January 1, 2024

The Railroad Employees National Health and Welfare Plan

Summary Plan Description

THE RAILROAD EMPLOYEES NATIONAL

HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

January 1, 2024

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I
IMPORTANT NOTICE

This booklet, dated January 1, 2024, describes the health care benefits provided for U.S. residents under The Railroad Employees National Health and Welfare Plan ("Plan") for employees represented by certain participating labor organizations covered by a collective bargaining agreement with a participating employer that provides for the Plan benefits this booklet describes. Other benefits provided by the Plan are described in a separate booklet entitled Life Insurance Benefits for U.S. Employees and Retirees and Accidental Death and Dismemberment Insurance Benefits for U.S. Employees under The Railroad Employees National Health and Welfare Plan. Except as otherwise noted in this booklet, the information described in this booklet is effective as of January 1, 2024.

If you are employed by a participating railroad that does not engage in national collective bargaining and has not yet adopted the terms of the most recent national collective bargaining agreements, or if you are represented by a labor organization that has not yet agreed to the terms of the most recent national collective bargaining agreements concerning this Plan, this booklet does not apply to you. You can obtain a copy of the booklet that applies to you by contacting the company that administers your benefits.

Plans other than The Railroad Employees National Health and Welfare Plan are occasionally mentioned in this booklet, including a separate plan collectively bargained between the railroads and SMART – Transportation Division ("SMART-TD"). To make it easier for you to distinguish references to different plans, The Railroad Employees National Health and Welfare Plan will be referred to as the "Plan" or this "Plan", always with a capital "P". Other plans will be referred to by their full name or a

shorthand designation. For example, the plan that the railroads have bargained with SMART-TD for may be referred to as the "The SMART – TD Health and Welfare Plan" or the "SMART-TD Plan".

In limited circumstances, certain employees of participating railroads who work under a collective bargaining agreement with either SMART-TD or the Brotherhood of Locomotive Engineers and Trainmen ("BLET"), a Division of the Rail Conference of the International Brotherhood of Teamsters, are also eligible for coverage under the Plan. Additional details are provided in the "Eligibility and Coverage" section of the booklet.

* * * *

The Plan's health care benefits described in this booklet are the Managed Medical Care Program ("**MMCP**"), the Comprehensive Health Care Benefit ("**CHCB**"), the Mental Health and Substance Use Disorder Benefit (as provided through the **MMCP** and **CHCB**) ("**MHSUD**"), and the Managed Pharmacy Services Benefit ("**MPSB**"). The Plan also provides ancillary benefits, including **Telemedicine**, expert second opinion services, health advocacy, and end-of-life planning. The benefits provided by this Plan are not insured. They are payable directly by the Plan. The Plan has contracted with third-parties to help administer the benefits – the most up-to-date contact information for each of the companies that administer benefits for the Plan can be found on www.yourtracktohealth.com.

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

* * * *

NOTICE TO ALL ELIGIBLE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS:

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 DESIGNED BY THE COMPANIES ADMINISTERING BENEFITS UNDER THE PLAN TO ADDRESS INSTANCES OF FRAUD OR INTENTIONAL MISSTATEMENT. AS PART OF THESE PROCEDURES, 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 BE NOTIFIED AT LEAST 30 DAYS IN ADVANCE. THE AFFECTED MEMBER HAS A 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.

* * * *

IMPORTANT: Changes to the Plan benefits and provisions that have been made to comply with the **Affordable Care Act** or regulations promulgated under it will remain in effect only so long as necessary to continue such compliance. If any mandate or requirement addressed by a change in Plan benefits or provisions made to comply with or reflect it is hereafter reversed, repealed or modified by regulatory agency action, judicial decision or legislation, the Plan will be amended to incorporate terms and conditions that give full effect to the reversal, repeal or modification. Such amendment will automatically become effective on the later of the first day of the calendar quarter that begins after the effective date of the reversal, repeal or

modification, or the first day of the second month that begins after the effective date of the reversal, repeal or modification.

* * * *

The Plan is intended to comply with the Health Insurance Portability and Accountability Act (HIPAA) privacy and security provisions. The Plan has policies 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 Railroad Enrollment Services at the phone number listed on www.yourtracktohealth.com. An electronic version of the notice is also available at www.yourtracktohealth.com.

II
IMPORTANT CONTACT INFORMATION

Important toll-free phone numbers and website information is provided below.

Aetna			
Member Services	1-800-842-4044	8am-6pm	www.aetna.com
Medical Management	1-800-821-5615	8am-6pm	www.aetna.com
Highmark BCBS			
Member Services	1-866-267-3320	8am-8pm	www.myhighmark.com
Medical Management	1-866-267-3320	8am-8pm	www.myhighmark.com
UnitedHealthcare			
Member Services	1-800-842-9905	8am-8pm	www.myuhc.com
Medical Management	1-800-842-4555	8am-7pm	www.myuhc.com
United Behavioral Health			
Member Services (MHSUD benefits)	1-866-850-6212	24 hours	www.liveandworkwell.com
Express Scripts			
Member Services	1-800-842-0070	24 hours	www.express-scripts.com
Optum			
Case Management	1-866-735-5685	8am-7pm	
Disease Management Services	1-866-735-5685	8am-7pm	
24/7 Nurses	1-866-735-5685	24 hours	
Wellness Program	1-866-735-5685	10am-9pm	
Cleveland Clinic			
Member Services	1-866-441-5691	9am-5pm	
Health Advocate			
Member Services	1-866-799-2690	24 hours	www.HealthAdvocate.com/Railroad
Lantern (formerly SurgeryPlus)			
Member Services	1-888-726-0823	7am-11pm	my.surgeryplus.com (in 2025, my.lanterncare.com)
Teladoc/Best Doctors			
Telemedicine Member Services	1-800-835-2362	24 hours	member.teladoc.com/railroad
Expert Second Opinion Member Services	1-800-835-2362	8am-9pm	member.teladoc.com/railroad
Vital Decisions			
Member Services	1-833-364-6896	9am-8pm	vitaldecision.net

* Note that all times are based on Eastern Time and are generally for Monday through Friday, except for State and Federal holidays. If you call outside a company's normal hours of operation, you may leave a message with your telephone number, and your call will be returned within one working day.

III
HIGHLIGHTS

Here is a brief outline of the health care benefits for U.S. residents provided by the Plan. A more elaborate description of the benefits, including limitations, exclusions and other details, appears in the body of this booklet.

Managed Medical Care Program (MMCP), including the Mental Health and Substance Use Disorder Benefit (MHSUD) for MMCP Enrollees

	In-Network Services	Out-of-Network Services
Deductible per Calendar Year*		
Individual	$350	$700
Family	$700	$1,400
Out-of-Pocket Maximum per Calendar Year*		
Individual	$2,000	$4,000
Family	$4,000	$8,000

The following fixed-dollar co-payments apply to certain visits as noted below. If one of these fixed-dollar co-payments applies, the remainder of the cost of the visit is not subject to coinsurance or the **MMCP/MHSUD** deductibles. However, medical diagnostic services and other medical services performed during the visit will be subject to coinsurance and the **MMCP/MHSUD** deductibles, except where these services are **ACA Preventive Health Services**.

Office Visit Fixed-Dollar Co-Payment for Providers in General Practice, Behavioral Health (Including Virtual Office Visit), Pediatrics, Obstetrics/Gynecology, Family Practice, and Internal Medicine, and with Nurse Practitioners, Physician Assistants, Physical Therapists, and Chiropractors	$25	N/A
Office Visit Fixed-Dollar Co-Payment in a **Convenient Care Clinic**	$10	N/A
Office Visit Fixed-Dollar Co-Payment for All Other Providers	$40	N/A
Telemedicine Visit Fixed-Dollar Co-Payment (through the Plan's designated ancillary benefit **Telemedicine** vendor)	$10	N/A
Urgent Care Center Visit Fixed-Dollar Co-Payment	$25	N/A
Emergency Room Visit Fixed-Dollar Co-Payment	$100**	$100**
Eligible Expenses Payable After Deductible is Satisfied (coinsurance)	90%	70%***
Eligible Expenses Payable After Out-of-Pocket Maximum Is Reached	100%	100%***

**Please see pages 64 through 67 and 70 through 73 to determine how the deductibles and out-of-pocket maximums interact within*

*the **MMCP** (including the **MHSUD**), and among the **MMCP** and the **CHCB**.*

***This charge may exceed $100 if the care you receive does not meet the Plan's definition of an **Emergency**. However, this charge will not apply if the **Emergency** visit results in admission to the **Hospital**. See pages 68 and 73 through 74.*

****The percentage of **Eligible Expenses** payable may be reduced if applicable medical management procedures and notice requirements are not followed. See pages 77 through 78 and 92.*

See pages 129 through 132 for special rules applicable to routine physical exams.

To the extent required by applicable law, the **MMCP** (including the **MHSUD**) deductibles, fixed-dollar co-payments and coinsurance described above will not apply to **ACA Preventive Health Services** obtained from an **In-Network Provider**.

Comprehensive Health Care Benefit (CHCB), including the Mental Health and Substance Use Disorder Benefit (MHSUD) for CHCB Enrollees

The CHCB is available only in areas where MMCP coverage is not mandatory.

Deductible per Calendar Year*	
Individual	$350
Family	$700
Out-of-Pocket Maximum per Calendar Year*	
Individual	$3,000
Family	$6,000
Eligible Expenses Payable After Deductible is Satisfied (coinsurance)	80%**
Eligible Expenses Payable After Out-of-Pocket Maximum is Reached	100%**

Please see pages 79 through 82 to determine how the deductibles and out-of-pocket maximums interact within the **CHCB (including the **MHSUD**), and among the **CHCB** and the **MMCP**.*

***The percentage of **Eligible Expenses** payable may be reduced if applicable medical management procedures and notice requirements are not followed. See pages 83 and 92.*

See pages 129 through 132 for special rules applicable to routine physical exams.

To the extent required by applicable law, the **CHCB** (including the **MHSUD**) deductibles and coinsurance described above will not apply to **ACA Preventive Health Services**.

Managed Pharmacy Services Benefit (MPSB)

PRESCRIPTION DRUG CARD PROGRAM	
(Supply of 21 days or less)	
In-Network Pharmacy	
Co-Payment per **Generic Drug** Prescription	$10
Co-Payment per **Brand Name Drug** Prescription for **Formulary Drugs** Ordered by Your **Physician** To Be "Dispensed As Written" or Where There Is No Equivalent **Generic Drug**	$30
Co-Payment per **Brand Name Drug** Prescription for **Non-Formulary Drugs** Ordered by Your **Physician** To Be "Dispensed As Written" or Where There Is No Equivalent **Generic Drug**	$60
Co-Payment per **Brand Name Drug** Prescription for **Formulary Drugs** Where There Is a **Generic Drug** Equivalent and **Brand Name Drug** Was Not Ordered by Your **Physician** To Be "Dispensed As Written"	$30 plus the difference in cost between the equivalent **Generic Drug** and the **Brand Name Drug** dispensed

Co-Payment per **Brand Name** Drug Prescription for **Non-Formulary Drugs** Where There Is a **Generic Drug** Equivalent and **Brand Name Drug** Was Not Ordered by Your **Physician** To Be "Dispensed As Written"	$60 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 attempt to obtain 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 benefits only for a 21-day supply under the Plan.

MAIL ORDER PRESCRIPTION DRUG PROGRAM

(Supply of 22 to 90 days)

Co-Payment per Prescription (**Generic Drug**)	$10*
Co-Payment per Prescription (**Brand Name Drug** that is a **Formulary Drug**)	$60
Co-Payment per Prescription (**Brand Name Drug** that is a **Non-Formulary Drug**)	$120

Eligible Expenses Payable After
Co-Payment is Satisfied 100%

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

The **MPSB** co-payments described above will not apply to medicines and drugs that qualify as **ACA Preventive Health Services** obtained from an **In-Network Pharmacy** or through the Mail Order Prescription Drug Program.

Employee Contributions

Employees are required to make monthly contributions to the Plan, except for those who "opt out" as described under the "Opting Out of Plan Coverage" sections of this booklet or who are eligible to receive continuation of coverage (e.g., furloughed employees) as described under the "Continuation of Coverage After You Last Rendered Compensated Service" section of this booklet. Your contributions will be deducted from your wages by your employer and will be made on a pre-tax basis. The amount deducted will not be counted as part of your wages for Federal tax purposes. The amount of the contribution is determined by a formula set forth in collective bargaining agreements between your employer and the labor organization representing you.

Opting Out of Plan Coverage

If you certify that you have medical, mental health/substance use disorder and prescription drug coverage for yourself and your dependents under another group health plan or health insurance policy, you may "opt out" of the Plan's coverage. By opting out, you will be giving up this Plan coverage for yourself (except for coverage for on-duty injuries and for life and accidental death and dismemberment insurance) and your dependents.

If you opt out, the monthly employee contributions to the Plan described under the "Employee Contributions" section of this booklet will not be deducted from your wages. In addition, and subject to some exceptions, you will receive a monthly bonus of $100 in most months.

Even if you opt out, you will still be covered under the Plan for employee health benefits for on-duty injuries and for life and accidental death and dismemberment insurance.

Details of the opt-out opportunity, including a description of the exceptions to receiving the monthly bonus, are set forth under the subsequent "Opting Out of Plan Coverage" section of this booklet.

IV
ELIGIBILITY AND COVERAGE

Who Is Eligible For Coverage

Eligible Employees

You are an **Eligible Employee** if you are:

- a resident of the United States;
- employed by a participating employer; and
- represented by a participating labor organization that has reached an agreement with a participating employer for the Plan benefits and related matters described in this booklet.

Your organization's representative or your supervisor can tell you if your position meets these eligibility requirements.

The following is a special definition that applies to certain employees who may sometimes work in train service and sometimes work in engine service.

You are an **Eligible Employee** and therefore eligible for coverage under this Plan if you are a U.S. resident, you are employed by a participating employer, you work under a collective bargaining agreement with either SMART-TD or the BLET, and you satisfy one of the following four conditions:

- the Plan has been advised before the last Friday in August of the prior calendar year that your earnings from engine service is in excess of 50% of your total train and engine service earnings during the 12-month period ending June 30 of the prior calendar year. (Note, however, that if you

are already enrolled in the SMART-TD Plan, then and only then can you elect to remain in that plan even if you become eligible for coverage under this Plan as a result of the predominance of your earnings, subject to renewal of applicable agreements concerning this issue);

or

- you are listed in the Plan's records as working under a BLET collective bargaining agreement as of the last Friday in August of the prior calendar year, but the Plan has not been timely advised of your eligible status based on the predominance of your earnings as described above;

or

- you were hired after the last Friday in August of the prior calendar year under a BLET agreement, provided you did not last work under a collective bargaining agreement with SMART-TD;

or

- you moved after the last Friday in August of the prior calendar year to a position covered by a BLET agreement, provided that as of the date of the move you did not last work under a SMART-TD agreement.

All other employees who sometimes work in train service and sometimes work in engine service are not eligible for coverage during a given calendar year even if they work under a BLET agreement from time to time during that year. These employees may continue to be eligible for coverage under the SMART-TD Plan.

Eligible Employees *of hospital association railroads, who must look to their hospital association for their health care benefits,*

have limited Employee Health Care Benefits under the Plan (see pages 46, 49 through 50, and 57 through 58 for details).

A person who is a living donor of an organ or tissue to a **Covered Family Member** will be considered to be a **Covered Family Member** for purposes of the Plan's health care benefits, but such benefits will be paid only for **Eligible Expenses** in connection with the donation of an organ or tissue to a **Covered Family Member** under the **CHCB** or **MMCP**, as applicable.

Eligible Dependents

Your **Eligible Dependents** are:

- Your spouse.
- Your children (as defined below), other than your stepchildren, until the end of the month in which they reach age 26.
- Your stepchildren until the date on which they reach age 26.
- Your grandchildren (as defined below) under age 19.
- Your unmarried grandchildren (as defined below) between 19 and 25 who are registered students in regular full-time attendance at a postsecondary educational institution.
- Your unmarried children (as defined below) age 26 or over who:
    - have a permanent physical or mental condition that began prior to age 19, and
    - are unable to engage in any regular employment, and

    - 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 their legal residence with you.

- Your unmarried grandchildren (as defined below) age 19 or over who:

    - have a permanent physical or mental condition that began prior to age 19, and

    - are unable to engage in any regular employment.

For purposes of this "Who is Eligible for Coverage" section of the booklet:

- Your "children" is defined to mean your natural children, stepchildren and adopted children, including any child who is placed with you for adoption or who is an "Alternate Recipient" under a **Qualified Medical Child Support Order.**

- Your "grandchildren" is defined to mean your natural grandchildren or adopted grandchildren, provided they 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.

- "Grandchildren" does not include your step-grandchildren and, as a result, step-grandchildren are not eligible for coverage under the Plan.

- Same-sex spouses will be **Eligible Dependents** so long as the spouse and the **Eligible Employee** are legally married under Federal law.

When Coverage Starts

If you are an **Eligible Employee**, you become covered under this Plan on the first day of the calendar month following the month in which you first render the **Requisite Amount of Compensated Service**. Your **Eligible Dependents** become covered on the same day you become covered.

You and your **Eligible Dependents** continue to be covered during the month following each month in which you render or receive, in the aggregate, the **Requisite Amount of Compensated Service** or the **Requisite Amount of Vacation Pay**, except that you will not be covered for any health care benefits, other than those provided for on-duty injuries, and your **Eligible Dependents** will not be covered, during any month with respect to which you have opted out of Plan coverage. (The opt-out opportunity, including a description of the special rules that may apply if your spouse is also a railroad employee, is described in the subsequent "Opting Out of Plan Coverage" section of this booklet.)

If you were an **Eligible Employee** but your employment relationship with a participating employer ends and you then return to work with the same or a different participating employer, you will once again become an **Eligible Employee,** and you and your **Eligible Dependents** will become covered under the Plan on the first day of the first calendar month after the month in which you first render the **Requisite Amount of Compensated Service**.

When Coverage Stops

Coverage for all health care benefits stops when:

- you become covered under **Another Railroad Health and Welfare Plan**;

- your employer or labor organization stops participating in the Plan; or

- the class of employees you belong to stops being included under the Plan.

In addition, except as provided in the "Continuation of Coverage After You Last Rendered Compensated Service" section of this booklet, coverage for all health care benefits for you and your **Eligible Dependents** stops on the earlier of the following:

- the last day of the month following the month you last rendered or received, in the aggregate, the **Requisite Amount of Compensated Service** or the **Requisite Amount of Vacation Pay**; or

- the date your employment relationship ends for reasons other than retirement, such as resignation.

However, coverage for an individual dependent stops sooner when:

- a dependent child becomes covered as an **Eligible Employee** under this Plan, unless the dependent child affirmatively elects to be covered as an **Eligible Dependent** under this Plan or the SMART-TD Plan; or

- a dependent grandchild becomes covered as an **Eligible Employee** under this Plan; or

- a dependent is no longer an **Eligible Dependent**.

The following provisions apply only to a medically necessary leave of absence or other change in student status that began on or after January 1, 2010.

- If your unmarried grandchild between 19 and 25 who was covered based on the grandchild's status as a registered student in regular full-time attendance at a postsecondary educational institution, ceases to qualify as an eligible full-time student immediately before and solely because the grandchild takes a medically necessary leave of absence from school (or experiences any other medically necessary change in student status, such as a reduction to part-time status), that grandchild will still be treated as an eligible full-time student for purposes of dependent coverage until the earlier of:

    - one year from the date the medically necessary leave of absence (or other change in student status) begins, or

    - the date that coverage would otherwise terminate under the Plan for reasons other than the medically necessary leave of absence (or other change in student status).

- To qualify for this extension of coverage, you must provide a written certification from a treating **Physician** that the grandchild's change in student status is the result of a serious illness or injury and that the leave of absence or other change in student status is medically necessary.

Continuation Of Coverage After You Last Rendered Compensated Service

Furloughed Employees

If you are furloughed after you became an **Eligible Employee** AND you have rendered compensated service for three months, you will be covered for Employee and Dependents Health Care Benefits during your furlough until the end of the fourth month following the month in which you last rendered compensated service.

If you received **Vacation Pay** before the date on which you are furloughed, but in a month subsequent to the month in which you last rendered compensated service, the continued coverage described above will be measured from the month in which you received that **Vacation Pay**.

If you return to work as an **Eligible Employee** before your coverage ends, you will continue to be covered during the month in which you again render compensated service.

If you return to work as an **Eligible Employee** after your coverage ends, you will not be covered again until the month following the month in which you next render the **Requisite Amount of Compensated Service**.

If you become disabled before your coverage ends, you should refer to the "Disabled Employees" section of this booklet.

Suspended or Dismissed Employees

If you are suspended or dismissed after you became an **Eligible Employee,** and

- you have had an employment relationship with your employer for at least six months, and

- you have rendered compensated service for three months as an **Eligible Employee**,

you will be covered for Employee and Dependents Health Care Benefits during your suspension or after your dismissal until the end of the fourth month following the month in which you last rendered compensated service or, if you are a Suspended Employee, the month in which you last received **Vacation Pay**, if later.

If you received **Vacation Pay** before the date on which you are dismissed, but in a month subsequent to the month in which you last rendered compensated service, the continued coverage described above will be measured from the month in which you received that **Vacation Pay**.

If you return to work as an **Eligible Employee** before your coverage ends, you will continue to be covered during the month in which you again render compensated service.

If you return to work as an **Eligible Employee** after your coverage ends, you will not be covered again until the month following the month in which you next render the **Requisite Amount of Compensated Service**.

If you are awarded full back pay for all time lost as a result of your suspension or dismissal, your coverage will be provided as if you had not been suspended or dismissed in the first place.

If you become disabled before your coverage ends, you will be covered for benefits as described in the "Disabled Employees" section of this booklet.

Pregnant Employees

If you cease to render compensated service as a result of your pregnancy, you will be covered for Employee and Dependents

Health Care Benefits until the end of the fifth month following the month in which you last rendered compensated service.

If you return to work as an **Eligible Employee** before your coverage ends, you will continue to be covered during the month in which you again render compensated service.

If you return to work as an **Eligible Employee** after your coverage ends, you will not be covered again until the month following the month in which you again render the **Requisite Amount of Compensated Service**.

Disabled Employees

If you cease to render compensated service solely as a result of disability, including disability due to your pregnancy, or if you become disabled by reason of pregnancy or otherwise before your coverage as a Furloughed, Suspended or Dismissed Employee ends, and provided in any case that you remain continuously disabled, you will be covered for Employee Health Care Benefits until the end of the second calendar year next following the year in which you last rendered compensated service and for Dependents Health Care Benefits until the end of the calendar year next following the year in which you last rendered compensated service.

If you received **Vacation Pay** before the date on which you relinquished your employment rights for any reason, but in a year subsequent to the year in which you last rendered compensated service, the continued coverage described above will be measured from the year in which you received that **Vacation Pay**.

If your disability ends before the end of the second calendar year next following the year in which you last rendered compensated service, your coverage will end at the same time your disability ends, unless you then return to work and render compensated

service, in which event your coverage by reason of disability will continue until the end of the month in which your disability ends.

You may be required to submit proof of your disability to the company that administers your benefits. Failure to provide this proof of disability, when requested, will cause your coverage for Employee and Dependents Health Care Benefits to end. In that event, the company that administers your benefits will determine the date that coverage terminated based on the most current disability information available.

Retired Employees

If you retire, you will be covered for Employee and Dependents Health Care Benefits during the month following the month in which you last rendered compensated service.

If you received **Vacation Pay** before the date on which you relinquished your employment rights to retire, but in a month subsequent to the month in which you last rendered compensated service, the continued coverage described above will be measured from the month in which you received that **Vacation Pay**.

Retired Employees may be eligible for benefits under The Railroad Employees National Early Retirement Major Medical Benefit Plan. See the "Options After Coverage Ends" section of this booklet.

Deceased Employees

If you die while covered for Dependents Health Care Benefits, benefits will continue until the end of the fourth month following the month in which you die for any dependent covered at the time of your death.

Employees Under Compensation Maintenance Agreements, etc.

All coverage will continue for as long as your employer is obligated to provide continued coverage of the kind provided under the Plan because of an agreement, statute, or order of a regulatory authority, but only if your employer makes a payment for you as if you had rendered the **Requisite Amount of Compensated Service** and you have not relinquished your employment rights.

Employees Opting Out of Plan Coverage

If you have opted out of Plan coverage with respect to any month in which coverage would otherwise be continued as described above because of furlough, suspension or dismissal, pregnancy, disability, retirement, death or compensation maintenance agreements, etc., Employee on-duty Health Care Benefits will continue to be provided and you will continue to be covered for life and accidental death and dismemberment insurance. No other benefits under this Plan, except as described above, will continue, including Dependents Health Care Benefits.

Returning Veterans

If you had been an **Eligible Employee** and if you return to work for the same employer after completion of service in the armed forces of the United States, your coverage will begin on the day you first render compensated service upon your return.

Employees Taking Family or Medical Leave Pursuant to the Family and Medical Leave Act of 1993

Taking authorized leave under the Federal Family and Medical Leave Act ("FMLA") can impact two areas – coverage and contributions. The following rules apply if you take authorized leave under FMLA:

- For purposes of determining coverage for Employee and Dependents Health Care Benefits during a calendar month, and whether employee contributions are due, a day of authorized FMLA leave will be treated as a day of compensated service, unless in the following month the **Eligible Employee** is entitled to continued coverage under the Plan because of one of the reasons described under the "Continuation of Coverage After You Last Rendered Compensated Service" section of this booklet.

- A day of FMLA leave will not be treated as a day of compensated service for purposes of measuring any continued coverage described under the "Continuation of Coverage After You Last Rendered Compensated Service" section of this booklet.

- A day of authorized FMLA leave will not be treated as a day of compensated service for any reason if immediately prior to the beginning of authorized FMLA leave, you are not covered for any Employee Health Care Benefits other than Employee on-duty Health Care Benefits or your dependents are not covered for any Dependents Health Care Benefits under the Plan.

If you do not return to compensated service at the end of FMLA leave, you may be responsible for reimbursing your employer for its cost of continuing health care benefits under the Plan for you and your dependents during your leave.

Contact your employer for more information about FMLA leave.

Please note that your coverage ends immediately upon termination of your employment relationship with a participating employer, unless that termination occurs by reason of retirement, dismissal, or death.

Summary of Continuation of Coverage if You Cease to Render Compensated Service (Other Than Continuation of Coverage Under COBRA or the Family and Medical Leave Act) and Have Not Opted Out

Reason for Ceasing to Render Compensated Service	**The Date Coverage Terminates (See Note 1)**
Furlough, Suspension or Dismissal	End of fourth month following the month in which you last rendered compensated service or received **Vacation Pay**. (See Note 2)
Leave of Absence	End of month following the month in which you last rendered or received, in the aggregate, the **Requisite Amount of Compensated Service** or the **Requisite Amount of Vacation Pay**.
Employment Relationship Terminates Other Than for Retirement or by Dismissal	Date of termination of employment relationship. (See Note 3)
Employment Relationship Terminates for Retirement	End of month following the month in which you last rendered compensated service or received **Vacation Pay**. (See Note 4)
Disability – Inability to Perform Work in Your Regular Occupation	Earlier of date your disability ends or end of second calendar year following the year in which you last rendered compensated service or received **Vacation Pay** for Employee Health Care Benefits (end of first calendar year for Dependents Health Care Benefits).
Pregnancy	End of fifth month following the month in which you last rendered compensated service.

Notes:

1. For complete information concerning termination of coverage, including modifications of the provisions outlined above, see the "Eligibility and Coverage" section of this booklet. Under certain circumstances, benefits may be payable after coverage terminates. Information in this regard is also contained in the "Eligibility for Benefits" section of this booklet.

2. For a Furloughed Employee, **Vacation Pay** must be received prior to furlough. For a Dismissed Employee, **Vacation Pay** must be received prior to dismissal.

3. In the event an **Eligible Employee** dies while covered, coverage for Dependents Health Care Benefits continues to the end of the fourth month following the month in which the **Eligible Employee** died.

4. For a **Retired Employee**, **Vacation Pay** must be received prior to the relinquishment of employment rights.

See the "Options After Coverage Ends" section of this booklet for information as to other coverage available upon termination of your coverage under this Plan.

Optional Continuation of 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.** When you become eligible for **COBRA**, you may also become eligible for other coverage options that may cost less than **COBRA** continuation coverage.

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, contact Railroad Enrollment Services toll free at the phone number listed on www.yourtracktohealth.com.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

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.

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

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

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

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than your spouse's gross misconduct;
- your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- you become divorced or legally separated from your spouse.

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

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than the parent-employee's gross misconduct;
- the parent-employee 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 Railroad Enrollment Services has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify Railroad Enrollment Services 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 losing eligibility for coverage as a dependent child), you must notify Railroad

Enrollment Services 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

In addition to providing notice, Railroad Enrollment Services may require additional information, such as a divorce decree or a completed full-time student verification form. Please contact Railroad Enrollment Services for more information.

How is COBRA Coverage Provided?

Once Railroad Enrollment Services receives proper 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 employees 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. When the qualifying event is the end of the employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, **COBRA** continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered

employee becomes entitled to Medicare 8 months before the date on which the employee's employment terminates, **COBRA** continuation coverage for the employee's spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, **COBRA** continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of **COBRA** continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled, or has a total and permanent disability entitling you or anyone in your family covered under the Plan to an annuity under the Railroad Retirement Act, and you notify Railroad Enrollment Services of the determination within 60 days from the date it was made, you and your entire family may be entitled to receive up to an additional 11 months of **COBRA** continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of **COBRA** continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

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

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP)[1], or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

[1] www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/ (as updated from time to time).

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[2] to sign up for Medicare Part A or B, beginning on the earlier of:

- the month after your employment ends; or
- the month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

[2] www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start (as updated from time to time).

For more information visit www.medicare.gov/medicare-and-you (as amended from time to time).

If You Have Questions

Questions about your Plan or your **COBRA** continuation coverage rights should be addressed to the company administering your benefits or Railroad Enrollment Services at the phone number listed on www.yourtracktohealth.com. For more information about your rights under ERISA, including **COBRA**, the Patient Protection and Affordable Care Act, 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. For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep Railroad Enrollment Services 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 Railroad Enrollment Services.

Optional Continuation of Coverage Under USERRA

This part of your booklet contains important information about the right to USERRA continuation coverage, which is a temporary extension of coverage under the Plan that is available to **Eligible Employees** who are unable to perform compensated service because they are serving in the military or other applicable uniformed services (e.g., National Guard duty under a Federal statute or the commissioned corps of the Public Health Service). The right to continuation of coverage was created by a Federal law, the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). USERRA rights are similar but not identical to **COBRA** rights. Where **COBRA** provides greater benefits than USERRA, **COBRA** will govern; where USERRA provides greater benefits than **COBRA**, USERRA will govern. **COBRA** rights and USERRA rights will run concurrently.

What follows is only a summary of your USERRA continuation coverage rights. For additional information about your rights and obligations under the Plan and under Federal law, you should contact Railroad Enrollment Services toll free at the phone number listed on www.yourtracktohealth.com.

If you cease to render compensated service as an **Eligible Employee** to perform service in the uniformed services, you and your **Eligible Dependents** can continue coverage for up to 24 months following the date you last rendered compensated service to your railroad employer prior to performing service in the uniformed services.

To continue coverage under USERRA, you must provide your railroad employer with advance notice of your decision to continue coverage in accordance with their procedures. Your railroad employer will notify Railroad Enrollment Services of

your decision. You must also make timely payments to cover the cost of USERRA premiums for continuation of coverage.

If you fail to properly provide advance notice to your railroad employer of your decision to elect continued coverage or if you fail to make timely payments for continued coverage, you will lose your right to continue coverage pursuant to USERRA unless the requirement to provide advance notice of your election or make timely payments has been excused in accordance with USERRA because such notice was impossible, unreasonable or precluded by military necessity. If the requirement that you provide advance notice or make timely payments has been properly excused, your coverage will be reinstated retroactive to the date that your coverage was terminated upon your election to continue coverage and your remittance of all unpaid payments. Note: this exception *does not apply* if you were able to give your employer timely notice of service in advance of your departure.

If you elect continuation of coverage under USERRA, you may also elect that for your **Eligible Dependents.** If you do not elect continuation of coverage under USERRA for yourself, your **Eligible Dependents** have no right to elect that coverage on their own (though your spouse and dependent children will retain whatever rights they may have to elect their own COBRA continuation coverage).

Your right to continued coverage under USERRA may end sooner than 24 months if you:

- fail to return to your employment or apply for reemployment with your railroad employer upon completing service in the uniformed services within the time allotted by USERRA;

- fail to make on time the required payments for USERRA coverage; or

- lose your USERRA rights as a result of other than an honorable discharge or if you are dismissed or dropped from military rolls under conditions that result in a loss of reemployment rights under USERRA.

Other Continuation of Coverage Provisions

Under certain circumstances, your coverage may continue, often without cost to you, for all or part of the 18-, 29- or 36-month continuation period (see the "Continuation of Coverage After You Last Rendered Compensated Service" section of this booklet). Coverage can be continued under **COBRA** for the remainder of the 18-, 29- or 36-month continuation period by making the required payments.

Eligibility For Benefits

Employees of Non-Hospital Association Railroads

If you are an **Eligible Employee** employed in a position that does not require your employee health care benefits to be provided by a hospital association, you and your **Eligible Dependents** are eligible for Employee and Dependents Health Care Benefits under the Plan.

Employees of Hospital Association Railroads

If you are an **Eligible Employee** employed in a position that requires your Employee Health Care Benefits to be provided by a hospital association, you are eligible only for Dependents Health Care Benefits and Employee on-duty Health Care Benefits (excluding prescription drug coverage) under the Plan, except as described below.

You are eligible for Employee Health Care Benefits if you are Suspended or Dismissed. Coverage for Suspended Employees begins on the first day of the second calendar month after the date you last rendered any compensated service. Coverage for Dismissed Employees begins on the date of dismissal. In both cases, coverage ends on the last day of the fourth calendar month following the month in which you last rendered any compensated service or received **Vacation Pay**. In the case of Dismissed Employees, payment for vacation must be received prior to dismissal to be considered as **Vacation Pay**.

Your other health care benefits, including pregnancy benefits, will be provided by your hospital association under its eligibility rules, and not by this Plan.

Employees Who Have Opted Out of Plan Coverage

If you have opted out of Plan coverage, you are eligible only for Employee on-duty Health Care Benefits and for life and accidental death and dismemberment insurance.

Benefits While You are Covered by the Plan

You are eligible for Employee and Dependents Health Care Benefits for **Eligible Expenses** incurred while you are covered by the Plan.

Benefits After Coverage Ends

Employee Health Care Benefits

After your coverage ends, Employee Health Care Benefits (or for employees who have opted out, only Employee on-duty Health Care Benefits) will continue to be payable, but only for injuries that occurred and sicknesses (or pregnancies) that commenced before or while you were covered, and then only until the earliest of the following:

- For Injury or Sickness:
    - three months from the date your coverage ends, unless at the end of that three-month period you are under treatment by a **Physician** for a disability that was caused by an injury that occurred, or a sickness that commenced, before or while you were covered, and the disability prevents you from performing work in your last regular occupation and any other comparable occupation. *Under no circumstance are benefits payable after the end of this three-month period for any injury or sickness that does not cause your continuous disability or*

for any injury occurring or sickness commencing after your coverage ends;

- until the end of your disability; or

- when you fail to render compensated service or receive **Vacation Pay** for two calendar years. Such **Vacation Pay,** however, must be received prior to your furlough or dismissal, or before you relinquish your employment rights in connection with your retirement. Moreover, such **Vacation Pay** must be received before:

    - you become covered under **Another Railroad Health and Welfare Plan**,

    - your employer or labor organization stops participation in the Plan, or

    - the class of employees to which you belong is excluded under the Plan.

- For Pregnancy:

    - if you are pregnant on the date your coverage ends, benefits will continue to be payable for **Eligible Expenses** related to that pregnancy.

Dependents Health Care Benefits

If your **Eligible Dependent** is disabled on the date that dependent's coverage ends, Dependents Health Care Benefits will be payable for **Eligible Expenses** incurred in the calendar year in which coverage stops and the next two succeeding calendar years, but only for the injury, sickness or pregnancy causing the continuous disability of your **Eligible Dependent** after coverage stops.

If you cease to render compensated service due to pregnancy and your child is born after your coverage ends, Dependents Health Care Benefits will apply to the **Eligible Expenses** of your newborn child only during the 14 days immediately following the child's birth.

Dependents Health Care Benefits for a pregnancy of a dependent spouse will be payable for **Eligible Expenses** incurred, if conception occurs before or while you are covered.

None of the three immediately preceding paragraphs applies to you if you have opted out of Plan coverage.

Dependent Spouses Covered as Employees Under a Hospital Association Plan

Health care benefits under this Plan are limited with respect to spouses who are covered as **Eligible Dependents** and who are also **Eligible Employees** under this Plan or the SMART-TD Plan who must look to a hospital association for employee health care benefits, and who have not opted out of foreign-to-occupation health care coverage under this Plan and the hospital association plan. Dependents Health Care Benefits under this Plan will be payable for such a spouse only:

- for any covered injury or sickness if the spouse is covered under this Plan as a Suspended or Dismissed Employee, and

- for any covered injury or sickness, if under this Plan the spouse's employee coverage is other than as a Suspended or Dismissed Employee, 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;

- the spouse 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 a retiree eligible for coverage under The Railroad Employees National Early Retirement Major Medical Benefit Plan, who must look to a hospital association for early retiree health care benefits, Dependents Health Care Benefits will be payable under this Plan only to the extent that the 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; and

- 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 of an employee covered by that plan and of an **Eligible Employee** 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 Employee** covered under this Plan has a birthday earlier in the calendar year than the employee covered by the other plan(s); 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.

Participation in the Managed Medical Care Program (MMCP)

The **MMCP** is available throughout the United States. Participation in the **MMCP** is mandatory in certain geographic areas, called **Mandatory Network Areas,** and optional in other geographic areas, called **Non-Mandatory Network Areas**. If you reside in a **Mandatory Network Area,** you and your **Eligible Dependents** – or if you are an **Eligible Employee** of a hospital association railroad, only your **Eligible Dependents** – must participate in the **MMCP**. An **MMCP** Information Statement will be sent to you. You cannot participate in the **CHCB**.

If you live in a **Mandatory Network Area** where the Plan has selected UnitedHealthcare but not Aetna as a managed care vendor, you may choose the **MMCP** administered by UnitedHealthcare or the **MMCP** administered by Highmark BCBS. If you live in a **Mandatory Network Area** where the Plan has selected Aetna but not UnitedHealthcare as a managed care vendor, you may choose the **MMCP** administered by Aetna or the **MMCP** administered by Highmark BCBS. If you fail to make a choice, you will be enrolled in the **MMCP** administered by the company that administered your benefits at the time you failed to make this choice.

If you reside in a **Non-Mandatory Network Area**, you and your **Eligible Dependents –** or if you are an **Eligible Employee** of a hospital association railroad, only your **Eligible Dependents** – may participate in the **CHCB** instead of the **MMCP**. If you reside in a **Non-Mandatory Network Area** and you choose to participate in the **MMCP**, you may choose the **MMCP** administered by any of the companies that have a point of service medical care network (UnitedHealthcare or Aetna) or preferred provider medical care network (Highmark BCBS) in your area at any time during the calendar year; however, you may not change back to the **CHCB** until the next open enrollment period with your choice being

effective the next January 1. You must call Railroad Enrollment Services at the phone number listed on www.yourtracktohealth.com to begin the special enrollment process.

If you are enrolled in the **MMCP**, you may obtain In-Network level of benefits from any **In-Network Provider** affiliated with the managed care vendor you have selected, even if that Provider is in a different network area. Please bear in mind that if you are enrolled in the **MMCP**, you may obtain the In-Network level of benefits only from **In-Network Providers,** unless you have an **Out-of-Network Authorization**. **Covered Health Services** you receive from any provider who is not an **In-Network Provider**, are covered at the **Out-of-Network Services** benefits level, unless you have an **Out-of-Network Authorization**. This holds true whether you reside in a network area or not.

In-Network Providers for UnitedHealthcare can be found at www.myuhc.com (select the "Choice Plus" option) and for Aetna at www.aetna.com (select the "Choice POS II" option). If you are enrolled in the **MMCP** administered by Highmark BCBS, you can identify **In-Network Providers** at www.myhighmark.com by following the prompts for the PPO plan. (Note: If you are a Wyoming resident, you should follow the prompts for the "Traditional" product type.) You can also call Highmark BCBS's Member Services at the phone number listed on www.yourtracktohealth.com, and speak with a member service representative.

For purposes of the following eligibility rules, your residence is determined by the latest information provided to the Plan by your employer. It is thus very important that you promptly notify your employer of any residence change.

Existing Employees

Each **Eligible Employee** living in a **Mandatory Network Area** must be enrolled in the **MMCP** along with the employee's **Eligible Dependents**. Similarly, each **Eligible Employee** living in a **Non-Mandatory Network Area** will automatically be enrolled in the **MMCP**, along with the employee's **Eligible Dependents**, only if and when the Plan designates the area where the employee lives as a **Mandatory Network Area.** See the "Participation in the Managed Medical Care Program (MMCP)" section of this booklet for rules regarding which **MMCP** you will be enrolled in if this situation should occur.

Newly Hired Employees

Each newly hired **Eligible Employee** who, at the time the employee first renders the **Requisite Amount of Compensated Service** and who lives in a **Mandatory Network Area**, will be enrolled, along with the employee's **Eligible Dependents,** in an interim **MMCP** administered by UnitedHealthcare or Aetna. Such enrollment in the interim **MMCP** will start with the first day of the month following the month the employee first renders the **Requisite Amount of Compensated Service** and will continue until completion of enrollment in the **MMCP**, but not beyond the end of the third month following the month the **Eligible Employee** first renders the **Requisite Amount of Compensated Service.** This interim **MMCP** is identical to the **MMCP** except that the payments for **Out-of-Network Services,** as described on page 71, are 85% and 68% instead of 70% and 56%.

If by the end of the third month following the month the **Eligible Employee** first renders the **Requisite Amount of Compensated Service**, the **Eligible Employee** who lives in a **Mandatory Network Area** has not completed enrollment in the **MMCP**, the employee and the employee's **Eligible Dependents** will be placed in the **MMCP** administered by UnitedHealthcare or Aetna until the next open enrollment.

Each newly hired **Eligible Employe**e who, at the time the employee first renders the **Requisite Amount of Compensated Service**, and who lives in a **Non-Mandatory Network Area**, will be enrolled, along with the employee's **Eligible Dependents,** in the **CHCB** administered by UnitedHealthcare.

Returning Employees

Eligible Employees who return to compensated service and become eligible for coverage within 24 months of loss of eligibility for coverage, and whose employment relationship has not terminated at any time prior to such return, will, along with their **Eligible Dependents,** be enrolled in the benefit (with the same administrator) in which they were enrolled when their eligibility for Plan coverage was lost.

An **Eligible Employee** who does not return to service within 24 months of losing eligibility for coverage, or whose employment relationship terminates before returning to work even if the employee comes back within the 24-month period, will be considered a newly hired employee for purposes of determining in which Plan benefit the employee and the employee's **Eligible Dependents** will be enrolled.

Transferring Employees

Eligible Employees who move, and their **Eligible Dependents**, will have the following options:

- If they were covered under the **MMCP** administered by Highmark BCBS before the move, they will remain covered under the **MMCP** administered by Highmark BCBS, provided they have moved to a **Mandatory Network Area**.

- If they move to a **Non-Mandatory Network Area** they will be covered under the **CHCB** administered by Highmark

BCBS, unless they choose the **CHCB** administered by UnitedHealthcare or they choose the **MMCP** administered by the companies available in that area at any time during the calendar year. However, they may not change back to the **CHCB** until the next open enrollment period with their choice being effective the next January 1.

- If they were covered under the **MMCP** administered by either UnitedHealthcare or Aetna before the move:

    - If they move to a **Mandatory Network Area**, and the **MMCP** administered by the same company is available in the new location, they will remain in the **MMCP** administered by that same company.

    - If they move to a **Mandatory Network Area,** and the **MMCP** administered by the same company is not available in the new location, but the **MMCP** administered by the other company (either UnitedHealthcare or Aetna) is available in the new location, they must choose such other company or Highmark BCBS. If they do not make a choice, they will be transferred to the **MMCP** administered by the other company, i.e., not by Highmark BCBS. In this event, an interim **MMCP** will apply until enrollment in the **MMCP** in the new network area is completed, but not beyond the end of the first month following the month during which UnitedHealthcare receives notice that the **Eligible Employee** has moved to the new network area. The interim **MMCP** is identical to the **MMCP** except that the payments for **Out-of-Network Services,** as described on page 71, are 85% and 68% instead of 70% and 56%.

    - If they move to a **Non-Mandatory Network Area**, they must choose UnitedHealthcare or Highmark

BCBS to administer the **CHCB** for them or **MMCP** administered by the companies available in that area at any time during the calendar year; however, they may not change back to the **CHCB** until the next open enrollment period with their choice being effective the next January 1.

- If they were covered under the **CHCB** administered by Highmark BCBS before the move, they will be covered under the **CHCB** administered by Highmark BCBS. However, if they were covered under the **CHCB** and move to a **Mandatory Network Area**, they will be enrolled in the **MMCP** administered by Highmark BCBS, unless they choose the **MMCP** administered by another company (Aetna in some areas or UnitedHealthcare in others).

- If they were covered under the **CHCB** administered by UnitedHealthcare before the move, they will be covered under the **CHCB** administered by UnitedHealthcare. However, if they were covered under the **CHCB** and move to a **Mandatory Network Area**, they will be enrolled in the **MMCP** administered by Aetna in some areas or UnitedHealthcare in others, unless they choose to have their **MMCP** administered by Highmark BCBS.

Employees of Hospital Association Railroads

The description of the coverage – **MMCP** or **CHCB** – applicable to Existing Employees, Newly Hired Employees, Returning Employees, and Transferring Employees applies only to the **Eligible Dependents** of **Eligible Employees** of hospital association railroads and not to the **Eligible Employees** themselves, except that **Eligible Employees** are eligible for **MMCP** or **CHCB** benefits for Employee on-duty Employee Health Care Benefits (excluding prescription drug coverage) and when Suspended or Dismissed. If an **Eligible Employee** of a hospital association railroad loses hospital association coverage and becomes covered for

Employee Health Care Benefits under the Plan, the employee will have the same coverage – **MMCP** or **CHCB** (in each case, administered by the same company) – selected for the employee's **Eligible Dependents.** If the **Eligible Employee** has no dependents, the employee will be covered just as if the employee was a newly hired employee.

Enrollment Changes

In October of each year, or during any other open enrollment period announced by the Plan, all **Eligible Employees** enrolled in the **MMCP** who do not reside in a **Mandatory Network Area** may elect to be enrolled, along with their **Eligible Dependents,** in the **CHCB** administered by Highmark BCBS or in the **CHCB** administered by UnitedHealthcare. Also, any **Eligible Employee** enrolled in the **MMCP** may, along with their **Eligible Dependents,** elect to move to the **MMCP** administered by a different company in the area where the **Eligible Employee** lives. Similarly, **Eligible Employees** enrolled in the **CHCB** may move from the **CHCB** administered by UnitedHealthcare to the **CHCB** administered by Highmark BCBS or from the **CHCB** administered by Highmark BCBS to the **CHCB** administered by UnitedHealthcare. Any **Eligible Employee's** election will be effective on the subsequent January 1, or on such other date as may be announced by the Plan. In addition, **Eligible Employees** enrolled in the **CHCB** may elect to be enrolled, along with their **Eligible Dependents,** in the **MMCP** (where available) at any time.

V
EMPLOYEE AND DEPENDENTS HEALTH CARE BENEFITS

The Plan provides the Managed Medical Care Program **(MMCP),** the Comprehensive Health Care Benefit **(CHCB)**, the Mental Health and Substance Use Disorder Benefit **(MHSUD**, as provided through the **MMCP** and **CHCB),** and the Managed Pharmacy Services Benefit **(MPSB)**. The **MMCP, CHCB** and **MHSUD** provide payment for **Eligible Expenses** for **Covered Health Services.** The **MPSB** provides payment for **Eligible Expenses** for **Prescription Drugs** obtained from a pharmacy or by mail order. The general rules that apply in determining whether or not an expense is an **Eligible Expense** and **Covered Health Services** are explained in the "Eligible Expenses and Covered Health Services" section of this booklet.

Special Arrangements with Providers Applicable to the Out-of-Network Services Portion of the MMCP and MHSUD, and to the CHCB

The Plan enjoys arrangements with various health care providers pursuant to which those providers' charges for **Eligible Expenses** under the **CHCB** or the **Out-of-Network Services** portion of the **MMCP** and **MHSUD** are discounted. These discounts are made available to **Covered Family Members** as a result of direct and indirect arrangements with the providers through the company administering your benefits. If you seek services from a provider that has a discount arrangement with the company administering your benefits, then you are responsible for speaking with your provider and the company administering your benefits, as appropriate, to understand how these discounts impact the amount you will be required to pay for those services. You will receive an Identification Card showing that you and your **Eligible**

Dependents are entitled to discounts through these arrangements. This Identification Card must be shown every time health care services are given. This is how the provider know that you or your **Eligible Dependent** is covered under a discount program. Otherwise, you could be billed for the provider's normal charge.

Managed Medical Care Program

The **MMCP** provides payment for a wide range of expenses for **Medical Care.** The "Eligible Expenses and Covered Health Services" section of this booklet explains what is covered under the **MMCP**.

Eligible Expenses for **Covered Health Services** for **Prescription Drugs** obtained as part of outpatient **Medical Care** (except with respect to **Home Health Care Agency** services), are not covered under the **MMCP**. The Plan does cover these **Eligible Expenses**, however, to the extent provided under the **MPSB**, as described in the "Managed Pharmacy Services Benefit" section of this booklet. Additional information related to **Eligible Expenses** for **Covered Health Services** that consist of **Mental Health Care** or **Substance Use Disorder Care** that are covered under **MHSUD** (as provided through the **MMCP**) is in the "Mental Health and Substance Use Disorder Benefit" section of this booklet.

The **MMCP** pays for **Eligible Expenses** at two different benefit levels. One benefit level is for **In-Network Services.** The other is for **Out-of-Network Services.**

A brief comparison of these two benefit levels is shown in the "Highlights" section of this booklet.

In-Network Services

Eligible Expenses for **ACA Preventive Health Services** rendered by **In-Network Providers** are paid at 100% with no fixed-dollar co-payment, deductible or coinsurance applied.

All other **Eligible Expenses** for **In-Network Services** are paid either at 90% after any applicable deductible is satisfied or at 100% following payment of an applicable fixed-dollar co-payment. In other words, the 10% "coinsurance" amount does

not apply to services subject to a fixed-dollar co-payment, as explained below.

Fixed-Dollar Co-Payments

- Your fixed-dollar co-payment is $10, $25 or $40 for each office visit to an **In-Network Provider**, unless the primary purpose of the office visit is the delivery of an **ACA Preventive Health Service** and the **ACA Preventive Health Service** is not billed separately from the office visit.

- The $25 office visit fixed-dollar co-payment applies to each office visit to any **In-Network Provider** in general practice or who specializes in behavioral health (including a virtual office visit provided through the company that administers your **MHSUD** benefits), pediatrics, obstetrics/gynecology, family practice, or internal medicine, or who is a Nurse Practitioner, Physician Assistant, Physical Therapist, or Chiropractor.

- Your fixed-dollar co-payment is $10 for each visit to a **Convenient Care Clinic** that is an **In-Network Provider**.

- Your fixed-dollar co-payment is $40 for each office visit to any other **In-Network Provider**.

- Your fixed-dollar co-payment is $10 for each **Telemedicine** office visit through the Plan's designated ancillary benefit **Telemedicine** vendor.

- Note the following exceptions to the office visit fixed-dollar co-payment rules discussed above:

    - There is no office visit fixed-dollar co-payment for visits to your OB/GYN for treatment of a pregnancy after the initial visit to the same OB/GYN for treatment of the same pregnancy.

- There is no office visit fixed-dollar co-payment for visits solely for the administration of an allergy shot.

- See pages 68 through 69 for additional information regarding these exceptions to the office visit fixed-dollar co-payment rules.

- Your fixed-dollar co-payment is $25 for each visit to an urgent care center that is an **In-Network Provider**.

- Your fixed-dollar co-payment is at least $100 for each visit to the emergency room of any **Hospital** whether the **Hospital** is an **In-Network Provider** or an **Out-of-Network Provider**. This $100 emergency room fixed-dollar co-payment applies to **Eligible Expenses** for charges made by the **Hospital** for care received in its emergency room. The fixed-dollar co-payment does not apply if inpatient admission to that **Hospital** is required.

    - A **Hospital** that is an **Out-of-Network Provider** may ask you to pay more than the $100 emergency room fixed-dollar co-payment. The **Hospital** may even require payment in full at the time services are rendered. However, if your situation meets the applicable Plan definition of an **Emergency** and the visit does not result in an inpatient admission to that hospital, the **MMCP** will reimburse you for the full amount of the **Hospital** charge except for $100.

    - Regardless of whether the **Hospital** from which you receive **Emergency** care is an **In-Network Provider** or an **Out-of-Network Provider,** if your situation does not meet the applicable Plan definition of an **Emergency**, the **MMCP** will pay benefits at the level paid for **Out-of-Network Services**.

Annual Deductibles

Where a fixed-dollar co-payment does not apply, there are two types of deductibles for **In-Network Services**, an Individual Deductible and a Family Deductible.

- The Individual Deductible is $350. It applies separately to each **Covered Family Member** each calendar year.

- The Family Deductible is $700. This is the most you and your **Eligible Dependents** will have to pay for Individual Deductibles in any calendar year. This Family Deductible applies no matter how many **Covered Family Members** you have.

Only **Eligible Expenses** which count towards satisfying a person's Individual Deductible count towards satisfying the Family Deductible.

Any amounts applied towards satisfying the deductibles for **Out-of-Network Services** do not count towards satisfying the deductible for **In-Network Services**.

If a fixed-dollar co-payment applies to an **Eligible Expense**, the remainder of that **Eligible Expense** will not be subject to any **MMCP** deductible for **In-Network Services**. Any amounts paid for fixed-dollar co-payment will not apply towards the satisfaction of deductibles.

Amounts paid towards satisfying any **CHCB** deductible will count towards satisfying the **MMCP** deductibles for **In-Network Services** described above for any **Eligible Employee** who becomes enrolled in the **MMCP** by reason of having moved to a geographic area where **MMCP** participation is mandatory, or who is currently enrolled in the **CHCB** and lives/moves into a geographical area where the **Eligible Employee** has the option to elect either the **MMCP** or the **CHCB**.

Percentage of Eligible Expenses Paid

Benefits for **Eligible Expenses** for **In-Network Services** under the **MMCP**, other than those services that are subject to a fixed-dollar co-payment, are paid as follows after the applicable deductible is satisfied:

- Before the annual In-Network Out-of-Pocket Maximum is met, the **MMCP** pays 90% of **Eligible Expenses** and you pay the remaining 10% of **Eligible Expenses**.

- After the annual In-Network Out-of-Pocket Maximum is met, the **MMCP pays** 100% of **Eligible Expenses** for the remainder of the calendar year.

Annual Out-of-Pocket Maximum

The **In-Network Services** Out-of-Pocket Maximum limits the amount of **Eligible Expenses** you will have to pay in a calendar year for **In-Network Services**.

There are two types of **In-Network Services** Out-of-Pocket Maximums, Individual and Family.

- The Individual **In-Network Services** Out-of-Pocket Maximum is $2,000 each calendar year.

- The Family **In-Network Services** Out-of-Pocket Maximum is $4,000 each calendar year. This Family Out-of-Pocket Maximum applies no matter how many **Covered Family Members** you have.

Only **Eligible Expenses** which count towards satisfying a person's Individual Out-of-Pocket Maximum count towards satisfying the Family Out-of-Pocket Maximum.

Payments made for coinsurance for **In-Network Services** under the **MMCP** will count towards satisfying these Out-of-Pocket

Maximums, except that amounts paid towards reaching any **CHCB** Out-of-Pocket Maximum will count towards reaching the **MMCP** In-Network Out-of-Pocket Maximum for any **Eligible Employee** who becomes enrolled in the **MMCP** by reason of having moved to a geographic area where **MMCP** participation is mandatory, or who is currently enrolled in the **CHCB** and lives/moves into a geographical area where the **Eligible Employee** has the option to elect either **MMCP** or **CHCB**.

Only applicable coinsurance payments will count towards satisfying these Out-of-Pocket Maximums. For example, the following expenses do not count towards the **MMCP** In-Network Out-of-Pocket Maximum:

- Charges you pay for **Out-of-Network Services** for **MMCP** that are in excess of the **Reasonable Charge**.

- Charges you pay that are in excess of specific Plan limits or exclusions or for expenses not covered by the Plan.

- Any fixed-dollar co-payments you make under the **MMCP** (including the **MHSUD**) or any co-payments you make under the **MPSB** (including other **MPSB** charges, such as coinsurance or the difference in cost between the equivalent **Generic Drug** and the **Brand Name Drug** dispensed).

- Any charges you pay towards any deductible under the **CHCB** or the **MMCP** (which includes charges you pay under the **MHSUD**).

- Any charges you pay towards satisfaction of the Out-of-Pocket Maximum under the Out-of-Network portion of the **MMCP** (which includes charges you pay under the **MHSUD**).

- Charges you pay as a result of the 20% reduction in benefits under the **Out-of-Network Services** portion of the **MMCP** if (i) a required notice under the applicable medical management procedures of the company administering your **MMCP** is not given or (ii) that company determines that the service or supply, although a **Covered Health Service**, is not **Medically Appropriate**.

- Charges you pay as a result of the 20% reduction in benefits under the **MHSUD** (as provided through the **Out-of-Network Services** portion of the **MMCP**, or the **CHCB**) if (i) you fail to provide notice as required by the company administering your **MHSUD** benefits or (ii) the service or supply, although a **Covered Health Service**, is determined not to be **Medically Appropriate**.

Obtaining Benefits

To obtain benefits for **In-Network Services**, you or your **Eligible Dependent** must use an **In-Network Provider** or obtain an **Out-of-Network Authorization** to receive services from an **Out-of-Network Provider** which will be covered at the level of benefits payable for **In-Network Services**. You are not required to choose a Primary Care Physician. Nor are you required to obtain a referral or authorization in order to receive benefits for obstetrical or gynecological care, or specialist care.

Limit on Patient Liability (Balance Billing)

As long as you receive services from an **In-Network Provider**, or through an **Out-of-Network Authorization** prior to receiving specified services from an **Out-of-Network Provider,** your **Eligible Expenses** will be covered as if they were **In-Network Services**, in accordance with the rules described above.

An **In-Network Provider** cannot charge you for any **In-Network Services** which are not **Covered Health Services,** unless you agree to pay for them. The Plan does not cover them.

Emergencies

In an **Emergency**, the provider does not have to be an **In-Network Provider**. If your situation falls within the Plan's definition of an **Emergency**, the **MMCP** will pay benefits at the In-Network level. If, however, your situation does not fall within the Plan's definition of an **Emergency** and the provider is an **Out-of-Network Provider**, the **MMCP** will pay benefits at the Out-of-Network level.

To receive the In-Network level of benefits after the **Emergency** has ended, you must use **In-Network Providers**.

No In-Network fixed-dollar co-payment, deductible or coinsurance will apply to separately billed charges for services in a **Hospital's** emergency room if you are admitted to that **Hospital** as an inpatient in connection with the **Emergency** for which you went to the emergency room. The In-Network deductible and coinsurance will apply, however, if the **Hospital's** emergency room services are not billed separately, but rather, are included in the **Hospital's** overall bill for services rendered.

Pregnancy/Pre-Natal Care

The applicable fixed-dollar co-payment under the **MMCP** will apply to the initial office visit to an In-Network OB/GYN for treatment of a pregnancy, but no fixed-dollar co-payment will apply to subsequent visits to the same OB/GYN for treatment of the same pregnancy. However, the **MMCP** In-Network deductibles and coinsurance will apply to the OB/GYN's charges for these subsequent visits if the OB/GYN does not bill separately for these visits, unless the charges relate to an **ACA Preventive Health Service**, in which case no deductibles or coinsurance will

apply. If the OB/GYN bills separately for the subsequent office visits, then no **MMCP** In-Network fixed-dollar co-payments, deductible or coinsurance will apply to the subsequent visits.

Eligible Expenses for routine prenatal care provided by an **In-Network Provider** will be paid at 100% with no fixed-dollar co-payments, deductible or coinsurance applied, if the routine prenatal care qualifies as an **ACA Preventive Health Service**.

Allergy Shots

No fixed-dollar co-payment under the **MMCP** will apply to an office visit to an **In-Network Provider** solely for the administration of an allergy shot. However, In-Network deductibles and coinsurance under the **MMCP** will apply.

Chemotherapy/Other IV Medications

The In-Network deductible and coinsurance under the **MMCP** do not apply to charges for the administration of chemotherapy or of other infused medications in a **Physician's** office because an office visit fixed-dollar co-payment applies to this service. The In-Network deductible and coinsurance do apply, however, to the administration of chemotherapy or of other infused medications other than in a **Physician's** office, and to the charges for the drugs themselves because the office visit fixed-dollar co-payments do not apply to those services or medications.

Laboratory Services

The In-Network deductible and coinsurance, not the office visit fixed-dollar co-payment, under the **MMCP** apply to charges for laboratory services, such as blood tests, urinalysis and throat cultures. However, if the laboratory services qualify as **ACA Preventive Health Services**, then the services are not subject to fixed-dollar co-payments, deductibles or coinsurance under the **MMCP**.

Out-Of-Network Services

All **Eligible Expenses** for **Out-of-Network Services** are paid at the percentage set forth below if any applicable deductible has been satisfied and no **Out-of-Network Authorization** has been granted.

*To receive the maximum benefit for **Out-of-Network Services,** you must comply with the medical management procedures of the company administering your **MMCP** (see the "MMCP Medical Management" section of this booklet). For more information, call the Medical Management phone number listed on* www.yourtracktohealth.com *for the company administering your benefits.*

Annual Deductibles

There are two types of deductibles for **Out-of-Network Services**, an Individual Deductible and a Family Deductible.

- The Individual Deductible is $700. It applies separately to each **Covered Family Member** each calendar year.

- The Family Deductible is $1,400. This is the most you and your **Eligible Dependents** will have to pay for Individual Deductibles in any calendar year. This Family Deductible applies no matter how many **Covered Family Members** you have.

Only **Eligible Expenses** which count towards satisfying a person's Individual Deductible count towards satisfying the Family Deductible.

Payments made towards satisfying any deductible under the **Out-of-Network Services** portion of the **MMCP** (which includes

payments made under the **MHSUD**) will also count towards satisfying the applicable deductible under the **CHCB**.

Any amounts applied towards satisfying the deductibles for **In-Network Services** do not count towards satisfying the deductible for **Out-of-Network Services.**

Percentage of Eligible Expenses Payable

Benefits for **Eligible Expenses** for **Out-of-Network Services** are paid as follows:

- Before the annual Out-of-Pocket Maximum is met, the **MMCP** pays:
    - 70% of **Eligible Expenses**, but only
    - 56% of **Eligible Expenses** if a required notice to the company administering your **MMCP** is not given or if that company determines in performing its medical management function that the service or supply, although a **Covered Health Service**, is not **Medically Appropriate**.
- After the annual Out-of-Pocket Maximum is met, the **MMCP** pays:
- 100% of **Eligible Expenses** for the remainder of the calendar year, but only
- 80% of **Eligible Expenses** if a required notice to the company administering your **MMCP** is not given or if that company determines in performing its medical management function that the service or supply, although a **Covered Health Service**, is not **Medically Appropriate.**

Annual Out-of-Pocket Maximum

The Out-of-Pocket Maximum limits the amount of coinsurance for **Eligible Expenses** you will have to pay in a calendar year for **Out-of-Network Services.**

There are two types of Out-of-Pocket Maximums, Individual and Family.

- The Individual Out-of-Pocket Maximum is $4,000 each calendar year.

- The Family Out-of-Pocket Maximum is $8,000 each calendar year. This Family Out-of-Pocket Maximum applies no matter how many **Covered Family Members** you have.

Only **Eligible Expenses** which count towards satisfying a person's Individual Out-of-Pocket Maximum count towards satisfying the Family Out-of-Pocket Maximum.

Payments made towards satisfying the **MMCP** (which includes payments made under the **MHSUD**) Out-of-Network Out-of-Pocket Maximum will also count towards satisfying the Out-of-Pocket Maximum under the **CHCB**, and vice versa.

Only applicable coinsurance payments will count towards satisfying these Out-of-Pocket Maximums. For example, the following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay for **Out-of-Network Services** for **MMCP** that are in excess of the **Reasonable Charge**.

- Charges you pay that are in excess of specific Plan limits or exclusions or for expenses not covered by the Plan.

- Any fixed-dollar co-payments you make under the **MMCP** (including the **MHSUD**) or any co-payments you make under the **MPSB** (including other **MPSB** charges, such as coinsurance or the difference in cost between the equivalent **Generic Drug** and the **Brand Name Drug** dispensed).

- Any charges you pay towards any deductible under the **MMCP** or the **CHCB** (which includes charges you pay under the **MHSUD**).

- Any charges you pay towards satisfaction of the Out-of-Pocket Maximum under the In-Network portion of the **MMCP**.

- Charges you pay as a result of the 20% reduction in benefits under the **Out-of-Network Services** portion of the **MMCP** if (i) a required notice under the applicable medical management procedures of the company administering your **MMCP** is not given or (ii) that company determines that the service or supply, although a **Covered Health Service**, is not **Medically Appropriate**.

- Charges you pay as a result of the 20% reduction in benefits under the MHSUD (as provided through the **Out-of-Network Services** portion of the **MMCP**, or the **CHCB**) if (i) you do not provide notice as required by the company administering your **MHSUD** benefit or (ii) the service or supply, although a **Covered Health Service**, is determined not to be **Medically Appropriate**.

NOTE: When you get **Emergency** care or get treated by an out-of-network provider at an in-network **Hospital** or **Ambulatory Surgical Center**, you are protected from surprise billing or balance billing (i.e., an unexpected bill for the difference between what the Plan pays and the full amount charged for a service). For more information about your rights and protections against

surprise medical bills, please refer to www.yourtracktohealth.com.

Exclusions applicable to the Managed Medical Care Program are set forth under the "General Exclusions and Limitations" section of this booklet. 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 "Coordination of Benefits" section of this booklet. Other limitations with respect to Dependents Health Care Benefits are described on pages 48 through 51.*

MMCP Medical Management

The **Out-of-Network** portion of the **MMCP** requires you and/or your **Physician** to notify the company administering your benefits prior to receiving certain **Out-of-Network Services**. Failure to provide this notification can result in a reduction in your benefit, as described below.

When to Notify Medical Management

If applicable with respect to the company administering your benefits, medical management at that company must be notified as soon as possible after you know that you require any of the services or supplies shown below:

- Inpatient admissions to a **Hospital**, **Birth Center** or **Skilled Nursing Facility**.
- Home health care.
- **Hospice** care.
- Purchase or rental of durable medical equipment that exceeds $1,000.
- Reconstructive procedures.
- Dental services rendered as a result of an accident.
- Private duty nursing.

With regard to organ/tissue transplants, medical management 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.

You should notify medical management promptly after you become aware that you are pregnant. You are required to give this notice, however, only if and when 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 must be given in sufficient time to allow the company administering your benefits to complete a review of the matter before the services are rendered. In the absence of sufficient advance notice, the company involved 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, whether it is **Medically Appropriate**.

With respect to an in-patient confinement which follows an **Emergency**, you (or your representative or **Physician**) must call medical management within one day (excluding weekends and holidays) from the date an in-patient confinement which follows an **Emergency** begins.

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

This notification requirement does not apply to injuries incurred by an **Eligible Employee** while on duty for an employing railroad, but customer service representatives for the company that

administers your benefits are available to answer questions about proposed medical treatment.

How to Notify Medical Management

Notice must be given by telephone. Call the Medical Management telephone number listed on www.yourtracktohealth.com for the company administering your benefits to provide notice. If you call outside the company's usual hours of operation, you may leave a message with your telephone number on an answering machine, and your call will be returned within one working day.

What Happens After You Give the Required Notice?

The company administering your **MMCP** 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**. Review by medical management only determines whether the service or supply is a **Covered Health Service**, and, if so, whether it is **Medically Appropriate**, solely 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 call medical management as required by the company administering your benefits or if that company determines that the service or supply, although a **Covered Health Service,** is not **Medically Appropriate.** In either case, the benefit will be reduced from 70% to 56% of **Eligible Expenses.** If you

have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to 80%.

- No benefits are payable if medical management at the company administering your benefits determines that the service or supply is not a **Covered Health Service**.

If the company administering your benefits determines that a service is not a **Covered Health Service** or is not **Medically Appropriate**, you or your **Physician** can appeal that determination. See the "Processing of Claims and Appeals" section of this booklet for a description of the claims and appeals process.

Concurrent and Retroactive Review

Out-of-Network Services for which you do not notify the company administering your **MMCP** in accordance with the requirements explained above will be subject to concurrent and retroactive review to determine whether the services are **Medically Appropriate**. As explained above, the benefits payable by the **MMCP** will be reduced by 20% if you do not provide the required notice or the company administering your **MMCP** determines that the services are not **Medically Appropriate**.

Comprehensive Health Care Benefit

The **CHCB** pays a percentage of **Eligible Expenses** for **Covered Health Services** that consist of **Medical Care** in a calendar year that exceed the applicable deductible. However, the **CHCB** will pay 100%, with no deductible or coinsurance applied, of **Eligible Expenses** for **ACA Preventive Health Services**. The "Eligible Expenses and Covered Health Services" section of this booklet explains what is covered under the **CHCB**.

To receive the highest benefit level, you must comply with medical management requirements (see the "CHCB Medical Management" section of this booklet).

Eligible Expenses for **Covered Health Services** for **Prescription Drugs** obtained as part of outpatient **Medical Care** (except with respect to **Home Health Care Agency** services) are not covered under the **CHCB**. The Plan does cover these **Eligible Expenses**, however, to the extent provided under the **MPSB,** as described in the "Managed Pharmacy Services Benefit" section of this booklet. Additional information related to **Eligible Expenses** for **Covered Health Services** that consist of **Mental Health Care** or **Substance Use Disorder Care** that are covered under the **MHSUD** (as provided through the **CHCB**) is in the "Mental Health and Substance Use Disorder Benefit" section of this booklet.

Annual Deductibles

There are two types of deductibles, Individual and Family. The Individual Deductible is $350. It applies separately to each **Covered Family Member** each calendar year.

The Family Deductible is $700. This is the most you and your **Eligible Dependents** will have to pay for Individual Deductibles in any calendar year. This Family Deductible applies no matter how many **Covered Family Members** you have. Only **Eligible**

Expenses which count towards a person's Individual Deductible count towards the Family Deductible.

Payments made towards satisfying the **CHCB** deductibles (including payments made under the **MHSUD**) will also count towards satisfying any deductible under the **Out-of-Network Services** portions of the **MMCP**, and vice versa.

Percentage of Covered Eligible Expenses Payable

The **CHCB** pays:

- 80% of **Eligible Expenses** incurred until the Out-of-Pocket Maximum is reached, but only

- 64% of **Eligible Expenses** if a required notice to the company administering your **CHCB** is not given or if that company determines in performing its medical management function that, although the service or supply is a **Covered Health Service**, it is not **Medically Appropriate**.

When the annual Out-of-Pocket Maximum is met, the **CHCB** pays:

- 100% of **Eligible Expenses** for the remainder of the calendar year, but only

- 80% of **Eligible Expenses** if a required notice to the company administering your **CHCB** is not given or if that company determines in performing its medical management function that, although the service or supply is a **Covered Health Service**, it is not **Medically Appropriate**.

Annual Out-of-Pocket Maximum

The Out-of-Pocket Maximum limits the amount of **Eligible Expenses** you will have to pay in a calendar year.

There are two types of Out-of-Pocket Maximums, Individual and Family.

- The Individual Out-of-Pocket Maximum is $3,000 each calendar year.

- The Family Out-of-Pocket Maximum is $6,000 each calendar year. This Family Out-of-Pocket Maximum applies no matter how many **Covered Family Members** you have. Only **Eligible Expenses** which count towards a person's Individual Out-of-Pocket Maximum count towards the Family Out-of-Pocket Maximum.

Payments made towards satisfying the **CHCB** Out-of-Pocket Maximum (including payments made under the **MHSUD**) will also count towards satisfying the Out-of-Pocket Maximum under the **Out-of-Network Services** portions of the **MMCP**, and vice versa.

Only applicable coinsurance payments will count towards satisfying these Out-of-Pocket Maximums. For example, the following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the **Reasonable Charge**.

- Charges you pay that are in excess of specific Plan limits or exclusions or for expenses not covered by the Plan.

- Any fixed-dollar co-payments you make under the **MMCP** (including the **MHSUD**) or any co-payments you make

under the **MPSB** (including other **MPSB** charges, such as coinsurance or the difference in cost between the equivalent **Generic Drug** and the **Brand Name Drug** dispensed).

- Charges you pay towards any deductible under the **CHCB** or **MMCP** (which includes charges you pay under the **MHSUD**).

- Charges you pay as a result of the 20% reduction in benefits under the **Out-of-Network Services** portion of the **MMCP** if (i) a required notice under the applicable medical management procedures of the company administering your **MMCP** is not given or (ii) that company determines that the service or supply, although a **Covered Health Service**, is not **Medically Appropriate**.

- Charges you pay as a result of the 20% reduction in benefits under the **MHSUD** (as provided through the **Out-of-Network Services** portion of the **MMCP**, or the **CHCB**) if (i) you do not provide notice as required by the company administering your **MHSUD** or (ii) the service or supply, although a **Covered Health Service**, is determined not to be **Medically Appropriate**.

*Exclusions applicable to the Comprehensive Health Care Benefit are set forth under the "General Exclusions and Limitations" section of this booklet. 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 "Coordination of Benefits" section of this booklet. Other limitations with respect to Dependents Health Care Benefits are described on pages 48 through 51.*

CHCB Medical Management

The medical management procedures (including notice instructions) that apply under the Out-of-Network portion of the MMCP also apply to the CHCB (unless otherwise described below). They are described in the "MMCP Medical Management" section of this booklet . Please review the procedures carefully.

Effects on Benefits

- Benefits are reduced if you do not call medical management as required by the company administering your benefits or if that company determines that the service or supply, although a **Covered Health Service**, is not **Medically Appropriate**. In either case, the benefit will be reduced from 80% to 64% of **Eligible Expenses**. If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to 80%

- No benefits are payable if medical management at the company administering your benefits determines that the service or supply is not a **Covered Health Service**.

If the company administering your benefits determines that a service is not a **Covered Health Service** or is not **Medically Appropriate**, you or your **Physician** can appeal that determination. See the "Processing of Claims and Appeals" section of this booklet for a description of the claims and appeals process.

Concurrent and Retroactive Review

CHCB services for which you do not notify the company administering your **CHCB** in accordance with the requirements explained above will be subject to concurrent and retroactive review to determine whether the services are **Medically Appropriate**. As explained above, the benefits payable by the

CHCB will be reduced by 20% if you do not provide the required notice or the company administering your **CHCB** determines that the services are not **Medically Appropriate**.

Mental Health and Substance Use Disorder Benefit

The **MHSUD** provides payment for **Eligible Expenses** for **Mental Health Care** and/or **Substance Use Disorder Care** (also collectively referred to as "behavioral health" in this booklet). The "Eligible Expenses and Covered Health Services" section of this booklet explains what is covered under the **MHSUD**. **NOTE:** While the **MHSUD** is described as a separate benefit, the **MHSUD** program is fully integrated into the **MMCP** and **CHCB**. This means that the fixed-dollar co-payments (if you are enrolled in **MMCP**), deductibles, coinsurance, and out-of-pocket maximums generally applied under **MMCP** and **CHCB** also apply to mental health and substance use disorder care, subject to mental health parity laws. Additionally, any payments you make under the **MHSUD** will accumulate toward the deductibles and out-of-pocket Maximums under **MMCP** and **CHCB**, as applicable.

All questions about Plan benefits, rules and procedures with regard to **Mental Health Care** or **Substance Use Disorder Care**, including the names of **MHSUD In-Network Providers** in your area, or any question about the Plan's definitions of **Mental Health Care** or **Substance Use Disorder Care**, or whether the **MHSUD** applies to a particular sickness or injury, should be directed to the company administering your **MHSUD** benefits at the phone number listed on www.yourtracktohealth.com.

Obtaining Benefits – MMCP Enrollees

Different levels of benefits are paid under the **MHSUD** depending upon whether you obtain **In-Network Services** or **Out-of-Network Services.** The information described in the "Managed Medical Care Program" section of this booklet generally applies to **Eligible Expenses** unless otherwise specified in this "Mental Health and Substance Use Disorder Benefit" section. To receive the highest benefit level, you must use **In-Network Services.** To

receive the maximum benefit that is payable when you use certain **Out-of-Network Services**, you must comply with the notification requirements of the company administering your **MHSUD** benefits as described in the "Required Notification for Certain Services Under the MHSUD" section of this booklet. Please note the required timeframes for notification.

In-Network Services

To obtain benefits for **In-Network Services** as described in the "Mental Health and Substance Use Disorder Benefit" section of this booklet, you or your **Eligible Dependent** must receive **Covered Health Services** from an **In-Network Provider** or through an **Out-of-Network Authorization** (i.e., if an **In-Network Provider** is not available, you can receive authorization from the company administering your **MHSUD** benefits to receive the services from an **Out-of-Network Provider** or **Facility** paid at in-network benefit levels).

Limit on Patient Liability (Balance Billing)

As long as you receive services from an **In-Network Provider** or **Facility**, or through an **Out-of-Network Authorization** prior to receiving specified services from an **Out-of-Network Provider** or **Facility,** your **Eligible Expenses** will be paid in accordance with the rules described above and as explained in the "Managed Medical Care Program" section of this booklet.

An **In-Network Provider** and **Facility** cannot charge you for any services which are not **Covered Health Services,** unless you agree to pay for them. The Plan does not cover them.

*You are responsible for verifying that a provider or **Facility** is considered to be **In-Network**. You should not assume that a referral from an **In-Network Provider** will always be to another **In-Network Provider**. You can verify that the provider or **Facility** is **In-Network**, or request an **Out-of-Network Authorization**, by calling the **MHSUD** member services phone number listed on* www.yourtracktohealth.com, *24 hours a day, seven days a week.* You may also use the website listed on www.liveandworkwell.com using access code "Railroad" to find an **In-Network Provider** or **Facility** in your area.

*If you or an **Eligible Dependent** agrees to receive a service or supply from an **In-Network Provider** or* **Facility** *which is not a **Covered Health Service**, no benefits will be paid by the Plan and you or the **Eligible Dependent** will be fully responsible for all expenses related to such non-covered service or supply.*

Out-of-Network Services

To obtain benefits for **Out-of-Network Services** you or your **Eligible Dependent** receive from an **Out-of-Network Provider** or **Facility**, you must submit a claim as described in the "How to File a Claim for Mental Health and Substance Use Disorder (MHSUD) Benefits" section of this booklet.

If you or your **Eligible Dependent** receive services from an **Out-of-Network Provider** or **Facility** and you do not receive an **Out-of-Network Authorization**, the **MHSUD** (through the **MMCP**) will pay for **Medically Appropriate Out-of-Network Services** in accordance with the terms described under the "Out-of-Network Services – MMCP" section of this booklet, provided you have satisfied any applicable deductible.

*To receive the maximum benefit for **Out-of-Network Services**, you must comply with the notification requirements set forth in the "Required Notification for Certain Services Under the MHSUD" section of this booklet. If you have any questions about what services may require notification, please call the **MHSUD** Member Services number listed on* www.yourtracktohealth.com.

No benefits are payable if the service or supply is determined not to be a **Covered Health Service**.

If a service is not a **Covered Health Service** or is not **Medically Appropriate**, you or your **Out-of-Network Provider** can appeal that determination. See the "Processing of Claims and Appeals" section of this booklet for a description of the claims and appeals process.

NOTE: When you get **Emergency** care or get treated by an **Out-of-Network Provider** at an **In-Network** hospital or **Ambulatory Surgical Center**, you are protected from surprise billing or balance billing (i.e., an unexpected bill for the difference between what the Plan pays and the full amount charged for a service). For more information about your rights and protections against surprise medical bills, please refer to www.yourtracktohealth.com.

Obtaining Benefits – CHCB Enrollees

The information described in the "Comprehensive Health Care Benefit" section of this booklet applies to **Eligible Expenses** for **Covered Health Services** that consist of **Mental Health Care** and **Substance Use Disorder Care**.

Required Notification for Certain Services Under the MHSUD

To obtain the maximum amount payable under the **MHSUD** (for **Out-of-Network Services** under the **MMCP** and certain services under the **CHCB**), you (or your representative or provider) must notify the company administering your **MHSUD** benefits as soon as possible after you know that you or your **Eligible Dependent** require any of the following **Out-of-Network Services** under the **MMCP** or as provided under the **CHCB** :

- Inpatient admission to an **Out-of-Network Provider** under the **MMCP** or as provided under the **CHCB**;
- Less intensive inpatient or outpatient care alternatives to acute care facilities, such as residential treatment, partial hospitalization, or intensive outpatient treatment, group homes, halfway houses or structured outpatient treatment;
- Outpatient transcranial magnetic stimulation;
- Outpatient applied behavior analysis; or
- Psychological testing.

When and How to Provide the Required Notice

*You are responsible for calling the company administering your **MHSUD** benefits to provide the required notification.* You should call the **MHSUD** Member Services phone number listed on www.yourtracktohealth.com. You can call at any time, day or night. If you call outside the company's usual hours of operation, you may leave a message with your telephone number on an answering machine, and your call will be returned within one working day.

Except in the case of an **Emergency**, you or your provider must provide notification prior to receiving the services listed above, and in sufficient time to allow the company administering your **MHSUD** benefits to complete a review of the request before the services are rendered. After receiving notification, the company administering your **MHSUD** benefits will determine, before you incur expenses, if the service is a **Covered Health Service** and, if so, whether it is **Medically Appropriate**. In the absence of sufficient advance notice, the company administering your **MHSUD** benefits may not be able to complete its review and make its determination.

*If you receive the above specified services covered under the **MHSUD** without a determination by the company administering your **MHSUD*** benefits *that the services are **Medically Appropriate**, benefits will be reduced by 20% of the amount that would otherwise have been payable. This reduction in benefits applies both before and after the annual Out-of-Pocket Maximum is reached, and the provider or facility may balance bill you for the difference.*

Inpatient Admission following an Emergency – MMCP Enrollees

For an inpatient admission at an **Out-of-Network Provider** which follows an **Emergency**, you (or your representative or **Physician**) must call the company administering your **MHSUD** benefits within 48 hours (excluding weekends and holidays) from the admission date. You do not need to notify the company administering your **MHSUD** benefits when outpatient **Out-of-Network Services** are rendered on an **Emergency** basis.

Following notification of the admission, the company administering your **MHSUD** benefits will make a determination as to whether or not an **Emergency** existed, and if it does not, whether or not the treatment is a **Covered Health Service**. If such notification is made and the company administering your

MHSUD benefits determines that an **Emergency** did exist and that the treatment is a **Covered Health Service**, the Plan will pay the level of benefits for **In-Network Services** for any services covered under the **MHSUD** that are received during the **Emergency**.

If notification is made as required and the company administering your **MHSUD** benefits determines that an **Emergency** did not exist, but that the treatment rendered is a **Covered Health Service**, the Plan will pay the level of benefits for **Out-of-Network Services** for any services covered under the **MHSUD** rendered by an **Out-of-Network Provider** or **Facility**.

The requirement to notify the company administering your **MHSUD** benefits in connection with certain **Out-of-Network Services** does not apply to injuries incurred by an **Eligible Employee** while on duty for an employing railroad, but the company administering your **MHSUD** benefits is available to answer questions about proposed **Mental Health Care** or **Substance Use Disorder Care** treatment.

Inpatient Admission following an Emergency – CHCB Enrollees

For an inpatient admission which follows an **Emergency**, you (or your representative or **Physician**) must call the company administering your **MHSUD** benefits within 48 hours (excluding weekends and holidays) from the admission date. You do not need to notify the company administering your **MHSUD** benefits when outpatient services are rendered on an **Emergency** basis.

Following notification of the admission, the company administering your **MHSUD** benefits will make a determination as to whether or not the treatment is a **Covered Health Service**. If such notification is made and the company administering your **MHSUD** benefits determines that the treatment is a **Covered Health Service**, the Plan will pay the level of benefits for any services covered under the **MHSUD** that are received.

The requirement to notify the company administering your **MHSUD** benefits in connection with certain services does not apply to injuries incurred by an **Eligible Employee** while on duty for an employing railroad, but the company administering your **MHSUD** benefits is available to answer questions about proposed **Mental Health Care** or **Substance Use Disorder Care** treatment.

Remember: *The notification obligations described above are your responsibility. They are not the responsibility of your* ***Physician****, your Hospital or any other provider.*

The ultimate decision on your medical care must be made by you and your provider. Review by the company administering your ***MHSUD*** *benefits only determines whether the service is a* ***Covered Health Service****, and, if so, whether it is* ***Medically Appropriate,*** *solely for purposes of deciding what, if any, amounts are payable with respect to the service under the* ***MHSUD***.

Effects on Benefits

If you do not provide the required notification as described above:

- The benefit payable under the **MHSUD** will be reduced from 70% to 56% (if you are enrolled under the **MMCP**) or from 80% to 64% (if you are enrolled under the **CHCB**) of **Eligible Expenses**. If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to 80% of **Eligible Expenses**.

- No benefits are payable if the service is determined not to be a **Covered Health Service**.

Concurrent and Retroactive Review

Services for which you do not notify the company administering your **MHSUD** benefits in accordance with the requirements explained above will be subject to concurrent and retroactive review to determine whether the services are **Medically Appropriate.** The benefits payable by the **MHSUD** will be reduced if you do not provide the required notice or the services are not **Medically Appropriate**.

Integrated Mental Health Services

Integrated mental health services are also provided under the Plan. These services focus on providing information about treating and managing certain medical and mental health conditions occurring at the same time. You will be contacted if it is determined that integrated mental health services are appropriate in your case. Participation is voluntary, and there is no charge to **Covered Family Members** for these services.

Through integrated mental health 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**.

* * * *

*Exclusions applicable to this **MHSUD** are set forth under the "General Exclusions and Limitations" section of this booklet. 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 "Coordination of Benefits" section of this booklet. Other limitations with respect to Dependents Health Care Benefits are described on pages 48 through 51.*

Managed Pharmacy Services Benefit

The **MPSB** covers **Prescription Drugs** that are approved for coverage (as determined pursuant to the coverage approval procedures described in the "Coverage Approval (also known as Prior Authorization)") section of this booklet and that are given for the treatment or prevention of an injury, sickness or pregnancy. There are no deductibles or annual out-of-pocket maximums applicable to the **MPSB**.

IMPORTANT NOTE: This "Managed Pharmacy Services Benefit" section is applicable through December 31, 2024. Starting on January 1, 2025, please refer to the Summary of Material Modification on www.yourtracktohealth.com for information related to the Managed Pharmacy Services Benefit.

Prescription Drug Card Program

This program pays for outpatient **Prescription Drugs** filled at either an In-Network Pharmacy or an Out-of-Network Pharmacy (as each term is defined below). The prescription drug identification card that you will receive under the **MPSB** may be used only at In-Network Pharmacies.

In-Network Pharmacy

An In-Network Pharmacy is any pharmacy that participates in the **Pharmacy Benefit Manager's** (**PBM's**) retail network. For more information on which pharmacies participate in the **PBM** retail network, go to www.yourtracktohealth.com for the **PBM's** website and phone number.

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 a $10 co-payment.

Brand Name Drugs

If a **Brand Name Drug** that is a **Formulary Drug** is dispensed for either of the following reasons, you pay a $30 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** that is a **Formulary Drug** is dispensed instead of an equivalent **Generic Drug** for any reason other than those set forth above, you must pay:

- a $30 co-payment, and

- the difference in cost between the **Generic Drug** and the **Brand Name Drug**.

If a **Brand Name Drug** that is a **Non-Formulary Drug** is dispensed for either of the following reasons, you pay a $60 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** that is a **Non-Formulary Drug** is dispensed instead of an equivalent **Generic Drug** for any reason other than those set forth above, you must pay:

- a $60 co-payment, and

- the difference in cost between the **Generic Drug** and the **Brand Name Drug**.

Any co-payments under the Prescription Drug Card Program and any difference in cost between a **Generic Drug** and **Brand Name Drug** are not **Eligible Expenses** under the **MMCP**, **CHCB,** or **MHSUD**.

Out-of-Network Pharmacy

An Out-of-Network Pharmacy is any pharmacy that does not participate in the **PBM** Pharmacy 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 **Eligible Expenses** for up to a 21-day supply of a **Prescription Drug** that you buy at an Out-of-Network Pharmacy.

If you attempt to obtain 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 benefits only for a 21-day supply under the Plan.

Mail Order Prescription Drug Program

Under the Mail Order Prescription Drug Program, 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 the **PBM**. If you or your **Eligible Dependent** is not covered under the Plan when a new prescription is received by the **PBM**, 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

- the **PBM** 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.

If a **Generic Drug** is dispensed, you pay a $10 co-payment.

If a **Brand Name Drug** that is a **Formulary Drug** is dispensed, you pay a $60 co-payment.

If a **Brand Name Drug** that is a **Non-Formulary Drug** is dispensed, you pay a $120 co-payment.

These co-payments are not **Eligible Expenses** under any other 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 the **PBM**, along with a check or money order for the appropriate co-payments. If you prefer to pay for all of your orders by credit card, you can join the **PBM's** automatic payment program by enrolling online or by calling the Member Services phone number listed on www.yourtracktohealth.com.

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 the pharmacist's 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, go to www.yourtracktohealth.com for the PBM's website and phone number.

ACA Preventive Health Services

In general, any **Prescription Drug** that is filled at an **In-Network Pharmacy** or through the Mail Order Prescription Drug Program will be available under the **MPSB** at no cost to you if the drug is an **ACA Preventive Health Service** for you or your **Covered Family Member**. The following are exceptions to this general rule:

- Tobacco cessation **Prescription Drugs** are available at no cost only if those drugs are obtained through the Mail Order Prescription Drug Program.

- Non-emergency contraceptive **Generic Drugs** and single-source **Brand Name Drugs** are available at no cost only if those drugs are prescribed to a woman with reproductive capacity and obtained through the Mail Order Prescription Drug Program. Contraceptive multi-source **Brand Name Drugs** are not available at no cost under the **MPSB**.

- Emergency contraceptive **Generic Drugs** and single-source **Brand Name Drugs** are available at no cost only if those drugs are prescribed to a woman with reproductive capacity and obtained at an **In-Network Pharmacy**.

Limitations Under the Managed Pharmacy Services Benefit

The benefit for any prescription filled at an In-Network or Out-of-Network Pharmacy is 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. ***If you attempt to obtain 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 benefits only for a 21-day supply under the Plan.*** Benefits for supplies of **Prescription Drugs** for more than 21 days are available under the **MPSB** only if the supply is ordered by mail, and then is limited to the quantity described under the "Obtaining Your Mail Order Drugs" section of this booklet.

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), but not under the Prescription Drug Card Program, **MMCP**, **CHCB**, or **MHSUD**. Such medicines must be prescribed for you by a **Physician** and, if necessary, be approved for coverage under the coverage approval procedures described in the "Coverage Approval (also known as Prior Authorization)" section of this booklet.

Not Covered

The **MPSB** 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 order:

- Drugs given other than for:
    - the treatment of an injury,
    - the treatment of a sickness, or

- with respect to female employees and female dependents or as otherwise required as an **ACA Preventive Health Service**, the prevention or treatment of a pregnancy.

- Drugs which are not approved for coverage under the coverage approval procedures described in the "Coverage Approval (also known as Prior Authorization)" section of this booklet.

- 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, except when ordered under the Mail Order Prescription Drug Program and, if necessary, approved for coverage. Please note that drug therapy for infertility is a **Covered Health Service** under the **MMCP**, **CHCB** and **MHSUD**.

- Vitamin supplements, except as otherwise required by the **ACA** or when ordered under the Mail Order Prescription Drug Program and, if necessary, approved for coverage.

- Allergy serum, immunization agents and biological sera, except as otherwise required by the **ACA**.

- Prescribed devices or supplies of any type, including colostomy supplies and contraceptive devices, except as otherwise required by the **ACA**. However, please note that prescription contraceptive devices are **Covered Health Services** under the **MMCP** or **CHCB**.

- Drugs given by a **Physician** either in the **Physician's** 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.

- Tobacco cessation medications that are not **ACA Preventive Health Services**, except if you obtain the medications under the Mail Order Prescription Drug Program and pay the applicable co-payments.

The **MPSB** also does not cover any expenses that are listed under the "General Exclusions and Limitations" section of this booklet.

Rx Clinical Management Rules/Programs

RationalMed ®

As part of the **MPSB**, 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 **MPSB** 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**.

Coverage Approval (also known as Prior Authorization)

For certain medications, the **PBM** 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.

Screen RX

This program is designed to encourage you to take your prescribed medications. If you are determined to be at risk of becoming non-adherent, i.e., not taking medicine as prescribed by your doctor, you will receive up to three automated calls from the **PBM**. The calls will specifically refer to your medications and you will be offered multiple opportunities to speak with a live pharmacist during the telephone call. If you are not reached by phone, you will receive a letter explaining how you can adhere to taking your prescriptions and a toll-free number you can call for support. This service is provided at no cost to you.

Medical Channel Management

For certain specified Specialty Drugs (as determined by the **PBM**), you will be required to receive administration of the drug through the Plan's **MPSB** rather than through the **MMCP** or **CHCB**.

Fraud, Waste, and Abuse

This program involves proactive utilization of advanced analytics to identify potential abuse of prescription medications, in particular controlled substances. If the **PBM** determines that you may be at risk of abusing prescription medication, the **PBM**, with cooperation from the company administering your medical benefits, will place restrictions on your ability to obtain certain prescription medication.

* * * *

To find out more about your prescription drug plan, please visit the **PBM's** website or call the **PBM's** Member Services phone number listed on www.yourtracktohealth.com.

*Additional exclusions applicable to the **MPSB** are set forth under the "General Exclusions and Limitations" section of this booklet. 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 "Coordination of Benefits" section of this booklet. Other limitations with respect to Dependents Health Care Benefits are described on pages 48 through 51.*

Consolidated Care Management

The Plan provides care management services for you and your **Eligible Dependents**. Care management is initiated when the company providing your care management determines that you may benefit from case management, disease management, access to nurses, wellness counseling, and/or treatment decision assistance or when you contact the company providing your care management. The company providing your care management may contact you to discuss enhanced services under the Plan, as well as ancillary programs that may be available to you. Participation in care management is voluntary.

Case Management Services

The company providing your care management provides case management services. These services focus on severe illnesses and injuries which could result in long-term hospital confinements. The company providing your care management will determine whether case management services are appropriate in your case. Through case 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**.

Disease Management Services

The company providing your care management also provides disease management services. These 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, the company coordinating your care may contact you to discuss this program. You can also call the Disease Management Services phone

number listed on www.yourtracktohealth.com to learn whether you are eligible to participate in a disease management program. 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

The company providing your care management 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 the 24/7 Nurses phone number listed on www.yourtracktohealth.com.

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

The company providing your care management also provides wellness programs to provide information on health issues and to 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 benefits, you can call the Wellness Program phone number listed on www.yourtracktohealth.com.

Treatment Decision Support Program

The company providing your care management 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. The term "Treatment Decision Support" may be updated from time to time.

Specialty Resource Services

The company administering your benefits will make available to you, if you wish to use them, consulting and similar services regarding treatment at certain hospitals and other facilities designated by the company administering your benefits as hospitals or facilities that have consistently achieved favorable clinical outcomes in connection with bariatric surgery, certain cancers, severe cardiac conditions, kidney disease, and musculoskeletal conditions. These consulting and similar services will be provided under both the **MMCP** and **CHCB** and at no cost to you. However, surgeries and associated hospital stays for conditions to which Specialty Resource Services pertain are subject to different rules, as described below.

Under the **In-Network Services** portion of the **MMCP** (and for certain services specified below, under the **CHCB**), for conditions to which Specialty Resource Services pertain, the **MMCP** (or **CHCB**) will pay 100% for the surgery and the immediate hospital stay occasioned by the surgery as follows:

- **Bariatric Surgery:** One surgery and associated hospital stay at a surgery center or hospital that is part of the designated network of specialty bariatric surgery centers and hospitals for the company administering your benefits.

- **Complex Cancers:** Under certain limited circumstances described in the program made available by the company administering your benefits, designated surgeries and associated hospital stays at hospitals and surgery centers that are part of the designated network of hospitals and centers for complex cancer surgery for the company administering your benefits. Surgeries covered by this enhanced benefit are those performed in cases of certain complex cancers that satisfy specific criteria established by the company administering your benefits. This

enhanced benefit is limited to surgeries; it does not apply, for example, to chemotherapy and/or radiation.

- **Kidney Disease:** Surgeries and associated hospital stays at particular hospitals and surgery centers that are part of the designated network of hospitals and centers for kidney transplants for the company administering your benefits. This enhanced benefit does not cover renal dialysis.

- **Severe Cardiac Conditions:** If you are diagnosed with a cardiac condition requiring surgery, you can request Cleveland Clinic to conduct a clinical assessment of your condition and determine whether surgical intervention is appropriate. If surgery is appropriate, Cleveland Clinic is available to you if you are in need of non-emergency heart surgery. This program is wholly voluntary and available at no cost to qualifying members (including costs related to the clinical assessment). If you require surgery, transportation (airfare) will be covered and lodging and meal expenses will be reimbursed at a per diem rate of up to $150 for you or up to $300 for you and a companion. Cleveland Clinic will assist the patient and family with travel and lodging arrangements. Refer to www.yourtracktohealth.com for contact information. This benefit also applies to the **CHCB**.

- **Musculoskeletal Conditions:** The Lantern (formerly SurgeryPlus) benefit is a comprehensive surgical program designed to provide you with covered benefits through a high-quality network of credentialed surgeons and facilities for spine or orthopedic surgery. Additionally, you will receive a concierge experience from a team of Care Advocates. Surgeries covered by this enhanced benefit are those performed in cases that satisfy specific criteria established by Lantern. This enhanced benefit does not cover testing, scans, imaging, durable medical equipment, and physical therapy expenses. If you require

surgery and utilize the Lantern program, generally the network is broad enough that significant travel is not required. If travel is required, certain travel expenses may be covered through Lantern. These may include air travel and lodging (as appropriate), car travel (up to $100, depending on miles traveled), and meal expenses will be reimbursed at a per diem rate of up to $35 for you or up to $70 for you and a companion. Refer to www.yourtracktohealth.com for contact information. This benefit is effective as of May 1, 2024 and also applies to the **CHCB**.

Each of the enhanced surgery benefits described above requires that the surgery be pre-approved by the company administering your benefits, Cleveland Clinic, or Lantern, as applicable, and that you work with an assigned case manager/care coordinator both before and after your surgery because of the complexity of the health care issues associated with these procedures.

For Specialty Resource Services related to bariatric surgery, complex cancers, and kidney disease, the **CHCB** will pay for the surgery and the immediate hospital stay occasioned by the surgery in accordance with the standard benefit provisions that apply to the **CHCB**.

Added Value Programs

The Plan provides coverage for voluntary programs to enhance the benefits you already receive. These services are wholly voluntary and your use of these services is not required to receive benefits otherwise available under the Plan. For additional information related to any of the following programs, please refer to www.yourtracktohealth.com for contact information.

- **Telemedicine**: **Telemedicine** is a service providing access to **Physician** visits via online video or phone consultations with 24 hours per day and 365 days per year availability. During a **Telemedicine** visit, you can obtain a diagnosis and possibly a prescription (restrictions apply). This benefit is designed to broaden your access to care and will be administered by the Plan's designated ancillary benefit **Telemedicine** vendor. If you are enrolled in **MMCP**, a fixed-dollar co-pay of $10 will be charged to you for each **Telemedicine** visit. If you are enrolled in **CHCB**, a **Telemedicine** visit will be paid at 80% (i.e., the coinsurance otherwise applied to Eligible Expenses under **CHCB**), whether or not your deductible is satisfied. Note that this ancillary benefit is separate from virtual office visits with **MHSUD** providers as provided by the company that administers your **MHSUD** benefits through the **MMCP** and **CHCB**.

- **Expert Second Opinion**: Expert Second Opinion is a service providing you the opportunity to request second opinions from experts in a particular field or condition. These second opinions will generally include a clinical evaluation of your medical situation, a thorough review and analysis of your medical records, and answers to complex medical questions. These services will be performed by experts affiliated with a leading national provider of these services. There will be no member cost associated with this program.

- **Health Advocacy**: You will be able to reach experienced registered nurses or benefits specialists by phone or online 24/7 to assist with resolving a number of issues that may include but are not limited to:

    - Finding the right in-network doctors and hospitals.
    - Scheduling appointments.
    - Coordinating expert second opinions.
    - Resolving insurance claims and medical billing issues.
    - Obtaining approvals for needed services from insurance companies.
    - Finding treatment for complex and serious diagnoses.
    - Explaining insurance plan options and enrollment.
    - Transferring medical records, x-rays and lab results.
    - Researching the latest approaches to care.
    - Coordinating services during and after a hospital stay.

    These services are administered by a leading nationwide company specializing in member advocacy. There will be no member cost associated with this program.

- **End-of-Life Planning**: You will be able to receive end-of-life planning under the Plan. This program is designed to improve the quality of the communication and shared decision-making processes between you, your family, and your physicians in connection with advanced illnesses (life expectancy of one year or less). Utilization of this program is on a voluntary and member-initiated basis and there is no member cost associated with this program.

Eligible Expenses and Covered Health Services

(Applicable to the Managed Medical Care Program, the Comprehensive Health Care Benefit and the Mental Health and Substance Use Disorder Benefit)

Eligible Expenses are the actual cost to you of the **Reasonable Charges** 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 "List of Covered Health Services" section of this booklet and is not excluded under the "General Exclusions and Limitations" section of this booklet.

- 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. To determine if they are **Covered Health Services,** the services and supplies you receive will be reviewed by the company that administers your benefits. Please refer to your Identification Card for the name of the company that administers your benefits.

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 questions as to whether services or supplies ordered or recommended by your provider are **Covered Health Services,** you may call the Member Services phone number listed on www.yourtracktohealth.com for the company administering your benefits.

List of Covered Health Services

Acupuncture, when performed by a **Physician**

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

Autism Spectrum Disorder

Covered services include speech, occupational, and physical therapies, Applied Behavior Analysis services (described below), and other medically appropriate intensive behavioral therapies; provided that, any such coverage shall be subject to medical management processes (such as prior authorization or treatment plan requirements) applied by the company administering your benefits.

To be a **Covered Health Service**, Applied Behavior Analysis (ABA) services for **Autism Spectrum Disorder** must be:

- Focused on the treatment of core deficits of **Autism Spectrum Disorder**;

- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision; and

- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others, and property, and impairment in daily functioning.

Covered services include the following:

- Diagnostic evaluations, assessments, and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

Any such coverage for ABA services may be subject to medical management processes applied by the company administering your benefits.

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.

Medical management at the company administering your benefits must be contacted for any purchase or rental which exceeds $1,000. It will determine whether the purchase or rental of the equipment is ***Medically Appropriate.***

Hearing Benefit

- Cochlear implants.
- Up to a maximum payment of $2,000 each calendar year for tests and examinations, including those by an audiologist or a hearing aid dispenser, to diagnose and determine the cause of a hearing loss, and for a hearing aid necessary to restore lost, or help impaired, hearing.

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 under the headings "Physical Therapy," "Occupational Therapy," and "Speech Therapy," respectively.

- **Prescription Drugs**.

- Medical supplies.

- X-rays and laboratory tests.

Visits made by members of the home health care team for **Out-of-Network Services** under the **MMCP** will be limited to 40 visits each calendar year.

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 6 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.

Any counseling services given in connection with a terminal illness will not be considered as **Mental Health Care** or **Substance Use Disorder Care**.

Services provided by a licensed pastoral counselor to a member of the counselor's congregation in the course of the counselor's normal duties as a pastor or minister will not be considered 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 normal vaginal delivery, or less than 96 hours following a Caesarean section, or require that a provider obtain authorization from the Plan, from care coordination/medical management 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 for 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.

Jaw Joint Disorders

Up to a lifetime maximum payment of $1,250 for services for treatment in connection with the temporomandibular joint (jaw joint or "TMJ") and the complex of muscles, nerves and other tissues related to that joint. (This lifetime maximum payment limitation does not apply to **In-Network Services** under the **MMCP**.)

Only the following services and supplies are covered:

- Fixed or removable appliances.
- Crowns and other restorations or alterations of the tooth structure.
- Adjustments to the appliances, crowns and other restorations or alterations.

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.

Mental Health and Substance Use Disorder Services

Mental Health and Substance Use Disorder Services consist of the following services, whether received on an inpatient or outpatient basis (unless otherwise specified):

- Diagnostic evaluations and assessments.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based counseling and case management services.
- Crisis intervention.
- Halfway house services.
- Ambulatory Detox (also known as outpatient detox).
- Partial hospitalization/day treatment.
- Services at a residential treatment facility.
- Intensive outpatient treatment.
- **Mental Health Care** and **Substance Use Disorder Care** on an acute inpatient basis (including inpatient detox).

Nursing Services

Services of a trained nurse or a **Nurse-Midwife,** other than services of a trained nurse or a **Nurse-Midwife** with respect to **Mental Health Care** or **Substance Use Disorder Care**.

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**, the Medical Care and Treatment provision set forth below will apply. The Qualified Procedure may be performed at a **Transplant Facility** or a **Network Transplant Facility**. Under **MMCP**, if a Qualified Procedure is not performed at a **Transplant Facility** or a **Network Transplant Facility**, the **Eligible Expenses** for the Qualified Procedure will be paid at the Out-of-Network level of benefits:

  - Heart transplants.
  - Lung transplants.
  - Heart/Lung transplants.
  - Liver transplants.
  - Kidney transplants.
  - Pancreas transplants.
  - Kidney/Pancreas transplants.
  - Bone marrow/stem cell transplants.
  - Other transplant procedures that the company that administers your **CHCB** or **MMCP** determines are **Medically Appropriate**.

- **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**

  The following benefits for Transportation and Lodging expenses are available for those **Medically Appropriate** Qualified Procedures, as listed above, that are performed at a **Network Transplant Facility**. If a **Network Transplant Facility** is not used, then these Transportation and Lodging benefits will not be covered.

  Care coordination/medical management 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 **Network 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 Employee**. You will receive appropriate notification of any such taxable amounts paid to you.

Note, there are separate transportation and lodging rules if you are diagnosed with a severe cardiac condition or musculoskeletal condition and intend to receive surgery through the Cleveland Clinic program or the Lantern

program (as appropriate). Please refer to the "Specialty Resource Services" section of this booklet for more information.

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 (sometimes 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.

- Gender reassignment surgery. (Note that coverage is subject to the medical management practices of the company that administers your benefits. Please contact the company that administers your benefits for more information regarding the coverage requirements for this service.)

- 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.** A surgical assistant's services are covered at the same or a 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.

- Specialty Resource Services

  - Under the **MMCP**, you may be eligible for enhanced benefits associated with bariatric surgery, certain cancers, severe cardiac conditions, kidney disease, and musculoskeletal conditions if you participate in Specialty Resource Services. Different rules apply for these services if you are under the **CHCB**. See the "Specialty Resource Services" section of this booklet.

Prescription Drugs

Preventive Health Care

Eligible Expenses for **ACA Preventive Health Services** are covered with no fixed-dollar co-payment, deductible or coinsurance under the **In-Network Services** portion of the **MMCP** when given by an In-Network Provider, and under the **CHCB**. This rule also applies to the **MHSUD**, depending on whether you are enrolled in the **MMCP** or **CHCB**.

In addition, to the extent they are not **ACA Preventive Health Services**, **Eligible Expenses** for the health care services listed below are covered under the **In-Network Services** portion of the **MMCP** when given by an **In-Network Provider**. The $25 or $40

fixed-dollar co-payment, depending on the type of **Physician** you visit, for each office visit will apply to these services:

- Routine physical exams for you and your **Eligible Dependent** spouse, including diagnostic tests and immunizations.
- Child preventive care services given in connection with routine pediatric care, including immunizations.
- Phenylketonuria blood tests (PKU) for infants under the age of one year.
- One routine well-woman exam every calendar year. A well-woman exam may be given by any gynecologist listed in your directory of **In-Network Providers.** A well-woman exam includes the following:
    - Breast examination and/or mammogram.
    - Pelvic examination.
    - Pap smear.
- Office visits for female employees and female dependents related to the prevention of pregnancy, including prescription contraceptive drugs approved by the U.S. Food and Drug Administration administered during those visits.
- Prescription contraceptive devices approved by the U.S. Food and Drug Administration.

In addition, to the extent they are not **ACA Preventive Health Services**, **Eligible Expenses** for certain health care services are covered under the **CHCB** or **Out-of-Network Services** portion of the **MMCP** as described in the chart below. **Eligible Expenses** are covered under the **CHCB** or **Out-of-Network** portion of the **MMCP** in excess of any applicable deductible and subject to the applicable coinsurance amount.

Eligible Expenses		
Service	**CHCB**	**MMCP Out-of-Network**
Routine childhood immunizations, including boosters, for Diphtheria, Pertussis or Tetanus (DPT), measles, mumps, rubella and polio	Up to age 18	Generally age 6 and under
Phenylketonuria blood tests (PKU)	Infants under age of one year	Infants under age of one year
Routine pap smear	One per year for women	One per year for women
Baseline mammogram	One for women age 35 through 39	One for women age 35 through 39
Periodic mammogram	One every two years for women age 40 through 49, or more frequently if recommended by a **Physician**	One every two years for women age 40 through 49, or more frequently if recommended by a **Physician**
Annual mammogram	One per year for women age 50 or over	One per year for women age 50 or over
Digital rectal examination	One per year for members age 40 or over	One per year for members age 40 or over
Stool blood slide test	One per year after age 49	One per year after age 49
Proctosigmoidoscopy	One every three years after age 49	One every three years after age 49
Office visits related to prevention of pregnancy, including prescription contraceptive drugs approved by the U.S. Food and Drug Administration administered during the visit	For female employees and female dependents	For female employees and female dependents
Prescription contraceptive devices approved by the U.S. Food and Drug Administration	For female employees and female dependents	For female employees and female dependents

Eligible Expenses		
Service	**CHCB**	**MMCP Out-of-Network**
Routine physical examination, including diagnostic tests and immunizations.	One per year. Note that no deductible or coinsurance percentage applies. The **CHCB** will pay 100% of the first $150 of **Eligible Expenses** and 75% of any **Eligible Expense** in excess of $150.	Not covered

Psychologists' Services

Services of a **Psychologist** if such services would have been covered if performed by a **Physician.**

Radiation Therapy

Skilled Nursing Facility Care After Hospital Confinement

Services and supplies up to 31 days of confinement following each **Hospital** confinement are covered under the **CHCB**. Services and supplies up to 60 days of confinement following each **Hospital** confinement per calendar year are covered for both **In-Network Services** and **Out-of-Network Services,** combined, under the **MMCP**.

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 one of the following:

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

In addition, services given as part of treatment for:

- **Autism Spectrum Disorder**,
- developmental delay,
- cerebral palsy,
- hearing impairment, or
- major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

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 – Emergency

Transportation services must be to a **Facility** in your local area. If there are no local **Facilities** equipped to provide the care needed, transportation service to the nearest **Facility** outside your local area qualified to give the required treatment is covered.

Transportation Services – Non-Emergency

Non-emergency ambulance transportation by a licensed ambulance service (either ground or air) between **Facilities**, only when the transport is **Medically Appropriate**, as determined by the company administering your benefits.

Transportation Services – Additional Benefits for Substance Use Disorder Care under the MHSUD

In addition to the emergency transportation services benefit described above, for **Substance Use Disorder Care**, transportation to or from a **Facility** that the company administering your **MHSUD** benefits determines provides the most appropriate and economical treatment program. The maximum amount payable for this transportation benefit is $500 per confinement.

Virtual Office Visits With MHSUD Providers

Virtual office visits provided through the company that administers your **MHSUD** benefits through the **MMCP** and **CHCB,** as applicable.

X-ray and Laboratory Tests, other than radiological services performed at a **Convenient Care Clinic**.

General Exclusions and Limitations

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

- Acupuncture, when not performed by a **Physician**.
- **Another Railroad 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 51.
- Completion of claim forms or missed appointments.
- Cosmetic/Reconstructive Surgery or treatment, except as specified under the description of "Physicians' Services" in the "List of Covered Health Services" section 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 the description of "Hospice Care Services" in the "List of Covered Health Services" section of this booklet.

- 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,

    - full or partial dentures, fixed bridgework, or repair to natural teeth, if needed because of injury to natural teeth, and

    - charges for treatment of jaw joint disorders specifically provided in the Plan.

- Dependents:

    - Except to the extent required by the **ACA**, the pregnancy of a dependent other than the employee's spouse, or the resulting childbirth, abortion or miscarriage.

    - A dependent child's or grandchild's expenses if the child or grandchild is receiving benefits for the same expenses under the Plan as an **Eligible Employee**.

- A dependent's work related injury or sickness - services or supplies for which your **Eligible Dependent** is entitled to indemnity under any worker's compensation or similar law.

- Donor Expenses and Services – expenses incurred by an organ donor except as provided under the "Eligible Employee" section of the booklet and under the description of "Organ/Tissue Transplants" in the "List of Covered Health Services" section of this booklet; 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 use disorder 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), the company that administers your benefits 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, the company that administers your benefits 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, medical 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;

- Habilitative services, except diagnosis and treatment of **Autism Spectrum Disorder**/Pervasive Developmental Disorder and speech therapy as part of a treatment for **Autism Spectrum Disorder**, developmental delay, cerebral palsy, hearing impairment or major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate;

- Hearing Services – ear examinations or hearing aids for diagnosis or treatment of hearing loss, except to the extent needed for repair of damages caused by bodily injury or as set forth under the description of "Hearing Benefit" in the "List of Covered Health Services" section of this booklet.

- 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**.
- A state licensed or authorized institution, program or other health facility, including an **Outpatient Clinic**, that provides covered **MHSUD** services.
- 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.

- Long-term care services, which include medical and non-medical care, other than care at a skilled nursing facility, provided to individuals who are unable to perform basic activities of daily living such as dressing or bathing. Long-term care services are typically provided at assisted living facilities or nursing homes, but may also be provided at home.

- **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 Part A or Part B of **Medicare,** except to the extent necessary so that the sum of the benefits payable under this Plan and under Part A or Part B of **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 **Eligible Dependent** 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;

- 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.

    - Male sterilization procedures, except to avoid a life-threatening condition.

    - With respect to the **Out-of-Network Services** portion of the **MMCP**, female sterilization procedures, except to avoid a life-threatening condition.

    - Reversal of sterilization.

- Preventive care, including newborn well-baby care, except as described under the description of "Preventive Health Care" in the "List of Covered Health Services" section of this booklet.

- 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 an employee or the employee's dependent becomes covered under this Plan.

- Speech therapy, except as set forth under the description of "Speech Therapy" in the "List of Covered Health Services" section 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

offered by the company administering your **MMCP** or **CHCB** or under the **MPSB** as described on pages 98 and 106, or as otherwise required as an **ACA Preventive Health Service**).

- Treatment or consultations provided via telephone, except for virtual office visits with **MHSUD** providers through the company that administers your **MHSUD** benefits and **Telemedicine** visits provided through the Plan's designated ancillary benefit **Telemedicine** vendor.

- 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, or 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 covered under a wellness program offered by the company administering your **MMCP** or **CHCB**, or as otherwise required as an **ACA Preventive Health Service**).

Coordination of Benefits

This section of your booklet describes how the health care benefits payable under this Plan will be coordinated with health care 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 "Dependents Covered Under Another Railroad Health and Welfare Plan" section of this booklet,

- an individual health insurance policy which a person may purchase with the person's 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. (That 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 the 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.

For example, if an employee participates in the **CHCB** and this Plan is secondary, and if the primary plan pays 50% of the charges covered under this Plan, then this Plan would pay 30% of those charges.

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 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 Employee** under this Plan is also covered as a laid-off or retired employee under another plan, then this Plan will be primary to that other plan provided the other plan has this same rule.

- 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 last.

- 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 Spouses Work for a Participating Employer and Are Covered Under This Plan

If a spouse is covered under this Plan both as an **Eligible Employee** 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 Employees,** the **Eligible Dependent** benefits will be paid on behalf of each **Eligible Employee** 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 One Spouse Is Covered Under The Railroad Employees National Early Retirement Major Medical Benefit Plan ("ERMA" or "GA-46000") or as an Employee Under The SMART-TD Plan and the Other Spouse Is Covered as an Employee Under This Plan

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, – *for this purpose, **Medicare** Part D is not considered "another health plan"* – you must follow the procedures shown below in seeking benefits under the Prescription Drug Card Program portion of the **MPSB** for prescriptions up to a 21-day supply (there is no benefit under the Prescription Drug Card Program for any portion of a prescription that 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 health plan.
- Attach the Explanation of Benefits form received from the primary health plan and a copy of the itemized receipt to the **PBM's** Coordination of Benefits (COB) claim form and return them to the **PBM**. You can request the **PBM's** COB claim forms on-line or by calling the Member Services phone number listed on www.yourtracktohealth.com. 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 health plan paid and 75% of the **Eligible Expenses** for the drug.

Remember, if you attempt to obtain a supply of **Prescription Drugs** for a period in excess of 21 days at either an In-Network Pharmacy or an Out-of-Network Pharmacy, you will receive benefits only for a 21-day supply under the Plan.

The provisions under the "If Both Spouses Work for a Participating Employer and Are Covered Under This Plan" and "If One Spouse Is Covered Under The Railroad Employees National Early Retirement Major Medical Benefit Plan ('ERMA' or 'GA-46000') or as an Employee Under The SMART-TD Plan and the Other Spouse Is Covered as an Employee Under This Plan" sections 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 or to **Medicare** Part D. This means that benefits under the Mail Order Prescription Drug Program will be paid as if there were no other coverage, and, unless you or your **Eligible Dependent** has rejected this Plan as primary to **Medicare** as provider of health benefits, benefits under both the Mail Order Prescription Drug Program and the Prescription Drug Card Program will be paid as if there were no **Medicare** Part D.

Opting Out Of Plan Coverage

You may "opt out" of "foreign-to-occupation" Employee Health Care Benefits (i.e., benefits other than for on-duty injuries) and Dependent Health Care Benefits under the Plan if you certify that you have medical, mental health/substance use disorder and prescription drug coverage for yourself (except with respect to on-duty injuries) and your dependents under a group health plan or health insurance policy other than the Plan. For example, if your spouse is enrolled in a group health plan provided by your spouse's employer that provides medical, mental health/substance use disorder and prescription drug coverage for you, your spouse and your other dependents, you could make the requisite certification. Forms for making this certification and electing to opt out are provided by Railroad Enrollment Services. Railroad Enrollment Services will also let you know when you must send a properly completed certification and election form to Railroad Enrollment Services for your opt-out election, if you choose to make one, to be effective.

If you opt out, the Plan will not pay health care benefits for you (except with respect to on-duty injuries) or for your spouse or other dependents. So, before you decide to opt out, please carefully compare the benefits available under the Plan with those available under the other group plan or policy that covers you and your family.

Note that even if you opt out, you will remain covered under the Plan for health care benefits for your on-duty injuries and for life and accidental death and dismemberment insurance. The Plan's life and accidental death and dismemberment insurance benefits are described in a separate booklet.

If you opt out, you will not be required to make the employee contributions described in the "Employee Contributions" section of this booklet that are required for all employees who have foreign-to-occupation Employee Health Care Benefits or

Dependent Health Care Benefits under the Plan. As a result, this amount will not be deducted from your wages. Also, in most cases, you will receive a taxable bonus of $100 per month in every month that your opt-out election is in effect if your employer is required to make a payment to the Plan in that month for your life and accidental death and dismemberment insurance. When your employer is required to make such a payment, it is usually because you rendered the **Requisite Amount of Compensated Service** or received the **Requisite Amount of Vacation Pay** in the prior month.

You will not be paid this bonus, however, if:

- you are on authorized leave under the Family and Medical Leave Act of 1993 on the date the bonus would otherwise be paid in any given month and did not render the **Requisite Amount of Compensated Service** or receive the **Requisite Amount of Vacation Pay** during the prior month, or

- your spouse is also a railroad employee who participates in this Plan or in the SMART-TD Plan, or

- your spouse is a railroad retiree who participates in ERMA.

An election to opt out generally stays in effect until the end of the calendar year in which it is made. Plan coverage is reinstated as of the beginning of the next calendar year unless you opt out for that year by completing and returning a new certification and election form within the time allowed for you to do so.

If you opt out (including an election to be covered as a dependent child instead of an **Eligible Employee**) for any calendar year, you will not, in most cases, be permitted to revoke that election and re-enroll for Plan coverage before the beginning of the next calendar year. But there are some important exceptions to this rule:

- If your other health insurance coverage is **COBRA** continuation coverage, you may re-enroll for Plan coverage when the **COBRA** coverage is exhausted.

- If your other health plan coverage is not **COBRA** continuation coverage, you may re-enroll for Plan coverage if that other coverage is terminated as a result of loss of eligibility for it (including losing such eligibility as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or if employer contributions towards that coverage are terminated.

- If you marry a person who is your tax dependent, or if you acquire a new tax dependent through marriage, birth, adoption or placement for adoption, you will be allowed to re-enroll for Plan coverage. Generally, a tax dependent is anyone whom you are entitled to list as a dependent on your Federal income tax return.

- If you or your **Eligible Dependent** is covered under Medicaid or a state Children's Health Insurance Program (CHIP) and such coverage is terminated due to a loss of eligibility, provided you request re-enrollment for Plan coverage no later than 90 days after the Medicaid or CHIP coverage terminates.

- If you or your **Eligible Dependent** becomes eligible for state premium assistance under Medicaid or CHIP, provided you request re-enrollment for Plan coverage no later than 90 days after you or your **Eligible Dependent** is determined to be eligible for premium assistance.

If you have made an opt-out election and are permitted to revoke it and re-enroll for Plan coverage, you can do so by completing a revocation form that Railroad Enrollment Services will send you upon your request. You must return that form, properly

completed, to Railroad Enrollment Services no later than 30 days (or 90 days, as set forth above) after the event that permits you to revoke your opt-out election. If you do not properly complete and return the revocation form within 30 or 90 days of this event, you may not change your election until the beginning of the next calendar year.

In general, if you are permitted to revoke your opt-out election and re-enroll for Plan coverage during a calendar year, you will be re-enrolled as of the first day of the calendar month after Railroad Enrollment Services receives your completed revocation form. For that reason, it is important to send your revocation form to Railroad Enrollment Services as promptly as you can.

If the reason that you are permitted to revoke your opt-out election is that you acquired a new tax dependent through birth, adoption or placement for adoption, then the revocation will be retroactively effective to the first day of the calendar month in which that event occurred. (Note that this retroactive coverage does not apply in the case of marriage.) As a result, you may be required to make a retroactive contribution to the Plan and to refund any $100 "opt-out" bonus that you received for that month. Any contributions and refunds will be deducted from your wages.

If you decide to opt out, the decision applies to your entire family. If you are a Hospital Association member who must look to the Hospital Association for your health care benefits, your election to opt out will apply to your coverage under the Hospital Association and your dependent coverage under the Plan. You cannot give up employee coverage only or dependent coverage only. If you do opt out, you will nevertheless remain covered under the Plan for on-duty injuries.

For purposes of determining eligibility for coverage under ERMA, an employee who is not covered under this Plan by reason of

having opted out will be treated as if the employee had not opted out.

Some special rules apply when both you and your spouse are railroad employees who participate in this Plan and/or the SMART-TD Plan, or your spouse is a railroad retiree who participates in ERMA.

- First, if both you and your spouse are **Eligible Employees** with dependent coverage under this Plan, only one of you may opt out of coverage. You and your spouse may decide which of you will opt out of coverage.

- Second, if you are an **Eligible Employee** with dependent coverage under this Plan and your spouse is a railroad employee with Employee Health Care Benefits and/or dependent coverage under the SMART-TD Plan, only one of you may opt out of coverage under the applicable Plan. You and your spouse may decide which of you will opt out of coverage.

- Third, if you opt out on the basis that your spouse is employed by a participating railroad and has employee and/or dependent health care coverage under this Plan or the SMART-TD Plan (or has retiree coverage under ERMA), you will not receive the $100 per month bonus. Nor will you be required to make the monthly contribution to the Plan that would otherwise be deducted from your wages.

- Fourth, for purposes of the "make whole" Coordination of Benefits rules under this Plan, the SMART-TD Plan and ERMA, employees who opt out will be treated as if they had not done so. These "make whole" Coordination of Benefits rules will continue to apply as if no opt-out election had been made.

Special rules also apply if you are both an **Eligible Employee** under this Plan and a child who is an **Eligible Dependent** of another **Eligible Employee** under this Plan or the SMART-TD Plan.

- First, you may opt out of foreign-to-occupation Employee health care coverage under this Plan but nonetheless remain eligible for coverage as an **Eligible Dependent** under this Plan or the SMART-TD Plan, as applicable. However, if you opt out on this basis, you will not receive the $100 per month bonus. Nor will you be required to make the Employee monthly contribution to the Plan that would otherwise be deducted from your wages. Also, neither your spouse nor your children will be your **Eligible Dependents** under this Plan even though you are an **Eligible Employee**.

- Second, if you cease to be an **Eligible Dependent** but remain an **Eligible Employee**, you will automatically become covered as an **Eligible Employee** and will be required to make the employee contributions described in the "Employee Contributions" section of this booklet.

Release Of Medical Information

Any company that administers health care 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 that member's 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 when the Plan may disclose medical information, see the HIPAA language on page 4 of this booklet.

Interpreting Plan Provisions

Each of the companies that administer health care benefits under the Plan has discretionary authority to determine whether and to what extent **Eligible Employees** 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. A company administering health care benefits under the Plan shall be deemed to have properly exercised this discretionary authority unless the company has acted arbitrarily or capriciously.

VI
DEFINITIONS

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

ACA Preventive Health Services
In-Network Services under the **MMCP**, medicines and drugs, including but not limited to **Prescription Drugs**, obtained at an **In-Network Pharmacy** or through the Mail Order Prescription Drug Program under the **MPSB**, and services under the **CHCB**, only to the extent they are required by the **Affordable Care Act** to be provided in accordance with the following recommendations and guidelines, as may be in effect from time to time:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("Task Force") with respect to the individual involved. Additional information can also be obtained by calling the Member Services number listed on your Identification Card.

- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. Additional information can also be obtained by calling the Member Services number listed on your Identification Card.

- With respect to **Covered Family Members** who are infants, children or adolescents, evidence-informed preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration ("HRSA"). Additional information can also be obtained by

calling the Member Services number listed on your Identification Card.

- With respect to **Covered Family Members** who are women, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force). Additional information can also be obtained by calling the Member Services number listed on your Identification Card.

Any additional recommendations provided in the future must be covered as of the first plan year beginning on or after the first anniversary of when the recommendations are updated, unless otherwise indicated by governmental regulation.

Affordable Care Act or **ACA**
The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010.

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 such licensing under the laws of the jurisdiction in which the facility is located; or

- 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 SMART-TD Plan, and ERMA. 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.

CHCB
The Plan's Comprehensive Health Care Benefit Program.

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

Convenient Care Clinic
A health care facility typically located in a high-traffic retail store, supermarket or pharmacy that provides affordable treatment for uncomplicated minor illness and/or preventive care to

consumers. Please contact Member Services using the phone number listed on www.yourtracktohealth.com for the company administering your benefits to locate a **Convenient Care Clinic**.

Covered Family Members
Eligible Employees and their **Eligible Dependents** who are covered under the Plan.

Covered Health Services
Those services and supplies described under the "Eligible Expenses and Covered Health Services" section 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; or

- 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/herself.

Eligible Dependent
An individual described under the "Eligible Dependents" section of this booklet.

Eligible Employee
An individual described under the "Eligible Employees" section 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 **MPSB**.

Emergency
A medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Facility
An **Ambulatory Surgical Center,** a **Hospital,** or a state licensed or authorized institution, program or other health facility, including an **Outpatient Clinic**, that provides covered **MHSUD** services, as applicable.

Formulary Drug
A **Brand Name Drug** that appears on a preferred list of medications (commonly called a "formulary"). This list includes a wide selection of medications, offering you a choice while helping to contain the cost to the Plan of its prescription drug benefits. For more information about the formulary applicable to

the Plan, see www.yourtracktohealth.com for the **PBM's** website and phone number.

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,** or
- it is established and operated in accordance with applicable licensing and other laws, or
- it meets all of the following criteria:
    - 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; and
    - 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 a **Hospice** for purposes 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 meets one of the following three tests:

- it is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations, or
- it is approved by **Medicare** as a hospital, or
- 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**;
    - 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.

In-Network Provider
*For purposes of the **MMCP** and **MHSUD**,* a provider participating in a managed care network of the company that administers your benefits in a geographical area in which the Plan offers a managed care network.

MHSUD providers may include a licensed or certified psychiatrist, **Psychologist,** psychiatric **Social Worker,** or other licensed or certified mental health or substance use disorder practitioner or **Qualified Counselor** who provide covered services to you or your **Eligible Dependents**.

In-Network Services
For purposes of the **MMCP** and **MHSUD, Medically Appropriate Covered Health Services** received from an **In-Network Provider**, or pursuant to an **Out-of-Network Authorization.** Please contact the company administering your benefits to locate an **In-Network Provider**.

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

Mandatory Network Area
A geographic area where the Plan determines that participation in the **MMCP** is mandatory for **Eligible Employees** and/or **Eligible Dependents** who reside in that area.

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, that have been accepted for inclusion as **Medical Care** by the Plan.

Medical Judgment
Judgment with respect to any of the following issues in connection with a claim for benefits:

- medical necessity;

- appropriateness of care;

- health care setting;

- **Level of Care**;

- effectiveness of a covered benefit; or

- a determination of whether a treatment or a procedure is experimental or investigational.

Medically Appropriate
A **Covered Health Service** which has been determined by the company that administers your benefits 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 the company making the determination.

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-TR published by the American Psychiatric Association, or its equivalent code 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 **Mental Health 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, Pervasive Developmental Disorder, Alzheimer's Disease, certain services for **Autism Spectrum Disorder** and intellectual disability.

- Treatment for stress, co-dependency, sexual addiction, and chronic pain when not a part of **Mental Health Care**.

- Treatment for smoking cessation, weight reduction, obesity, stammering, or stuttering.

MHSUD
The Plan's Mental Health and Substance Use Disorder Benefit.

MMCP
The Plan's Managed Medical Care Program.

MPSB
The Plan's Managed Pharmacy Services Benefit.

Network Transplant Facility
A **Transplant Facility** that the company that administers your benefits specifically designates as a **Network Transplant Facility**. A **Network Transplant Facility** has entered into an agreement with the company to render **Covered Health Services** for the treatment of specified diseases or conditions. A **Network Transplant Facility** may or may not be located within your geographic area. To be considered a **Network Transplant Facility**, the **Transplant Facility** must meet certain standards of excellence and have a proven track record of treating the specified disease or condition. Under **MMCP**, all **Covered Health Services** for transplants received at a **Network Transplant Facility** will be paid at the In-Network level of benefits.

Non-Formulary Drug
Any **Brand Name Drug** that does not appear on the preferred list of medications.

Non-Mandatory Network Area
A geographic area where participation in the **MMCP** is not required for **Eligible Employees** and **Eligible Dependents** who reside in that area.

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.

Out-of-Network Authorization
A determination made by the company administering your benefits that **Covered Health Services** provided by an **Out-of-Network Provider** shall be covered at the level of benefits payable for **In-Network Services**.

Out-of-Network Provider
For purposes of the **MMCP** and **MHSUD**, a provider not participating in the managed care network of the company that administers your benefits.

MHSUD providers may include a licensed or certified psychiatrist, **Psychologist,** psychiatric **Social Worker,** or other licensed or certified mental health or substance use disorder

practitioner or **Qualified Counselor** who provide covered services to you or your **Eligible Dependents**.

Out-of-Network Services
For purposes of the **MMCP** and **MHSUD, Covered Health Services** received from an **Out-of-Network Provider,** unless such services are received pursuant to an **Out-of-Network Authorization**.

Outpatient Clinic
A facility which provides an outpatient program of effective medical and therapeutic **Substance Use Disorder Care** and meets all of the following requirements:

- It is licensed, certified, or approved as a substance use disorder treatment facility by the appropriate agency of the state in which it is located.

- It provides a program of treatment approved by the attending **Physician,** a duly qualified alcohol rehabilitation counselor, an alcoholism para-professional or a certified addictions counselor.

- It has or maintains a written, specific, and detailed regimen requiring full-time participation by the patient.

Participating Provider or **Preferred Provider**
A provider who has agreed to negotiated charges for covered services under the **CHCB** or **MHSUD**.

Pharmacy Benefit Manager or **PBM**
The third-party the Plan has contracted with to manage pharmacy benefits.

Person Eligible under Medicare
You or your **Eligible Dependent** if **Medicare** benefits are primary to Plan benefits (see the "Important Notice About the Plan and Medicare" section of this booklet).

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.).
- Doctor of Optometry (O.D.).
- Provider, other than those listed above, who is properly licensed in the state in which the provider is practicing, that delivers services that may also be delivered by a medical doctor.
- Physician Assistant when operating under the direction of any of the above Doctors.

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**.

Psychologist
A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist.

- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Qualified Counselor
A qualified alcohol rehabilitation counselor, an alcoholism para-professional or a certified addiction's counselor.

Qualified Medical Child Support Order
A medical child support order as defined in clause (B) of 29 U.S. Code §1169(a)(2) that meets the requirements of clause (A) of that provision, i.e., §1169(a)(2). You can obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

Reasonable Charge

- For services rendered by a provider under a negotiated discount arrangement made available to the Plan through the company that administers your benefits, 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 the appropriate company administering your benefits 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.

Requisite Amount of Compensated Service
Compensated service rendered for an aggregate of at least 7 calendar days during a calendar month if you are covered under

the Plan pursuant to a Collective Bargaining Agreement that provides for the "seven-day" rule; otherwise compensated service rendered on at least 1 day during the month. Where the "seven-day" rule governs, it will be applied in accordance with the terms of the Collective Bargaining Agreement providing for it, including any side letter to such agreement dealing with application of the rule.

Requisite Amount of Vacation Pay
Vacation Pay received for an aggregate of at least 7 calendar days during a calendar month if you are covered under the Plan pursuant to a Collective Bargaining Agreement that provides for the "seven-day" rule; otherwise **Vacation Pay** received for at least 1 day during the month. Where the "seven-day" rule governs, it will be applied in accordance with the terms of the Collective Bargaining Agreement providing for it, including any side letter to such agreement dealing with application of the rule.

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 applicable licensing and other laws.
- It is under the supervision of a **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 a **Skilled Nursing Facility** for 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.

Substance Use Disorder 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-TR published by the American Psychiatric Association, or its equivalent code 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 Use Disorder Care** by the Plan.

Telemedicine
Health care services (including medical and behavioral health services) provided by the Plan's designated ancillary benefit **Telemedicine** vendor through telephone, internet, or phone-based application. For purposes of this Plan, **Telemedicine** does

not include virtual office visits with your **Physician** or **MHSUD** provider.

Transplant Facility
A **Hospital**, which may be an **In-Network Provider** or an **Out-of-Network Provider**, and is licensed and/or qualified to perform transplant procedures and has entered into a contract covering transplant services with the company that administers your benefits. With respect to the **MMCP**, the fact that a **Hospital** is an **In-Network Provider** for purposes of all non-transplant related **Covered Health Services** under the Plan, does not mean that the **Hospital** is an **In-Network Provider** for transplant services. In fact, all **Covered Health Services** for transplants that are not received at a **Transplant Facility** or a **Network Transplant Facility** will be paid at the **Out-of-Network Services** level of benefits.

Urgent Care
Care or treatment for a medical condition that (1) would seriously jeopardize your life or health or your ability to regain maximum function if care or treatment for the condition were delayed; or (2) in the opinion of a **Physician** who knows your medical condition, causes you severe pain that cannot be managed adequately without appropriate care or treatment.

Vacation Pay

- **Vacation Pay** received after an **Eligible Employee** is furloughed will not continue coverages or benefits after coverage ends.

- **Vacation Pay** received after an employment relationship has terminated will not continue coverage or benefits after coverage ends. This includes **Vacation Pay** received after an **Eligible Employee** has resigned, is dismissed, or has given up employment rights for retirement.

VII
CLAIM INFORMATION

How To File A Claim For Managed Medical Care Program (MMCP) Benefits

Necessary Pre-Approval

In order to receive full benefits for certain **Out-of-Network Services** under the **MMCP**, you must notify the company that administers your **MMCP** 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 in the "MMCP Medical Management" section of this booklet.

Post-Service Claims for Reimbursement or Payment

In-Network Services

If you receive **In-Network Services**, the **In-Network Provider** will file your medical claims for you. However, if you receive **Out-of-Network Services**, you must submit a claim.

Out-of-Network Services

If you are filing a claim for **Out-of-Network Services** send your claims to the claims submission address noted on www.yourtracktohealth.com for the company administering your **MMCP** or call the Member Services number on your Identification Card for more information.

In order for the company administering your benefits to process your claims promptly, the following information is necessary:

- the name and member identification number of the **Eligible Employee**,
- the patient's name and relationship to the **Eligible Employee**,
- the name of the Plan (i.e., The Railroad Employees National Health and Welfare Plan),
- the diagnosis, and
- an itemized statement of the services rendered, and dates of and charges for those services.

The company administering your benefits does not require a specific claim form and will accept standard claim forms generally accepted by medical benefits administrators.

How To File A Claim For Comprehensive Health Care (CHCB) Benefits

Necessary Pre-Approval

In order to receive full benefits for certain services as part of the **CHCB**, you must notify the company administering your **CHCB** benefits 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 in the "CHCB Medical Management" section of this booklet.

Post-Service Claims for Reimbursement or Payment

Participating Provider

If you receive services under the **CHCB** from a **Participating Provider**, all you need to do in most cases is present your Identification Card to the **Participating Provider**. The provider will bill the company administering your **CHCB** benefits directly. The company administering your **CHCB** benefits will send you copies of the payment record. The provider will bill you for any charges not covered by the **CHCB** and for any applicable deductible and coinsurance amount payable by you.

Other Than a Participating Provider

If you receive services from a provider other than a **Participating Provider,** you will receive a bill for them. To claim your benefits, unless the provider submits your claim for you, send a copy of the bill to the claim submission address noted on www.yourtracktohealth.com for the company administering your **CHCB** benefits or call the Member Services number on your Identification Card for more information.

When submitting your claim, be sure it includes all of the following information:

- the name and member identification number of the **Eligible Employee**,
- the patient's name and relationship to the **Eligible Employee**,
- the name of the Plan (i.e., The Railroad Employees National Health and Welfare Plan),
- the diagnosis, and
- an itemized statement of the services rendered, and dates of and charges for those services.

The same procedure should be followed with bills for hospital or professional provider care you receive outside the United States.

How To File A Claim For Mental Health and Substance Use Disorder (MHSUD) Benefits

Necessary Notification for Certain Services

In order to receive full benefits under the **MHSUD** (for certain **Out-of-Network Services** as provided through the **MMCP** and services under the **CHCB**), you must notify the company administering your **MHSUD** benefits before you receive the services. The services for which you must provide notification, and the process for providing notification, are described in the "Required Notification for Certain Services Under the MHSUD" section of this booklet.

Post-Service Claims for Reimbursement or Payment – MMCP Enrollees

In-Network Services

When you or your **Eligible Dependent** receives **In-Network Services** covered under the **MHSUD** (as provided through the **MMCP**), the **In-Network Provider** who renders the services will file the claim for you.

Out-of-Network Services

When you or your **Eligible Dependent** receives **Out-of-Network Services** under the **MHSUD** (as provided through the **MMCP**), you or your **Eligible Dependent** is responsible for ensuring that the claim is filed with the company administering your **MHSUD** benefits at the claim submission address noted on www.yourtracktohealth.com or call the Member Services number on your Identification Card for more information.

In order for the company administering your **MHSUD** benefits to process your claims promptly, the following information is necessary:

- the name and member identification number of the **Eligible Employee**,
- the patient's name and relationship to the **Eligible Employee**,
- the name of the Plan (i.e., The Railroad Employees National Health and Welfare Plan),
- the diagnosis, and
- an itemized statement of the services rendered, and dates of and charges for those services.

The company administering your **MHSUD** benefits does not provide claim forms specific to this Plan and will accept standard claim forms generally accepted by medical benefits administrators.

Post-Service Claims for Reimbursement or Payment – CHCB Enrollees

Participating Provider

If you receive services under the **MHSUD** (as provided through the **CHCB**) from a **Participating Provider**, all you need to do in most cases is present your Identification Card to the **Participating Provider**. The provider will bill the company administering your **MHSUD** benefits directly. The company administering your **MHSUD** benefits will send you copies of the payment record. The provider will bill you for any charges not covered by the **MHSUD** and for any applicable deductible and coinsurance amount payable by you.

Other Than a Participating Provider

If you receive services from a provider other than a **Participating Provider,** you will receive a bill for them. To claim your benefits, unless the provider submits your claim for you, send a copy of the bill to the claim submission address noted on www.yourtracktohealth.com for the company administering your **MHSUD** benefits or call the Member Services number on your Identification Card for more information.

When submitting your claim, be sure it includes all of the following information:

- the name and member identification number of the **Eligible Employee**,
- the patient's name and relationship to the **Eligible Employee**,
- the name of the Plan (i.e., The Railroad Employees National Health and Welfare Plan),
- the diagnosis, and
- an itemized statement of the services rendered, and dates of and charges for those services.

The same procedure should be followed with bills for hospital or professional provider care you receive outside the United States.

How To File A Claim For Prescription Drugs Obtained At An Out-Of-Network Pharmacy

If you fill your prescription at an Out-of-Network Pharmacy, you must file a claim form with the **PBM**. You can obtain a claim form by calling the Member Services number listed on www.yourtracktohealth.com or your Identification Card or by visiting the **PBM's** website. You must complete the claim form and send it to the **PBM** 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.

Proof Of Loss

The companies administering the Plan's various health care benefits 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:

    - coverage is being continued under the provisions applicable to Disabled Employees (see the "Disabled Employees" section of this booklet), or

    - you believe your child or grandchild meet the requirements set forth for a disabled child or grandchild in the definition of an **Eligible Dependent** (see the "Eligible Dependents" section of this booklet), or

    - you or an **Eligible Dependent** is eligible for benefits after coverage ends (see the "Benefits After Coverage Ends" section of this booklet).

- Require proof of student status if you believe your grandchild meet the requirements for a student in the definition of an **Eligible Dependent** (see the "Eligible Dependents" section of this booklet).

- Require periodic information as to whether an **Eligible Dependent** is employed and is covered under another plan (see the "Coordination of Benefits" section of this booklet).

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 Employee**, except that:

- If an employer or other person or organization has paid or is obligated to pay the **Eligible Employee's** health care expenses, Employee Health Care Benefits may be paid to such employer or other person or organization.

- If the benefits have been assigned, they will be paid to the assignee (except under the **MPSB** or under the **MMCP** or **CHCB** administered by Highmark BCBS), and the **Eligible Employee** will receive an Explanation of Benefits.

- If the benefits are for **In-Network Services** covered under the **MMCP** (including for the **MHSUD**), they will be paid directly to the appropriate **In-Network Provider**.

- With respect to a situation where it is administratively feasible to make payment to someone other than the **Eligible Employee**, and the company that administers your benefits has been informed:

    - that the patient is a minor living with a custodial parent or guardian who is not the **Eligible Employee**, or

    - of a specific situation and the company that administers the program involved determines that it is otherwise appropriate to send the payment and

Explanation of Benefits to someone other than the **Eligible Employee**.

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.

Note: Benefit payments under the **MMCP**, **CHCB**, and **MHSUD** may be made directly to your healthcare provider for services rendered to you, without regard to whether your Plan benefits have been legally assigned to the provider. When determining whether to send payment directly to your healthcare provider, the company administering your benefits may, but is not required to, consider whether you have instructed it to do so. Your instruction that the company administering your benefits should direct payment to your healthcare provider will not constitute an assignment of your benefits to the provider; that is, you will remain the sole beneficiary of the payment, and all legally required notices concerning your benefits will be directed to you.

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.

Overpayment Recovery

If the Plan pays benefits in excess of what the Plan terms provide, the recipient of those funds (be it you or your healthcare provider) must refund the excess amount. If no refund is made, the Plan or the company administering your benefits may recover the overpayment by reallocating the overpaid amount to pay future benefits that are payable in connection with services provided to you. If the recipient of the overpaid funds is a healthcare provider, the Plan or the company administering your benefits may also recover the overpayment by reallocating the overpaid amount to pay future benefits that are payable in connection with services provided to other persons covered by the Plan, or (in exchange for cash or a credit in the same amount as the reallocated overpayment) to pay future benefits that are payable in connection with services provided to persons covered

by another plan for which the company administering your benefits processes payment.

Special Notice Concerning Claims Against A Participating Railroad For On-Duty Injuries

The following is excerpted from the October 22, 1975 Health and Welfare Agreement:

> In case of an injury or a sickness for which an Employee who is eligible for Employee benefits and may have a right of recovery against the employing railroad, benefits will be provided under the Policy Contract, subject to the provisions hereinafter set forth. The parties hereto do not intend that benefits provided under the Policy Contract will duplicate, in whole or in part, any amount recovered from the employing railroad for hospital, surgical, medical or related expenses of any kind specified in the Policy Contract, and they intend that benefits provided under the Policy Contract will satisfy any right of recovery against the employing railroad for such benefits to the extent of the benefits so provided. **Accordingly, benefits provided under the Policy Contract will be offset against any right of recovery the Employee may have against the employing railroad for hospital, surgical, medical or related expenses of any kind specified in the Policy Contract. (Art. III, Sec. A.)**

Processing of Claims and Appeals

Overview

The claims and appeals procedures for Plan benefits consist of the steps explained below. You must exhaust the internal claims and appeals process as explained below before filing any judicial action against the Plan on a claim denied in whole or in part. A "claim" is a request for required pre-approval for care or treatment to be covered by the Plan (including notification under the **MHSUD**) or for reimbursement or payment by the Plan for care or treatment you have already received. References to "you" in this section also includes your designated representative, as appropriate.

Here is a summary of the process:

Step 1 – You must file an initial claim

This claim will be processed and reviewed within specified time frames, depending on whether it is a "pre-service request" or a "post-service request."

Step 2 – If your claim is denied, you may make an informal inquiry

If your initial claim is denied in whole or in part, you have the opportunity to make an informal inquiry into the reasons for the denial. You should generally receive an answer to your inquiry within 60 days. This informal inquiry process is not mandatory and does not impact your formal appeal rights.

Step 3 – You have the right to a formal appeal if your initial claim is denied

If your initial claim is denied in whole or in part you have two formal appeals levels:

1. The first level of appeal which is required for all claims, must be made to the company administering your benefits.

2. The second level of appeal, to an external independent review organization, is a right that is available to you if you so choose.

Each part of the process is explained more fully below.

Step 1 – Initial Claim Processing

Explanation of Benefits Will be Provided. If, in order to receive full benefits, you request required pre-approval of services involving **Urgent Care** under the **Out-of-Network Services** portion of the **MMCP** (including the **MHSUD**), or under the **CHCB**, 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 following information related to your claim: (1) the reasons for the decision, including a denial code and its corresponding meaning; (2) references to specific Plan provisions that explain the decision; (3) an explanation of any additional material or information that may be necessary to perfect your claim and why that information is necessary; (4) a description of the applicable internal appeal procedure and external review processes and the time limits applicable to such procedures; (5) a reference to any rule, guideline, protocol, or similar criterion that was relied upon in making the decision, or a statement that such information will be provided at no charge upon request; (6) either an explanation of the scientific or clinical judgment involved, applying the terms of

the Plan to your circumstances, or a statement that such an explanation will be provided to you at no charge upon request, if the adverse decision is based on a judgment about medical necessity, experimental treatment, or a similar Plan exclusion or limitation; (7) in the case of an **Urgent Care** claim, a description of the expedited review process to which you may be entitled; and (8) a statement about your rights to bring an action in court under ERISA Section 502(a) if the decision is still adverse to you once you complete the appeal process.

In addition to the notice standards described above, to the extent required by the **Affordable Care Act**, all adverse benefit determination notices will include the following: (1) information identifying the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, and the corresponding meaning of those codes; (2) the reason or reasons for the adverse benefit determination that includes the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used to deny the claim (for notices of final internal adverse benefit determinations, the description will include a discussion of the decision); (3) a description of available internal appeals and external review processes, including how to initiate an appeal; and (4) contact information for any applicable office of health insurance consumer assistance or ombudsman established under the **Affordable Care Act** to assist individuals with the internal claims and appeals and external review processes.

Time Periods and Process for Urgent Care Initial Claims

If you are requesting required pre-approval for **Urgent Care** in order to obtain full benefits under the **Out-of-Network Services** portion of the **MMCP** (including the **MHSUD**), under the **CHCB**, or under the **MPSB** and a prior authorization is involved, then 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 complete 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.

- Notice of a denial may be verbal with a written or electronic confirmation to follow within 3 days.

- 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 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.

Time Periods and Process For Non-Urgent Initial Claims

The time periods and process for initial claims depends on whether the claim involves a "pre-service request" or a "post-service request" as explained below.

Pre-Service Requests

If, in order to receive full benefits under the **Out-of-Network Services** portion of the **MMCP** (including the **MHSUD**) or the **CHCB**, you request required pre-approval of care or treatment, 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. The company administering your benefits charged by the Plan to process your request may take an additional 15 days to make a determination if such administrator 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 the administrator'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 for a period of time or a number of treatments, and the appropriate company administering your benefits 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 Requests

When you seek reimbursement or payment 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 will be paid or denied (in whole or in part) no later than 30 days after the receipt of your claim.

- The company administering your benefits charged by the Plan to process your claim may take an additional 15 days to make a benefit determination if the administrator 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.

Step 2 – Informal Inquiries Following Claim Denials

If a claim has been denied in whole 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 the company administering your benefits that processed your claim.

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.

Step 3 – Formal Appeals of Claim Denials: Rights and Procedures

The formal appeals process for denied claims consists of a first and second level appeal process as explained below.

First Level of Appeal for all Claim Denials – To the Company Administering Your Benefits

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 of a denied claim to the claims administrator that processed your claim.

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. Your request for a formal appeal must be submitted within 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 180 days after you make that informal inquiry.

You may submit additional information with your written request for formal appeal. Your formal appeal may include evidence and testimony, and written comments, documents, records, and other information relating to the claim for benefits (regardless of whether such information was considered in the initial claim for benefits). 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 company administering your benefits, considering your formal appeal, will provide you with new or additional evidence considered, relied upon, or generated by the company administering your benefits, or at its direction and any additional rationale for a denial prior to appeals decision in order to give you a reasonable opportunity to respond to the new evidence or rationale. This information will be provided sufficiently in advance of the date by which the company administering your benefits must provide the claims denial notice, to give you the opportunity to respond to the new or additional information. 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.

All decisions of first level appeals will be made without any deference to the initial decision on your claim. The individual who decides your formal first level appeal will not be the same person who initially decided your claim, nor will the individual be 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 will the health professional be 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 be written in a manner calculated to be understood by you, and will: (1) specify the reasons for the decision, including a denial code and its corresponding meaning; (2) include a description of the standard, if any, that was used in denying your claim, including a discussion of the decision; (3) contain a reference to specific Plan provisions relevant to the decision, (4) include 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; (5) specify 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; and (6) include, if the adverse benefit determination is based on a medical necessity, experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your circumstances, or a statement that such explanation will be provided to you free of 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. The notice will also include a description of the Plan's appeals procedures and your right to receive information about such procedures, your right to bring an action under ERISA Section 502(a) after you complete the appeal process, and a statement that you may have other voluntary alternative dispute resolution options that may be available by contacting your local U.S. Department of Labor

Office and your State insurance regulatory agency. You may appeal an adverse decision on your formal first level appeal as described below.

Final (Second Level) Appeal

The second level of the appeal process is explained below. There are two possible second level appeal processes – one for claims that do not involve **Medical Judgment** and one for claims that do involve **Medical Judgment**. A decision on your formal second level appeal will be final, except that you may appeal that decision to a court (see below).

Claims Not Involving Medical Judgment – To an External Independent Review Agency

The Plan has engaged an independent review agency to handle certain further appeals of claims under the **MMCP**, the **CHCB** and the **MHSUD** that do not involve **Medical Judgment**. If you are dissatisfied with the results of any initial appeal of your claim denial that does not involve **Medical Judgment**, you may file an additional appeal with the independent review agency. Your request for an appeal to the independent review agency must be submitted within 90 days after you receive the results from your initial appeal, and the process for filing an appeal to the independent review agency will be included with the results from your initial appeal.

With respect to the **MPSB**, if you are dissatisfied with the results of any initial appeal of your claim denial, you may file an additional appeal if the claim does not involve **Medical Judgment**. Your request for an appeal must be submitted within 90 days after you receive the results from your initial appeal, and the process for filing an appeal will be included with the results from your initial appeal.

Claims Involving Medical Judgment – To an External Independent Review Organization

If your claim involves **Medical Judgment** (excluding those that involve only contractual or legal interpretation without any use of **Medical Judgment**), and you exhaust the first level of appeal procedure, you will have the right to request a second level of appeal, which will consist of an independent review with respect to that claim. You must request this appeal/independent review within 4 months after receiving notice of an adverse benefit determination or final internal adverse benefit determination.

Within 5 business days after receiving your request, a preliminary review will be completed to determine whether: (1) you are/were covered under the applicable Plan benefit; (2) the denial was based on an issue involving **Medical Judgment**; (3) you exhausted the internal claims and appeals process (as required); and (4) you provided all information necessary to process the independent review. Within 1 business day after completing the preliminary review, you will be notified in writing if your request is not eligible for an independent review or if it is incomplete. If your request is complete but not eligible for independent review, the notice will include the reason(s) for ineligibility. If your request is not complete, the notice will describe any information needed to complete the request. You will have the remainder of the 4-month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an independent review, your request will be assigned to an independent review organization (IRO). The IRO will provide written notice of its final independent review decision within 45 days after the IRO receives the request for independent review. If the IRO reverses the adverse benefit determination or final internal adverse benefit determination, then the Plan will cover the claim.

In addition, you will have the right to an expedited independent review in the following situations:

1. Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal.

2. Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard independent review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

The IRO will provide notice of its final independent review decision as expeditiously as the claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the request.

Formal Appeals of Claim Denials: Timeframes for Receiving a Determination

Following is a summary of the timeframes for receiving a determination on your appeal of a denied claim.

Urgent Care Appeals – Claims Not Involving Medical Judgment

Your appeal may require prompt action if you are appealing the denial of your request for required pre-approval of **Urgent Care** under the **Out-of-Network Services** portion of the **MMCP** (including the **MHSUD**), under the **CHCB**, or under the **MPSB** and a prior authorization is involved. 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 and in writing or electronically as soon as possible, but no later than 72 hours from receipt of your appeal.

- Your appeal will no longer be processed as appealing a denial of a request for pre-approval 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 a post-service claim for reimbursement.

Non-Urgent Care Appeals

Pre-Service

If you are appealing the denial of your request for required pre-approval for medical care services or treatment under the **Out-of-Network Services** portion of the **MMCP** (including the **MHSUD**), the **CHCB** or the termination or reduction of benefits for medical care or treatment, your appeal will be handled as follows:

- A decision following the review of your first level appeal by the company administering your benefits charged by the Plan to perform such review will be sent to you within 15 days from the day your appeal of the denial is received.

- If you file a final (second level) appeal with the independent review agency (**MMCP**, **CHCB** or **MHSUD** claims) or with the **PBM** (**MPSB** claims) with respect to a claim not involving **Medical Judgment**, a decision will be sent to you within 15 days from the day your appeal is received by the independent review agency or the **PBM**.

- If you file a final (second level) appeal with respect to a claim involving **Medical Judgment**, the IRO's decision will be sent to you within 45 days from the day your appeal is received by the IRO.

- Your appeal will no longer be processed as appealing a denial of a request for pre-approval for 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 a post-service claim for reimbursement.

Post-Service

If you are appealing 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 the company administering your benefits charged by the Plan to perform such review will be sent to you within 30 days after your appeal of the denial is received.

- If you file a final (second level) appeal with the independent review agency (**MMCP**, **CHCB** or **MHSUD** claims) or with the **PBM** (**MPSB** claims) with respect to a claim not involving **Medical Judgment**, a decision will be sent to you within 30 days from the day your appeal is received by the independent review agency or the **PBM**.

- If you file a final (second level) appeal with respect to a claim involving **Medical Judgment**, the IRO's decision will be sent to you within 45 days from the day your appeal is received by the IRO.

Judicial Actions

You must exhaust the entire appeals processes described above before you file a lawsuit on any claim involving the Plan.

If you file a lawsuit concerning a claim without completing the appeals processes described above, the Plan will ask that your lawsuit be dismissed. You may not sue on your claim more than 3 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. If any such judicial proceeding is undertaken, the evidence presented will be strictly limited to evidence timely presented to the appeals reviewer during the applicable appeal.

VIII
ADDITIONAL INFORMATION

Important Notice About the Plan and Medicare

Medicare Eligibility and Enrollment

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 (ESRD), on the earlier 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.

Benefits for people who are eligible for Medicare may be paid differently depending on a variety of circumstances, some of which are described below. The Railroad Retirement Board or the Social Security Administration can provide you with more information about **Medicare** eligibility. Both agencies annually publish "Medicare and You," which gives valuable information about **Medicare** and can be obtained online at www.Medicare.gov/publications.

Order Of Benefits – Who Pays First

If an **Eligible Employee** or an **Eligible Dependent** is also eligible for **Medicare**, the following rules determine whether the Plan or **Medicare** is the primary payer.

Medicare Eligibility Due to Age or Disability

If the person is eligible for **Medicare** due to age or disability other than ESRD, then the Plan is primary for the **Eligible Employee** and the **Eligible Dependent** while the **Eligible Employee** is actively working, or if not actively working, while the **Eligible Employee** meets all of the following conditions:

- retains employment rights in the railroad industry;
- has not had a termination of employment by the employee's employer;
- is not receiving disability payments from an employer for more than 6 months;
- is not receiving disability benefits from Social Security or under the Railroad Retirement Act; and
- has Plan coverage that is not **COBRA** continuation coverage.

A person eligible for **Medicare** can reject the Plan as primary payer of health benefits. If Plan benefits are rejected, however, the Plan cannot provide any benefits for services and supplies covered by **Medicare**, even if the **Medicare** benefit is less than the benefit which would have been payable under the Plan. In this case, **Eligible Expenses** under the Plan are limited to services and supplies wholly uncovered by **Medicare**. The person must notify Railroad Enrollment Services in writing to reject Plan benefits.

Medicare Eligibility Due to ESRD

If the person is eligible for **Medicare** due to ESRD, the Plan is primary for all services (not just those related to ESRD) during the first 30 months of **Medicare** eligibility. After 30 months, **Medicare** becomes primary.

Dual Medicare Eligibility

If a person has dual eligibility for **Medicare** (is eligible due to age or disability other than ESRD, and also due to ESRD), the ESRD rule applies unless **Medicare** became the person's primary payer due to age or other disability *before* the person became eligible for **Medicare** due to ESRD.

*If **Medicare** benefits would be paid primary to Plan benefits, it is essential that the person be enrolled in **Medicare** Parts A and B. If the person fails to enroll in **Medicare** Part A and Part B, Plan benefits will still be determined as if the person had enrolled. This means that a person failing to enroll in **Medicare** Part A will **not** receive **Medicare** benefits for services covered by Part A, and a person failing to enroll in **Medicare** Part B will **not** receive **Medicare** benefits for services covered by Part B, but in each case, Plan benefits will still be calculated as if **Medicare** had paid primary; Plan benefits will **not** be increased to make up for the loss of **Medicare** benefits.*

*The Plan will reimburse the **Eligible Employee** for any **Medicare** premium paid during any month in which **Medicare** is primary (except during the final year of Employee-only coverage available to Disabled Employees). You may obtain a form to claim a refund of **Medicare** premiums by writing to:*

Railroad Enrollment Services
Railroad Administration
P.O. Box 150476
Hartford, CT 06115-0476

*The Plan will also reimburse the **Eligible Employee** for both Part A and Part B **Medicare** premiums paid during a period when a person is not eligible for premium free Part A **Medicare**.*

Medicare Premiums

Part A Medicare

For most people, there is no premium for Part A **Medicare** (Hospital Insurance). A person eligible for **Medicare** due to age or disability should enroll for Part A **Medicare** as soon as first eligible, even if the Plan provides primary benefits.

If neither you nor your spouse has the required age or years of service to be eligible for benefits under the Railroad Retirement Act or the Social Security Act, the person eligible for **Medicare** will be required to pay a monthly premium for Part A **Medicare**. If this is the case, see the section below about Part B **Medicare**. As soon as you or your spouse become eligible for benefits under the Railroad Retirement Act or the Social Security Act (even if you do not actually apply for those benefits), this premium for Part A **Medicare** is no longer required.

If the person is eligible for **Medicare** due to ESRD, see the "Special Rule for Persons with ESRD" section of this booklet.

Part B Medicare

There is a monthly premium required for Part B **Medicare** (Medical Insurance).

If **Medicare** is primary, benefits under the Plan will be reduced by any amount payable under **Medicare**. If the person does not enroll in Part B **Medicare,** the Plan will estimate the amount that would have been paid by Part B **Medicare** had the person enrolled, and will reduce the Plan benefits by that estimated amount. Therefore, when **Medicare** is primary, the person should enroll for Part B **Medicare** when the person enrolls for Part A **Medicare**.

A person who has rejected Plan benefits should also enroll for Part B **Medicare**.

If the Plan is primary, the person has two options:

1. Enroll in Part B **Medicare** as a secondary benefit.

2. Delay enrollment in Part B **Medicare**.

If the person delays enrollment in Part B **Medicare**, the person may enroll during the 8-month period that begins as of the first

day of the month immediately following the month in which the **Eligible Employee** ceases to be covered by the Plan or employment ends, whichever comes first, or would have ceased to be covered by the Plan had the employee not elected **COBRA** coverage. There is no penalty or waiting period for enrollment during this 8-month period.

If the person delays enrollment in Part B **Medicare**, and does not enroll during this 8-month period, the person may enroll during any subsequent general enrollment period. A general enrollment period is held each January 1 through March 31. **Medicare** coverage begins July 1 of the year of enrollment. A surcharge is required for each year the enrollment is delayed beyond the end of this 8-month period.

If the person is not eligible for premium free Part A **Medicare**, this information about Part B **Medicare** also applies to Part A **Medicare**.

Special Rule for Persons with ESRD

The Plan is primary during the first 30 months of **Medicare** eligibility. The person has two options:

1. Enroll in both Parts A and B **Medicare** when first eligible, or

2. Delay enrollment in both Parts A and B **Medicare** until the 31st month of **Medicare** eligibility.

If the person delays enrollment in Part B **Medicare** only, the person can later enroll in Part B **Medicare** during a general enrollment period, and will have to pay a premium surcharge for late enrollment.

Refund of Medicare Premiums

The Plan will refund a person's Part B **Medicare** premium for any month in which the person's **Medicare** benefits are paid primary to Plan benefits (excluding any month during the last calendar year of Employee Health Care Benefits for a Disabled Employee).

The Plan will also refund a person's Part A and Part B **Medicare** premiums during any month in which the person is required to pay a premium for Part A **Medicare**, even if Plan benefits are paid primary to **Medicare** benefits.

Medicare premiums are not reimbursed by the Plan when:

- the person's Plan benefits are paid primary to **Medicare** benefits (unless the person must also pay a premium for Part A **Medicare**);

- the person is covered as a Disabled Employee, in the final year of eligibility for Employee Health Care Benefits; or

- the person has rejected the Plan as primary payer of health benefits.

A form to request a refund of **Medicare** premiums can be obtained from:

Railroad Enrollment Services
Railroad Administration
P.O. Box 150476
Hartford, CT 06115-0476

Information Required By The Employee Retirement Income Security Act Of 1974 ("ERISA")

- **Name of Plan:**

  The Railroad Employees National Health and Welfare Plan

- **Plan Identification Numbers:**

  Employer Identification Number (EIN):

  80-0616625

  Plan Number (PN): 501

- **Plan Administrator:**

  The Joint Plan Committee, consisting of:

  National Carriers' Conference Committee
  251 18th Street, South
  Suite 750
  Arlington, Virginia 22202
  Telephone (202) 862-7200

  jointly with

  Cooperating Railway Labor Organizations
  3 Research Place
  Rockville, MD 20850
  Telephone (301) 948-4910

  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. The railroads and the organizations are represented in connection with the establishment and maintenance of the Plan by the National Carriers' Conference Committee and by the Cooperating Railway Labor Organizations, respectively. The two Committees administer the Plan. When acting as Plan Administrator, the Committees form a single Committee, called the Joint Plan Committee.

- **Type of Plan:** Group health plan.

- **Type of Administration:** Trusteed and Self-Administered.

- The Plan is administered directly by the Plan Administrator. The Plan's health care 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 (this booklet) provides a description of the health care benefits that are available under the Plan. In connection with these benefits, the Plan Documents give the various entities that administer them 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 determination made by any of those entities, you may request a review of your claim. See the "Processing of Claims and Appeals" section of this booklet for a description of the claims and appeals procedures.

- **Trustee:**

  Truist
  Not for Profit Division
  1445 New York Avenue, NW, 4th Floor
  Washington, DC 20005

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

    - Employers contribute to the Plan on a monthly basis. The amount of each contribution depends upon the number of qualifying employees who rendered the **Requisite Amount of Compensated Service** during, or received the **Requisite Amount of Vacation Pay** for, the preceding month and the applicable payment rate per employee.

    - Employees also contribute to the Plan on a monthly basis. During any month in which the employee's employer is required to make a contribution to the Plan with respect to foreign-to-occupation Employee Health Care Benefits, or with respect to Dependents Health Care Benefits, for the employee, the employee must also make a contribution to the Plan. Employee contributions are deducted from wages. The amounts of employee contributions are determined pursuant to the applicable collective bargaining agreement.

    - Health care 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 such benefits.

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

    Each Plan Year ends on a December 31.

- **Claims Procedures:**

    See the "Processing of Claims and Appeals" section of this booklet for information about claims and appeals 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 or labor organization has the right to terminate its participation in the Plan at any time by delivery to the Plan Administrator of written notice of such termination, except as such right may be limited by obligations undertaken by the employer or the labor organization 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 ERISA, which 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 the office of the Cooperating Railway

Labor Organizations), at the headquarters office of the labor organization that represents you, at each employer establishment in which 50 or more employees covered by the Plan customarily work, and at the meeting hall or office of each union local in which there are 50 or more members 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 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 Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator (either National Carriers' Conference Committee or the Cooperating Railway Labor Organizations), copies of documents governing the operation of the Plan, including collective bargaining agreements (as required by 29 C.F.R. §§ 2520.104b-1 and 2520.104b-30), a list of the employers that sponsor the Plan, and copies of the latest annual report (Form 5500 Series), and updated Summary Plan Descriptions. The Plan 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 financial report.

- Receive, without charge, from the Plan Administrator, upon written request to its address, information as to whether a particular railroad (or other 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 employees who are represented by such organization. However, the Plan Administrator cannot inform you whether you as an individual employee 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 health care coverage for you or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the "Optional Continuation of Coverage Under COBRA" and "Optional Continuation of Coverage Under USERRA" sections of this booklet for rules governing your **COBRA** or USERRA continuation of coverage rights.

    - Reduce or eliminate exclusionary periods of coverage for preexisting conditions under the Plan, if any, as 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, or when your **COBRA** continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your 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 employer, your union, or any other person, may fire you or 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 Plan 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 the companies described in this booklet as administering the benefits in which you participate or contact the Plan Administrator. If you have any questions about whether you are covered, you may obtain that information from your employer.

  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.

Miscellaneous

Options After Coverage Ends

When coverage ends under this Plan, other coverage may be available as follows:

- Coverage may be continued under this Plan for a limited period of time under the provisions of **COBRA** (see the "Optional Continuation of Coverage Under COBRA" section of this booklet) or USERRA (see the "Optional Continuation of Coverage Under USERRA" section of this booklet).

- Retired employees who are between 60 and 65 with 30 or more years of railroad service may be eligible for coverage under The Railroad Employees National Early Retirement Major Medical Benefit Plan.

- Certain employees and surviving dependents may enroll for health coverage under Group Policy GA-23111 issued by UnitedHealthcare.

Information about these options can be obtained by writing to Railroad Enrollment Services at the following address:

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

It is extremely important that you obtain information about these options before your coverage under this Plan ends. Information about the early retirement plan should be obtained while you are still working. If you wait longer, you may find that you are no longer eligible for one or more of these options.

Identification Cards

All new **Eligible Employees** will receive Plan Identification Cards. To request additional Identification Cards, call the company administering your benefits at the applicable toll free number shown on www.yourtracktohealth.com.

Address Changes

You should also report any changes in your address to your employer, so that you are enrolled in the proper network area of the Plan. If you are not an active employee, you must keep the Plan apprised of your current address so that you can receive all communications. Call Railroad Enrollment Services at the phone number listed on www.yourtracktohealth.com to obtain information on how to report a change in address.

Unclaimed Payments

As a condition of entitlement to a benefit under the Plan, you must keep the Plan informed of your (and your **Covered Family Members'**, if different) current mailing address and other relevant contact information. If the Plan Administrator (or its delegate) is unable to locate any individual otherwise entitled to a benefit payment hereunder after exercising reasonable efforts to do so (as determined in the sole discretion of the Plan Administrator (or its delegate)), the individual is not entitled to a benefit hereunder and forfeits any rights to any benefits. In addition, as a further condition to any benefit entitlement under the Plan, any person claiming the benefit must present for payment the check evidencing such benefit within 1 year of the date of the check. If any check for a benefit payable under the Plan is not presented for payment within 1 year of the date of issue, the Plan shall have no liability for the benefit payment, the amount of the check shall be deemed a forfeiture, and no funds shall escheat to any state.

Legal Action

No action at law or in equity may be brought to recover benefits allegedly due under the Plan before the claimant has exhausted the applicable claims procedures. A "claimant" refers to any person (or person's authorized representative) who may claim a right or benefit under the Plan. Nothing contained in the Plan gives any person or organization any right to join a participating employer as a codefendant in any action against a Plan participant nor may a participating employer be impleaded in such action by a participant or the participant's legal representative.

Any legal or equitable action for benefits under the Plan must be brought in the United States District Court for the Eastern District of Virginia.

Plan is Not an Employment Contract

The Plan will not be construed as a contract for or of employment, nor will it be construed as guaranteeing any terms or conditions of employment.

Non-Assignability of Rights

Your right to receive any benefit or reimbursement under the Plan is not alienable by you by assignment or any other method and is not be subject to being taken by your creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

No Guarantee of Tax Consequences

The participating employers do not make any commitment or guarantee that any amounts paid to you or for your benefit will

be excludable from your gross income for Federal or state income employment tax purposes, or that any other Federal or state tax treatment will apply to or be available to you. It is your obligation to determine whether each payment under the Plan is excludable from your gross income for Federal and state income and employment tax purposes, and to notify your employer if you have reason to believe that any such payment is not so excludable.

Severability

If any provision of this Plan is held invalid, unenforceable or inconsistent with any law, regulation or requirement, its invalidity, unenforceability or inconsistency will not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision were not a part of the Plan.

Construction of Terms

Words of gender shall include persons and entities of any gender, the plural shall include the singular and the singular shall include the plural. Section headings exist for reference purposes only and shall not be construed as part of the Plan.

Applicable Law

The Plan shall be construed and enforced according to the laws of the Commonwealth of Virginia to the extent not preempted by any Federal law.

No Vested Interest

Except for the right to receive any benefit payable under the Plan in regard to a previously incurred claim, no person shall have any right, title, or interest in or to the assets of any participating employer because of the Plan.

Changes in Law

Unless the context clearly indicates to the contrary, a reference to a Plan provision, statute, regulation or document shall be construed as referring to any subsequently enacted, adopted or executed counterpart; provided, however, that any other provision of this Plan to the contrary notwithstanding, this Plan may be operated in accordance with legal requirements before it is amended to reflect them.

UnitedHealthcare
Railroad Administration
PO Box 150476
Hartford, CT 06115-0476

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