklet before you file a lawsuit on any claim involving the Plan. If you file a lawsuit over a claim without completing the appeals process described above, the Plan will ask that your lawsuit be dismissed. You may not sue on your claim more than three years from the time proof of claim is required. However, if any applicable law requires that

you have more time to bring suit, you will have the time allowed by that law.

X

Additional Information

IMPORTANT NOTICE ABOUT THE PLAN AND MEDICARE

To receive the benefits available under **Medicare**, everyone at age 65, and every one with kidney disease which requires hemodialysis (regardless of age) must:

- Enroll under **Medicare** Part A (hospital insurance), Part B (medical insurance) and Part D (prescription drug insurance) as soon as they become eligible.
- Pay the required monthly premiums under **Medicare**.

Disabled Persons who become eligible for **Medicare** are automatically enrolled in **Medicare**.

(See the **Information About Medicare** section of this Notice for more detailed information on **Medicare**.)

Coverage under The Railroad Employees National Early Retirement Major Medical Benefit Plan terminates when an **Eligible Retiree** or an **Eligible Dependent** becomes eligible under **Medicare** as follows:

- Coverage for the **Eligible Retiree** and all **Eligible Dependents** terminates when the employee becomes eligible under **Medicare** due to age (65).
- Coverage for an **Eligible Retiree** terminates on the date he/she becomes eligible under **Medicare** due to disability. However, coverage for that person's **Eligible Dependents** continues until the date the **Eligible Retiree** would have become eligible under **Medicare** due to age (65).
- Coverage for an **Eligible Dependent** terminates on the date that the individual **Eligible Dependent** becomes eligible under **Medicare**. (This includes persons who may voluntarily enroll for **Medicare** Part A and persons

who would be eligible under **Medicare** except for reasons of citizenship or residence.)

- If an **Eligible Retiree** or an **Eligible Dependent** becomes eligible under **Medicare** because of End Stage Renal Disease, coverage for that person terminates after he or she has been eligible under **Medicare** for 30 months.

COVERAGE UNDER THE PLAN TERMINATES AS DESCRIBED ABOVE REGARDLESS OF WHETHER THE RETIRED EMPLOYEE OR DEPENDENT ENROLLS FOR MEDICARE. THEREFORE, TO AVOID BEING WITHOUT COVERAGE, ANYONE APPROACHING AGE 65 SHOULD CONTACT THE SOCIAL SECURITY ADMINISTRATION OR RAILROAD RETIREMENT BOARD OFFICE DURING THE THREE MONTHS PRECEDING THE MONTH OF THEIR 65TH BIRTHDAY TO APPLY FOR MEDICARE COVERAGE.

Information About Medicare

There are four ways a person can become eligible for **Medicare**:

1. On the first day of the month the person attains age 65,
2. On the first day of the 29th month following the day the person is found to be totally and permanently disabled under either the Railroad Retirement Act or the Social Security Act,
3. For persons with end stage renal disease, on the earliest of:
 - the first day of the third month after the month the person begins a course of maintenance dialysis treatments, or
 - the first day of the month the person is admitted to an approved **Hospital** for a kidney transplant or procedures preliminary to a transplant, or

- the first day of the month the person participates in a self-dialysis training program in a **Medicare**-approved training facility, or
4. When the person meets the eligibility requirements of a disabled child.

The Railroad Retirement Board or the Social Security Administration can provide details about **Medicare** eligibility. Both agencies annually publish “Medicare and You,” which gives valuable information about **Medicare**.

Individuals who are receiving age or disability benefits under Social Security or Railroad Retirement will be automatically enrolled under **Medicare** Parts A and B. Enrollment is required in Part D. No payment is required under Part A of **Medicare**. The required payment under Parts B and D of **Medicare** will be deducted automatically from the individual’s monthly benefit.

Individuals age 65 or over who are not otherwise eligible for coverage under Part A of **Medicare** may voluntarily enroll for such coverage. Such individuals must pay the full cost of such coverage and must also enroll for coverage under Parts B and D of **Medicare**. You must enroll for Parts A, B and D of **Medicare** to receive full benefits. Failure to apply will deprive you of valuable benefits and you will probably have to pay a large part of your medical bills.

A person with End Stage Renal Disease will have to enroll under **Medicare** to have coverage for **Medicare** benefits and should contact a Railroad Retirement Board office for information about such enrollment.

**INFORMATION REQUIRED BY THE
EMPLOYEE
RETIREMENT INCOME SECURITY ACT OF
1974 ("ERISA")**

- **Name of Plan:**

The Railroad Employees National Early Retirement
Major Medical Benefit Plan.

- **Plan Identification Numbers:**

Employer Identification Number (EIN): 52-1036399
Plan Number (PN): 506

- **Plan Administrator:**

National Carriers' Conference Committee
251 18th Street, South
Suite 750
Arlington, Virginia 22202
Telephone (571) 336-7600

- The Plan Administrator has authority to control and manage the operation and administration of the Plan and is the agent for service of legal process. Service of process upon the Plan may also be made by serving its trustee.
- The Plan was established and is maintained pursuant to collective bargaining agreements between the nation's railroads and railway labor organizations.
- **Type of administration of the Plan:** Trusteed and Self-Administered
 - The Plan is administered by the Plan Administrator. The Plan's benefits are funded directly by the Plan. They are not insured.
 - The Plan's administration is governed by the terms of the Plan Documents. The Summary Plan

Description provides a description of the benefits that are available under the Plan. In connection with those benefits, the Plan Documents give the various entities that administer the Plan's benefits pursuant to contracts with the Plan Administrator the discretion to construe and interpret the terms of the Plan. If you do not agree with a benefit determination made by any of those entities, you may request a review of your claim. See pages 83 through 92 of this booklet for a description of the appeal procedure.

- **Trustee:**

SunTrust
Mail Code GA-ATL-210
303 Peachtree St. 2nd Floor
Atlanta, GA 30308
Telephone: (404) 827-6724

- **Source of contributions to the Plan:** Employer Contributions.

Employers contribute to the Plan on a monthly basis. The amount of each contribution depends upon the number of qualifying employees who rendered compensated service during, or received vacation pay for, the preceding month and the applicable payment rate per employee.

Benefits under the Plan are payable from funds that are held in trust under the Plan and invested by the Plan's trustee until needed to pay benefits.

- **Date of the end of the Plan Year:**

Each Plan Year ends on December 31.

- **Claims Procedures:**

See Section IX of this booklet, pages 76 through 92, for information about claim procedures.

- **Plan Termination:**

The right is reserved in the Plan for the Plan Administrator to amend or modify the Plan in whole or in part at any time.

An employer has the right to terminate its participation in the Plan at any time by delivery to the Plan Administrator written notice of such termination, except as such right may be limited by obligations undertaken by the employer in collective bargaining agreements.

In the event of termination of the Plan, the assets of the Plan will be used towards payment of obligations of the Plan and any remaining surplus will be distributed in the manner determined by the Plan Administrator to best effectuate the purposes of the Plan in accordance with the applicable regulations under ERISA.

The Plan may terminate as to an employer that fails to pay in a timely fashion the full amount required by the Plan to be paid by the employer during any calendar month. Such termination would be effective as of the first day of the calendar month immediately following the month during which the amount the employer failed to pay was due and payable.

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

- **Receive Information About Your Plan and Benefits**
 - Examine, without charge, at the Plan Administrator's office (the office of the National Carriers' Conference Committee), or at the headquarters office of the labor organization that represented you, at each employer establishment in which 50 or more employees potentially covered by the Plan customarily work, at the meeting hall or office of each union

local in which there are 50 or more members potentially covered by the Plan] all documents governing the Plan, including the collective bargaining agreements pursuant to which the Plan was established and is maintained, a list of the employers that sponsor the Plan and of the railway labor organizations that have agreed to participate in the Plan, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements, a list of the employers that sponsor the Plan and of the railway labor organizations that have agreed to participate in the Plan, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Receive, without charge, from the Plan Administrator, upon written request to its address, information as to whether a particular employer participates in the Plan, as to whether a particular labor organization is a participating organization (and if so, its or their addresses), and as to whether such employer is a participating employer with respect to one or more groups of its retirees who were represented by such organization at the time they retired. However, the Plan Administrator cannot inform you whether you as an individual retiree are covered as a participant, because that information is subject to agreements between the respective employers and organizations, to which the Plan Administrator

is not a party and as to which it is not informed.

- **Continue Group Health Plan Coverage**

- Continue Plan coverage for your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Your dependents may have to pay for such coverage. Review pages 14 through 17 of this Summary Plan Description on the rules governing your **COBRA** continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under the Plan, if any, so long as you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan or UnitedHealthcare when you lose coverage under the Plan, 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.

- **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your former employer, your union, or any other person, may otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

- **Enforce Your Rights**

If your claim for a welfare 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. Under **ERISA**, there are steps you can take to enforce the above rights.

- For instance, if you request a copy of Plan Documents or the latest annual report from the Plan 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 Plan 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 Administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, but not until you exhaust the appeals process described in this booklet.
- In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court, but not until you exhaust the appeals process described in this booklet.
- If it should happen that Plan fiduciaries misuse the Plan'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.

- **Assistance with Your Questions**

If you have any questions about the terms of the Plan or about the proper payment of benefits, you may obtain more information from UnitedHealthcare or Express Scripts, or contact the Plan Administrator. If you have any questions about whether you are covered, you may obtain that information from the railroad that employed you immediately before your retirement.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest 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.

* * *

INTERPRETING PLAN PROVISIONS

UnitedHealthcare (with respect to Major Medical Benefits) and Express Scripts (with respect to the Managed Pharmacy Services Benefit) each has discretionary authority to determine whether and to what extent **Eligible Retirees** and **Eligible Dependents** are entitled to benefits that the company administers and to construe all relevant terms, limitations and conditions set forth in this booklet or in any other document or instrument pursuant to which the Plan is established or maintained. Each Company shall be deemed to have properly exercised this discretionary authority unless it has acted arbitrarily or capriciously.

RELEASE OF MEDICAL INFORMATION

Any company that administers benefits under the Plan may release medical information about the **Covered Family Member** to any other person or organization that is authorized by the Plan to receive it and that requests such information to enable it to accurately determine what benefits are payable under the Plan.

Furthermore, to the extent permissible under applicable law, before you may receive health care benefits under the Plan, each **Covered Family Member** may be required to agree with each of his/her other health providers that the provider may release medical information to any of the companies that administer health care benefits under the Plan that the company considers necessary to enable it to accurately determine what benefits are payable under the Plan.

For further information on where the Plan may disclose medical information, see "Notice of Privacy Practices" available at www.yourtracktohealth.com or upon request.

Miscellaneous

- Supplemental Coverage.
 - Coverage supplemental to the coverage under this Plan may be available. Information may be obtained from UnitedHealthcare by calling their toll-free number 1-800-842-5252, or by writing to

UnitedHealthcare
Railroad Administration
PO Box 150456
Hartford, CT 06115-0456

- When coverage ends under this Plan, other coverage may be available as follows:
 - Benefits may be continued under this Plan for a limited period of time under the provisions of **COBRA** (see pages 14 through 17).
 - **Eligible Retirees** and surviving dependents may enroll for health coverage under Group Policy GA-23111 issued by UnitedHealthcare.

Information about all of these options can be obtained from UnitedHealthcare.

It is extremely important that you obtain information about these options before your coverage under this Plan ends. If you wait longer, you may find that you are no longer eligible for these options.

NOTES

The Railroad Employees National Early Retirement Major Medical Benefit Plan (Group Health Plan GA-46000)

Application for Coverage

If you believe you currently are, or will soon be, eligible for coverage under the Railroad Employees National Early Retirement Major Medical Benefit Plan (GA-46000), complete this form as soon as possible and mail to the address on the back of the form. UnitedHealthcare will confirm your eligibility and send you identification cards, or advise you why you are not eligible.

Part 1 - Employee/Retiree Information

Last Name _____ First Name _____ MI _____ SSN _____

Street Address _____ City _____ State _____ Zip Code _____

Telephone Number _____ Former Employer _____ Union _____

Date you last worked _____ Date you applied for annuity _____ Annuity effective date _____

Number of service months _____ Date of Birth _____

If you received vacation pay after you stopped working, give date(s) _____

Type of Annuity (Check One)

☐ Full Age (60/30)

☐ Occupational Disability

☐ Total and Permanent Disability

☐ Other (describe) _____

Part 2 - Family Information

If an enrollment is being submitted for a spouse, dependent children under age 19, a student child aged 19-25, or an incapacitated child, you must complete the following for each person. If you need additional space to list dependents, please attach an additional sheet of paper and include all items listed below. A Social Security Number is required for every individual and a Health Insurance Claim number is required if the individual is eligible for Medicare.

Complete for each of your Eligible Dependents

	First Name	MI	Date of Birth	Sex	Social Security Number (Required)	Eligible for Medicare? Y/N	Health Insurance Claim Number (From Red/White/Blue Medicare Card) (Required if Medicare Eligible)
Spouse	_____						
Child 1	_____						
Child 2	_____						

The Railroad Employees National Early Retirement Major Medical Benefit Plan (Group Health Plan GA-46000)
Application for Coverage

Children are not covered after attaining age 19 except as indicated in the definition of an Eligible Dependent as stated in the booklet describing the Railroad Employees National Early Retirement Major Medical Benefit Plan. **IF YOU LISTED CHILDREN, AGE 19 OR OVER, COMPLETE THE SECTION BELOW.**

	First Name	MI	Disabled (Yes/No)	Student (Yes/No)	If student, give name, address and telephone number of the school
Child 1	_____	_____	_____	_____	_____
Child 2	_____	_____	_____	_____	_____

Part 3 - Employee Verification

Group Health Plan GA-46000 does not cover persons eligible under Medicare. Persons approved for disability Part A must enroll for additional Medicare Benefits. The member is responsible to notify UnitedHealthcare immediately when any person becomes eligible for Medicare. The member will become responsible for any medical bills that are paid without knowledge of Medicare. See the section in the booklet entitled "Additional Information" for more information regarding Medicare.

This information will be used in connection with all claims for benefits under the Plan. I understand it is the member's obligation to keep this information up to date by calling UnitedHealthcare at 1-800-842-5252 with any changes. Failure to do so may affect benefits under the Plan.

All information on this form is true and correct to the best of my knowledge.

Signature _____ **Date** _____

Important Note: Additional documents are required for processing your application for Group Health Plan GA-46000. Please send copies of the following completed documents along with this application (do not send in a separate envelope). These forms are provided by your Railroad Retirement Board.

☐ Your last BA-6 FORM

☐ Form AA-1 - RECEIPT FOR YOUR CLAIM

You may be asked to supply your Award Notice

When completed, mail all information to:
UnitedHealthcare
Railroad Administration
PO Box 30791
Salt Lake City, UT 84130-0791