Supplemental Sickness Benefit Plan For Railroad Yardmaster Employees

Provided Under Group Insurance Contract 9000
Issued by Trustmark Insurance Company

August 1, 2023

TABLE OF CONTENTS

I. IMPORTANT NOTICE

This booklet provides a summary of the Supplemental Sickness Benefit Plan for Railroad Yardmaster Employees (the “Plan”), as in effect on August 1, 2023, under collective bargaining agreements between railroads represented by the National Carriers' Conference Committee and employees represented by the SMART- Transportation Division (SMART-TD). Although this booklet references the Railroad Unemployment Insurance Act (“RUIA”) sickness benefits, you should review the application process and requirements with your employing railroad, local U.S. Railroad Retirement Board office (“RRB”), or union representative.

Plan benefits are fully insured by Trustmark Insurance Company ("Trustmark") under Group Policy 9000 issued to the railroads listed in Exhibit C to such Policy. Those participating railroads collectively constitute the Policyholder and are represented in such capacity by the National Carriers' Conference Committee.

The benefits and procedures set forth in this booklet apply to Periods of Total Disability beginning on or after August 1, 2023. For Periods of Total Disability that began prior to August 1, 2023, please contact Trustmark or refer to the booklet entitled “Supplemental Sickness Benefit Plan for Railroad Yardmaster Employees,” dated January 1, 2010.

Late Claims

You must file your Notice of Disability and Proof of Disability – Attending Physician’s Statement forms (enclosed) with Trustmark within 90 days of the start of disability or as soon after as is reasonably possible (subject to Trustmark’s determination of reasonableness). The “start of disability” is the first full day of Total Disability after you stop rendering compensated service for your employing railroad. If you do not file your claim with Trustmark within 90 days (or as soon after as is reasonably possible), your claim will be denied.

II. IMPORTANT CONTACT INFORMATION

Trustmark

If you have any questions about your benefits or your claim for benefits, you can speak with a customer service representative by calling 1-800-504-9052 from 8:30 am to 4:30 pm EST or visiting **yourtracktohealth.com**.

You may file a claim with Trustmark using any of the following methods:

By Mail Trustmark Insurance Company
P.O. Box 7901
Lake Forest, IL 60045-7901

By E-Mail LDMail@trustmarkbenefits.com

By Fax 847-615-3866

If you disagree with Trustmark’s claim determination, you may submit an appeal using any of the following methods:

By Mail Trustmark Insurance Company
P.O. Box 7901
Lake Forest, IL 60045-7901

By Fax 847-615-3866

Your Second Level appeal should be addressed to the attention of the Disputes Committee.

U.S. Railroad Retirement Board (RRB)

The RRB administers the RUIA sickness benefits. If you have any questions about your benefits or your claim for benefits, you can call 1-877-772-5772 or visit https://www.rrb.gov. You can find contact information for your local RRB office at **https://rrb.gov/Field-Office-Locator**.

III. HIGHLIGHTS: HOW TO FILE A CLAIM

Your benefits under the Plan are intended to supplement RUIA sickness benefits. In order to receive benefits under this Plan, you must also apply for and be approved for RUIA sickness benefits.

With Trustmark

(1) The Plan provides disability benefits beginning on the 5th consecutive day of Total Disability. Therefore, as soon as you know your disability will last more than 4 consecutive days, you and your attending physician should complete all parts of the Notice of Disability form (enclosed) and mail, e-mail, or fax it to Trustmark. Be sure your attending physician completes all items on the Proof of Disability – Attending Physician's Statement form (enclosed).

(2) If Trustmark provides you with any other forms, you (or your medical provider, as applicable) should complete and send them to Trustmark by e-mail, mail, or fax.

The mailing address, e-mail, and fax number for Trustmark are provided under "Important Contact Information" in Section II.

With the U.S. Railroad Retirement Board (RRB)

(1) To apply for RUIA sickness benefits, you should obtain Forms SI-1a (Application for Sickness Benefits) and SI-1b (Statement of Sickness) from your employer, local RRB office, or union representative.

(2) You should complete Form SI-1a and have your doctor complete Form SI-1b. Mail the completed forms together to U.S. Railroad Retirement Board, Office of Programs – Operations, P.O. Box 10695, Chicago, IL, 60610-0695. The RRB must receive your forms within 10 days of the first day for which you want to claim benefits. If your application is late, you may lose benefits.

(3) Once your RRB has processed your application, the Form SI-3 (Claims for Sickness Benefits) will be mailed to you periodically for as long as you remain unable to work and eligible for benefits. You must complete and return the form to the RRB office addressed on the form. The RRB office must receive your form within the later of (a) 30 days from the last day of the claim period, or (b) 30 days from the date the form was mailed to you.

IV. SCHEDULE OF BENEFITS

Benefit Start Date: 5th Consecutive Day of Total Disability
Maximum Benefit Period: 12 Months

Basic Benefit Amount

The basic benefit amount on or after July 1, 2023** is as shown below:

	Insured Employees Who Have *Not* Received Maximum RUIA Sickness Benefits in the RUIA Benefit Year Involved		Insured Employees Who Have Received Maximum RUIA Sickness Benefits in the RUIA Benefit Year Involved	
Class	**Per Month**	**Per Day***	**Per Month**	**Per Day***
Class 051	$3,349.00	$111.63	$5,133.00	$171.10

*The "per day" rate is the monthly rate divided by 30. The rate applies to a disability lasting less than a month or to the extra days for which a disability lasts more than a whole month.

****The RRB sets the daily benefit rate for each class on an annual basis, and additional changes could apply due to sequestration orders. After the RRB publishes new rates, the Plan Administrator will update yourtracktohealth.com with the Base Benefit Amount as soon as administratively practicable.**

An Insured Employee during his initial RUIA registration period (i.e., the first 14 days of Total Disability) after all certification requirements are met will receive:

(1) benefits for the 5th through the 14th day of disability at the applicable Basic Benefit Amount shown above, plus

(2) an amount equal to the total RUIA benefit that would have been payable for days of sickness, had it not been for RUIA's "waiting period" requirement. Benefit payments after that will be made monthly. A "month" is any period equal to 30 calendar days.

The Basic Benefit Amount may change during your Period of Total Disability (up to the Maximum Benefit Period under the Plan). See "Amount of Benefits" in Section VI.

The benefits shown in this booklet apply only to Periods of Total Disability that start on or after August 1, 2023. Contact Trustmark for information about benefits applicable to Periods of Total Disability that began prior to August 1, 2023.

V. ELIGIBILITY AND TERMINATION OF COVERAGE

Eligibility

Generally, you are eligible for coverage under this Plan while you are an "Insured Employee". To be an Insured Employee, you must satisfy the conditions for Employee, Qualified Employee, and Insured Employee defined below.

"Employee" means an individual who:

(1) Is employed by a participating railroad; and

(2) Is represented by the SMART-Transportation Division (SMART-TD) or another labor organization that participates in the Plan.

"Employee" also includes:

(1) Any other yardmaster employee of a participating railroad if the railroad has made the required premium payment to Trustmark; and

(2) Any General Chairman or other full-time labor representative of the SMART-Transportation Division (SMART-TD) if appropriate premiums are paid through that labor organization to Trustmark.

"Qualified Employee" means an Employee who:

(1) Has completed 30 days of continuous employment with the same participating railroad in a position represented by the SMART-Transportation Division (SMART-TD) (or another labor organization that participates in the Plan) and is covered by its schedule agreement; and

(2) Is a "qualified employee" as that term is defined in Section 3 of the RUIA, as amended from time to time.*

* Section 3 of the RUIA provides that an employee shall be a "qualified employee" in a RUIA benefit year if the employee has creditable earnings in the preceding calendar year (the "base year"), counting no more than a certain amount in any month. Additionally, a new employee must have at least 5 months of railroad service in the first year of work to be eligible for benefits in the following RUIA benefit year. The term "RUIA benefit year" means the period beginning on July 1 of any year and ending on June 30 of the next year. For RUIA benefit year 2023 (July 1, 2023 – June 30, 2024), a qualified employee must have creditable earnings of not less than $4,387.50 in calendar year 2022 (the base year), where a maximum of $1,755.00 of any calendar month is counted. And, if 2022 was the employee's first year of railroad service, he or she must have railroad service in at least 5 months in that year. The RRB sets the qualifying base year compensation and monthly compensation base on an annual basis.

In sum, an Employee who has satisfied paragraphs (1) and (2) above will be a Qualified Employee as of the first day of the benefit year (i.e., July 1st) next following the end of the base year in which the employee satisfies the RUIA's compensation standard.

Paragraph (1) above of the definition of Qualified Employee will not apply if an Employee who is furloughed by his employing railroad while covered under the Plan starts to work for another participating railroad while still covered.

"Insured Employee" means a Qualified Employee who, under a schedule agreement held by the SMART-Transportation Division (SMART-TD) or another participating labor organization, during any calendar month, where in the prior month:

(1) Rendered compensated service for a participating railroad; or

(2) Received vacation pay from a participating railroad.

However, if the Qualified Employee does not satisfy either of the conditions above because he or she became disabled while an Insured Employee and continued to be so disabled, he or she will remain eligible for benefits with respect to that disability, subject to other limitations on Plan benefits, even though, as a result of that disability, he or she did not render compensated service or receive vacation pay during the prior month.

A Qualified Employee who is no longer an Insured Employee due to disability, furlough, leave of absence, or discharge will again be an Insured Employee on the date he or she begins to render compensated service for a participating railroad, provided that the Employee:

(1) Renders compensated service within 12 calendar months after he or she is no longer an Insured Employee; and

(2) Renders compensated service under a schedule agreement held by the SMART-Transportation Division (SMART-TD) or other participating labor organization.

Such Employee will be an Insured Employee for the rest of that calendar month in which he or she began to render compensated service again.

A Qualified Employee who no longer renders compensated service may continue to be an Insured Employee if his employing railroad:

(1) Continues to provide Plan benefits under compensation maintenance provisions of an agreement, a statute, or an order of a regulatory authority; and

(2) Continues to make the same premium payments to Trustmark as if the Employee had rendered compensated service.

If an Employee is furloughed or ceases to maintain his employment relationship with a participating railroad, his receipt of vacation pay will not continue Plan coverage.

Termination of Coverage

Your coverage will end on the earlier of the date:

(1) The Plan ends;

(2) Your employing railroad or labor union no longer participates in the Plan;

(3) The Plan is changed to end the coverage for the class of Employees of which you are a member; or

(4) You are no longer an Insured Employee (although you may continue to receive benefits for a continuing disability that began while you were an Insured Employee, subject to other limitations on Plan benefits).

Return to Work

When an Insured Employee's physician determines that the Employee is no longer Totally Disabled and the Employee is medically qualified to return to work, but the railroad carrier's designated medical officer finds in his medical judgment that such employee is not medically qualified to return to work, the Employee shall be promptly notified by the employing railroad. The Employee's disability payments due under the Plan shall continue until the sooner of: (1) the date the Employee is found to be medically qualified to return to service by the railroad carrier's designated medical officer, or (2) the expiration of the 12-month limitation on Plan benefits for such disability.

Nothing contained herein shall be construed to extend the amount or duration of payments under the Plan to any employee beyond that currently provided.

VI. BENEFIT PROVISIONS

Benefits Payable

Benefits will be paid to you if you become Totally Disabled due to accident or sickness, subject to the following:

(1) The Period of Total Disability must start while you are an Insured Employee;

(2) You must be certified Totally Disabled by a legally qualified physician; and

(3) Benefits are subject to all the terms, conditions, limitations, and exclusions of the Plan.

Benefits start on the 5th consecutive day of Total Disability and will be paid monthly while a Period of Total Disability continues. The Maximum Benefit Period is 12 months of the Period of Total Disability.

"Total Disability" and **"Totally Disabled"** means that because of an accident or sickness:

(1) A legally qualified physician is giving you care which is appropriate for the nature of the condition. (Trustmark will waive this requirement, at its discretion, if continued care would be of no benefit to you); and

(2) You are unable to perform:

(a) The duties of any job available to you in your craft; or

(b) The duties of the last job on which you worked before your disability began, if there is no job available to you in your craft.

"Period of Total Disability" means a period of time during which you are Totally Disabled from one or more causes. It starts the first full day of Total Disability after you stop rendering compensated service for your employing railroad. The Period of Total Disability ends on the sooner of the following:

(1) The date you are no longer Totally Disabled; or

(2) The date you go back to active work for any employer.

Successive Periods of Total Disability
Whether or not your Total Disability started while you were an Insured Employee, successive periods of Total Disability will be considered as one Period of Total Disability unless the later period:

(1) Is separated by a period of 90 consecutive calendar days during which you have worked on a full time basis; or

(2) Is due to an entirely unrelated cause and begins after you have returned to compensated service on a full-time basis for at least one day.

Termination of Benefits
Benefits for your Total Disability will end on the sooner of the following:

(1) The date of your death;

(2) The date you are no longer Totally Disabled; or

(3) The date you have received 12 months of benefits with respect to your Total Disability, subject to item (10) under "Limitations and Exclusions".

Employees Paid in Canadian Funds
Dollars and cents for an employee paid by a railroad in Canadian funds will mean dollars and cents in Canadian funds. Payments made to these employees in United States funds under RUIA, other laws, or private plans will be converted to their Canadian equivalents when reductions are made if the value of the Canadian dollar varies by more than one cent from the value of the United States dollar.

Local Agreements
The benefits of Insured Employees represented by labor unions that have entered into local agreements with a participating railroad will generally be the benefits specified in this booklet (or, as communicated to you by the Plan Administrator on **yourtracktohealth.com** or otherwise), if the railroad is required to make the same premium payments for this Plan as those made by the railroads who are parties to the applicable national agreements.

Amount of Benefits

The amount of benefits is the "Basic Benefit Amount" reduced by the "Reductions Applicable to Basic Benefit Amount." Your benefits under the Plan are intended to supplement the RUIA sickness benefits and payments you receive from certain other sources.

Please note that if you are not qualified or eligible to receive RUIA sickness benefits for your disability, you are not eligible to receive benefits under the Plan.

Basic Benefit Amount
The Basic Benefit Amount (as shown in "Schedule of Benefits") is based on a number of factors, including: (1) the daily benefit rate established by the RRB, and (2) whether or not the Insured Employee has exhausted the maximum RUIA sickness benefits in the RUIA benefit year involved.

Reductions Applicable to Basic Benefit Amount
Your Basic Benefit Amount may change during your Period of Total Disability (up to the Maximum Benefit Period under the Plan).

RUIA Sickness Benefits

(1) If you receive the maximum RUIA sickness benefits during a RUIA benefit year, your Basic Benefit Amount will increase during your Period of Total Disability when you do not receive additional RUIA sickness benefits.

(2) If during your Period of Total Disability a new RUIA benefit year begins and you are qualified and eligible to receive RUIA sickness benefits again, your Basic Benefit Amount will decrease to the lower Basic Benefit Amount.

(3) If during your Period of Total Disability a new RUIA benefit year begins and you are not qualified and eligible to receive RUIA sickness benefits again, your Basic Benefit Amount will decrease to the lower Basic Benefit Amount.

(4) If RUIA sickness benefits increase, so that the sum of:

(a) 21.75 times the average daily sickness benefits under RUIA; plus

(b) The Basic Benefit Amount provided for you while receiving sickness benefits under RUIA is more than the Maximum Monthly Benefit Amount shown below, your Basic Benefit Amount will be reduced by an amount equal to the excess.

Maximum Monthly Benefit Amount

$5,395.00

The Plan Administrator will update yourtracktohealth.com with Maximum Monthly Benefit Amounts, as soon as administratively practicable after the next collective bargaining agreement has been finalized.

Other Payments

Your Basic Benefit Amount may also decrease if, together with your RUIA sickness benefit and payments received from other sources, your monthly amount exceeds the Maximum Monthly Benefit Amount as shown above. Other payments include the following:

(1) Annuity payments under the Railroad Retirement Act;

(2) Benefit payments under Title II of the Federal Social Security Act;

(3) Unemployment, maternity, or sickness benefits under any unemployment, maternity, or sickness compensation law other than RUIA; and

(4) Any other social insurance payments under any law.

If you do not receive sickness benefits under RUIA because of the provisions of Section 4 (a-1) (ii) of such Act,* the Basic Benefit Amount, reduced as provided above, will be paid. Item (11) under "Limitations and Exclusions" will not affect this provision.

*Section 4(a-1) (ii) of RUIA provides that you will be disqualified for benefits for any day for which you receive unemployment, maternity, or sickness payments under another law. If you receive payments as described in (1), (2), or (4) above, they will be offset against your payments under RUIA.

If you receive any payments described in (1), (2), (3), or (4) retroactively for a period for which benefits were paid under this Plan, Trustmark may get back any excess benefits it has paid. The amount returned will be the difference between the benefits actually paid under the Plan and the lesser amount that would have been paid under the Plan had the retroactive payments been made before the Plan's benefits were paid.

Other Disability Benefits

If you are eligible for benefits for a disability under any other plan, fund, or arrangement by any name for which an employer has contributed, the Basic Benefit Amount will be reduced so that the sum of:

(1) The benefits for which you are eligible under other plans, funds, or arrangements; plus

(2) Your sickness benefits under RUIA; plus

(3) The Basic Benefit Amount;

will not be more than the Maximum Monthly Benefit Amount as shown above.

A plan, fund, or arrangement includes, but is not limited to, the following:

(1) Any group life policy providing installment payments for permanent total disability;

(2) Any group annuity contract;

(3) Any pension or retirement annuity plan;

(4) Any group accident and health insurance paying loss of employment time benefits for disability;

(5) Any employer sick leave or wage continuation program; and

(6) Any loan arrangement between employee and employer where the employer has a right of recovery.

Off-Track Vehicle Accident

If you are disabled in an off-track vehicle accident covered under applicable provisions of the national agreements, the Basic Benefit Amount will be reduced by the amount of any payment made to you by reason of that coverage for time loss for the same disability.

Limitations and Exclusions

No payment will be made for any disability under this Plan for the following:

(1) The first 4 consecutive days of any Period of Total Disability;

(2) More than 12 months during any Period of Total Disability, subject to item (10) in this section;

(3) Any period during which you are not certified as receiving treatment by a legally qualified physician;

(4) Any day you render compensated service or otherwise work for or receive pay from any employer;

(5) Any disability that begins after you started work on a regular or permanent basis for a participating railroad other than in a position coming under a schedule agreement held by the participating labor union (covered position) unless the last position on which you worked before the start of your disability was a covered position;

(6) Any disability due to intentionally self-inflicted injury or sickness;

(7) Any disability caused by you committing or attempting to commit an assault, battery, or felony;

(8) Any disability due to war or act of war (whether war is declared or not), insurrection or rebellion, or your participation in a riot or civil commotion;

(9) Any disability starting after your employment with the participating railroad has ended. This exclusion will not apply if you are an Insured Employee and you leave the service of one participating railroad and, without missing more than 1 week of work, start work for another participating railroad on which you are already a Qualified Employee and, for that reason, end your employment with the former railroad;

(10) Any period for which you receive vacation pay during a disability (instead, the Plan's disability benefit period will be extended beyond 12 months by the number of days for which benefits are denied because of vacation pay);

(11) Any period for which you are eligible to receive RUIA sickness benefits but are denied benefits for any reason, including your failure to apply; or

(12) Any disability if you fail to provide notice of disability within the required timeframe.

VII. CLAIMS PROVISIONS

A claim for benefits under the Plan must generally be filed with Trustmark within 90 days of the start of disability, regardless of whether or not you qualify or are eligible for RUIA sickness benefits for the RUIA benefit year. Any reference to "you" in this Section VII will also include your authorized representation.

File a Claim with Trustmark

Notice of Claim/Disability
Written notice of any accident or sickness must be given within 90 days of the start of disability or as soon after as reasonably possible (subject to Trustmark's determination of reasonableness). The start of disability is the first full day of Total Disability after you stop rendering compensated service for your employing railroad. The Notice of Disability form (enclosed) must be mailed, e-mailed, or faxed to Trustmark with information that identifies you as an Insured Employee. (See the "Important Contact Information" section above.)

If you do not provide notice within 90 days of the start of disability or as soon after as is reasonably possible, Trustmark will deny your claim for benefits.

Proof of Disability
A claim for benefits must be supported by proof of Total Disability. The Proof of Disability form (enclosed) must be completed by your treating medical provider and mailed, e-mailed, or faxed to Trustmark. (See the "Important Contact Information" section above.) If the form cannot be completed, your medical provider must provide adequate written or oral information concerning the nature and extent of your disability. If you do not provide the form or required information within 90 days of the start of disability or as soon after as is reasonably possible, Trustmark will deny your claim for benefits. After both Notice of Disability and Proof of Disability claim forms are received, Trustmark will begin the review of your claim. During Trustmark's review, they may obtain your medical records, speak with your treating medical providers, and/or see other information concerning your claim to establish proof of Total Disability.

Investigation and Physical Examination
Trustmark may make such investigations of your claim as it deems necessary. Trustmark will have the right to examine you as often as it may reasonably require while a claim is pending. This will be at the expense of Trustmark. If you fail to cooperate with Trustmark's investigation of your claim or Trustmark's request that you submit to an examination, Trustmark will deny your request for benefits or terminate your benefits.

Timing of Determination
Trustmark will respond to your claim for benefits under the Plan within 45 days after it receives your claim. The period for response may be extended twice for periods no longer than 30 days each, if Trustmark notifies you of the need for extension before the end of the applicable period (e.g., the initial 45-day period or the 30-day extended period), and if the extension is needed because of matters beyond the control of the Plan. A written notice of extension will explain the reason for the extension, the date by which a decision is expected to be made, any unresolved issues that prevent a decision from being made, and any additional information needed from you to make a decision on your claim. You will have 45 days from the time a request for additional information is sent to provide the information to Trustmark. The period from which you are notified of the additional required information to the date you respond (or, if you fail to respond, until your response is due) is not counted as part of the determination period.

Determination Notice
If your claim for benefits under the Plan is denied, you will receive an explanation written in a manner that can reasonably be understood by you at no cost with the following information:

(1) Reason(s) for the denial;

(2) Reference to the Plan provision(s) (or Group Policy 9000 provision(s)) on which the denial is based;

(3) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such additional material or information is necessary;

(4) An explanation of the claims appeal procedures and the time limits associated with those procedures, including a statement of your right to bring suit under section 502(a) of ERISA after you have exhausted your administrative remedies;

(5) If your claim is denied because Trustmark determined that you were not receiving care which is appropriate for the nature of your condition, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan (or Group Policy 9000) to your medical condition, or a statement that such explanation will be provided to you at no charge upon request;

(6) Either the specific internal rules, guidelines, protocols, standards, or other similar criteria that Trustmark relied on in denying your claim, or a statement that such internal rules, guidelines, protocols, or other similar criteria do not exist;

(7) A statement that you are entitled to receive reasonable access to, and copies of, all documents, records, and other information relevant to your claim at no cost upon your request; and

(8) An explanation for disagreeing with or not following:

(a) The views of the health care professional treating you and vocation professionals who evaluated you, as presented by you in your claim,

(b) The views of medical or vocational experts whose advice was obtained in connection with the denial, without regard as to whether the advice was relied upon, and

(c) A disability determination regarding you made by the Social Security Administration or Railroad Retirement Board, as applicable.

First Level Appeal

If you disagree with Trustmark's determination, you may submit a written appeal by e-mail, mail, or fax. (See the "Important Contact Information" section above.) You must submit an appeal to Trustmark within 180 days of the date you received your claim denial notice. If your appeal to Trustmark is not filed on time, it will be denied. Your written appeal must include the following:

(1) A statement that you are appealing the claim's determination;

(2) Reasons for your disagreement; and

(3) Any evidence or documentation to support your position.

Upon written request, you have the right of reasonable access to, and copies of, all documents, records, or other information relevant to your claim for benefits. A qualified individual who was not involved in the decision being appealed, or a subordinate of such person, will be appointed to decide the appeal. If your appeal is related to a medical judgment, the review will be done in consultation with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved, or a subordinate of such person, in the prior determination. Trustmark may consult with, or seek the participation of, medical or vocational experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent health claim information.

The reviewer will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the prior determination. The reviewer will not afford deference to the initial determination. In addition, the reviewer will identify any medical or vocational experts whose advice was obtained in connection with a denial, even if the advice was not relied upon in making the determination. Before issuing a denial, Trustmark will provide to you: (1) any new or additional evidence considered, replied upon, or generated by or at the direction of the reviewer, and (2) any new or additional rationale upon which the denial is based. This information will be provided free of charge and sufficiently in advance of the decision to give you a reasonable opportunity to respond.

Timing of Appeal Determination

You will be notified of Trustmark's decision upon review within a reasonable period of time, but no later than 45 days after receipt of your appeal request. The 45-day period may be extended for an additional 45-day period if Trustmark determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by

which Trustmark expects to render a decision. If you must provide additional information, you will have 45 days from the time a request for additional information is sent to provide the information to Trustmark. The period from which you are notified of the additional required information to the date you respond (or, if you fail to respond, until your response is due) is not counted as part of the determination period.

Appeal Determination Notice

If your appeal is denied, you will receive an explanation written in a manner that can be reasonably understood by you at no cost with the following information:

(1) Reason(s) for the denial;

(2) Reference to the Plan provision(s) (or Group Policy 9000 provision(s)) on which the denial is based;

(3) A statement that you are entitled to receive reasonable access to and copies of all documents, records, and other information relevant your claim at no cost upon your request;

(4) An explanation of the claims appeal procedures and the time limits associated with those procedures, including a statement of your right to bring suit under section 502(a) of ERISA after you have exhausted your administrative remedies and a description of any applicable deadline to sue, including the calendar date on which the deadline to sue expires for the claim;

(5) If your claim is denied because Trustmark determined that you were not receiving care which is appropriate for the nature of your condition, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan (or Group Policy 9000) to your medical condition, or a statement that such explanation will be provided to you at no charge upon request;

(6) Either the specific internal rules, guidelines, protocols, standards, or other similar criteria that Trustmark relied on in denying your claim, or a statement that such internal rules, guidelines, protocols, or other similar criteria do not exist; and

(7) An explanation for disagreeing with or not following:

(a) The views of the health care professional treating you and vocation professionals who evaluated you, as presented by you in your claim,

(b) The views of medical or vocational experts whose advice was obtained in connection with the denial, without regard as to whether the advice was relied upon, and

(c) A disability determination regarding you made by the Social Security Administration or Railroad Retirement Board, as applicable.

Second Level Appeal

If you disagree with Trustmark's determination, you may submit a Second Level appeal by e-mail, mail, or fax. (See the "Important Contact Information" section above.) You must submit an appeal to the Disputes Committee within 60 days of the date you received your appeal denial notice. If your appeal to the Disputes Committee is not filed on time, it will be denied.

Your written appeal must include the following:

(1) Your name;

(2) Your claim number;

(3) Your employee number or social security number;

(4) Your employing railroad;

(5) Your division or department and location where employed;

(6) Name of the union representing you;

(7) Your date of disability;

(8) A copy of Trustmark's First Level appeal denial letter; and

(9) Reasons for your disagreement.

After receipt, your Second Level appeal will be referred to an independent review entity engaged by Trustmark. All expenses in connection with the resolution of disputes will be paid by the person(s) incurring the expenses. For example, fees and expenses of any health care professional consulted by the independent review entity will be paid by Trustmark.

If your appeal is related to a medical judgment (e.g., determination of physical condition, cause of disability, or start of disability), the independent review entity will appoint one or more legally qualified physician(s) with appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved, or a subordinate of the healthcare professional consulted with the decision being appealed, to review your case. The independent review entity will notify Trustmark of the appeal decision and Trustmark will send the appeal determination notice to you. Unless explained here, all other provisions that apply to a First Level appeal also apply to a Second Level appeal (e.g., appeal determination notice information).

The decision by Trustmark is final, conclusive, and binding. Trustmark has final claims adjudication authority under the Plan.

Legal Actions

No action can be brought by you to receive a benefit under the Plan until you have exhausted the appeals process. Furthermore, no action can be brought after 3 years have passed from the start of your disability.

Choice of Medical Provider

You are free to seek the services of any medical provider legally practicing medicine. Neither the Plan nor Trustmark will in any way disturb the doctor-patient relationship.

Approved Claim

Time of Payment
If your claim for benefits has been approved (e.g., Trustmark determines that you are Totally Disabled), all accrued benefits will be paid monthly. Any balance that has not been paid by the end of the Maximum Benefit Period during your Period of Total Disability will be paid immediately upon receipt of due written proof. The proof must include documentation that you have filed a claim and was approved and any other proof of disability that Trustmark requires.

Payment of Claims
All benefits will be paid to you, if living, or otherwise to your estate.

If benefits are payable:

(1) To your estate; or

(2) To a person who cannot legally give a valid release,

Trustmark may pay up to $1,000 to someone related to you by blood or marriage who Trustmark believes has a right to it. Neither the Plan nor Trustmark will be held responsible for any such payment made in good faith.

Periodic Review
If Trustmark makes a determination of Total Disability, Trustmark may periodically require proof that your Total Disability continues. Your treating medical provider must provide Trustmark with adequate additional information concerning your disability upon request. If you or your treating medical provider fails to cooperate with Trustmark's requests for this additional information, Trustmark will terminate your benefits.

If Trustmark finds that you are no longer Totally Disabled or otherwise entitled to receive benefits under the Plan, Trustmark will terminate your benefits and notify you in writing. This termination would be considered a denied claim for purposes of the claims procedures. Therefore, you are subject to the same rights and levels of appeal as if you are filing a claim.

VIII. ADDITIONAL INFORMATION

Federal Tax Information

Federal Law requires that benefit payments under this Plan be reported to the Internal Revenue Service. You will be furnished with a W-2 Form showing the amount of benefits, if any, you are paid each year.

Federal Law also requires that Railroad Retirement Tier I Taxes be withheld from Plan payments made during the first 6 months following the month of disability. Your employer is required to pay a matching share of the Railroad Retirement Tax withheld.

Liability Cases

This Plan has been established and maintained in fulfillment of certain collective bargaining agreements. The agreements contain the following provision:

"In case of a disability for which the employee may have a right of recovery against either the employing railroad or a third party, or both, benefits will be paid under this Plan pending final resolution of the matter so that the employee will not be exclusively dependent upon his sickness benefits under the Railroad Unemployment Insurance Act. However, the parties hereto do not intend that benefits under this Plan will duplicate, in whole or in part, any amount recovered for loss of wages from either the employing railroad or a third party, and they intend that benefits paid under this Plan will satisfy any right of recovery for loss of wages against the employing railroad to the extent of the benefits so paid. Accordingly, benefits paid under this Plan will be offset against any right of recovery for loss of wages the employee may have against the employing railroad; the insuring agent will be subrogated to any right of recovery for loss of wages the employee may have against any party other than the employing railroad…"

Thus, if benefits are paid under this Plan, the benefit payments will be deducted from any payment made in any case involving a claim for loss of wages and in which the employer or a third party may be liable for the injury.

Subrogation

In the event any benefits are paid to an Insured Employee under the Plan, Trustmark shall be subrogated and succeed to the Insured Employee's right to receive a payment for loss of wages against any third party, other than the employing railroad. The Insured Employee shall pay over to Trustmark all sums received, by suit, settlement, or otherwise, on account of such loss of wages, but not to exceed the amount of benefits paid under the Plan. As

a condition to paying any benefits under the Plan, Trustmark may require the Insured Employee to assign to Trustmark any payment or right thereto from any third party other than the employing railroad to the extent that benefits are payable under the Plan.

For purposes of this provision, a payment that does not specify the matters covered by it shall be deemed to include a payment for loss of wages to the extent of any actual wage loss due to the disability involved. The Insured Employee shall take such action, furnish such information and assistance, and execute such assignments and other instruments, all as Trustmark may require to facilitate enforcement of the rights of Trustmark, and shall take no action prejudicing the rights and interest of Trustmark.

Recovery of Overpayments

Trustmark has the right to recover any overpayments due to fraud; any error made in processing a claim; your receipt of other payments; your eligibility to receive benefits for a disability under any other plan, fund, or other arrangement for which an employer has contributed; or any other reason. In the event of an overpayment, you must reimburse Trustmark in full, regardless of whether you have retained the benefits you received and/or the payments you received from another source that gave rise to the overpayment. In any event, Trustmark shall automatically have a first priority lien upon any overpaid benefits and any benefits received from another source that gives rise to the overpayment, up to the amount of the overpayment. If Trustmark notifies you of an overpayment and you fail to reimburse Trustmark for the full amount, Trustmark and/or the Plan may initiate legal action to obtain legal and/or equitable relief to recover the overpayment. If Trustmark and/or the Plan is successful in that legal action, Trustmark and/or the Plan will seek the full relief available to it under the law, including, but not limited to, recovery of the overpayment, interest, costs, and attorney's fees. If Trustmark determines that the overpayment resulted from fraud, Trustmark and/or the Plan will pursue all appropriate legal remedies. Trustmark may also recover overpayments that you fail to reimburse by withholding all or some benefits that would otherwise be payable to you under the Plan until such time as the overpayment has been recovered.

Interpreting Plan Provisions

Trustmark has discretionary authority to determine whether and to what extent Insured Employees are entitled to benefits that Trustmark insures 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. Trustmark shall be deemed to have properly exercised this discretionary authority unless Trustmark has acted arbitrarily or capriciously.

IX. INFORMATION REQUIRED BY ERISA

The following information, together with the rest of this booklet, form the Summary Plan Description under the Employee Retirement Income Security Act of 1974, as amended from time to time, sometimes called "ERISA":

Required Information

Name of Plan:
Supplemental Sickness Benefit Plan for Railroad Yardmaster Employees

Plan Identification Numbers:
Employer Identification No. (EIN): 52-1036399Plan No.: 507

Type of Administration:
Fully Insured Plan. Trustmark is the insurer. Group Policy 9000 is the insurance policy. In connection with its review of claim determinations, Trustmark has been given the discretion, to be exercised in accordance with the Plan's terms, to construe disputed terms, limitations, and conditions of Group Policy 9000 and of any other document or instrument, including this booklet, under which the Plan is maintained.

Plan Administrator:
National Carriers' Conference Committee
250 18th Street, South
Suite 750
Arlington, VA 22202
571-336-7600

The Plan Administrator has authority to control and manage the operation and administration of the Plan and is the agent for service of legal process.

Date of End of Plan Year:
Each plan year ends on December 31.

Source of Plan Contributions:
Most participating employers pay as premiums the entire cost necessary for their employees to participate in the Plan. For employees of participating railroads that pay the entire cost of the Plan, there are no employee contributions. The cost of coverage for any covered General Chairman or other full-time labor representative will be paid through the labor union with which he or she is affiliated. A small number of participating employers may have collective bargaining agreements that provide for employees to contribute to the cost of the Plan through payroll deductions.

Claims Procedures:
See the “Claims Procedures” section.

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

A participating railroad or labor union has the right to terminate its participation in the Plan at any time by delivering to the Plan Administrator written notice of such termination, except as such right may be limited by obligations undertaken in collective bargaining agreements.

As a participant in the Plan, you are entitled to certain rights and protection under ERISA, including those described below.

Receive Information about Your Plan and Benefits

(1) You may examine, without charge, at the Plan Administrator’s office and at other locations, such as work sites and union halls, all Plan documents, including Group Policy 9000, the collective bargaining agreements under which the Plan was established and is maintained, 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.

(2) You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Group Policy 9000, the collective bargaining agreements under which the Plan was established and is maintained, copies of the latest annual report (Form 5500 series), and an updated summary plan description. The Administrator may make a reasonable charge for the copies.

(3) You are entitled to receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan participants, ERISA imposes duties upon persons 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 Plan benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a Plan 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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request copies 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 copies and pay you up to $110.00 a day until you receive the copies. This does not apply if 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 pursue the remedies outlined in this booklet and then seek review of any decision by initiating an action in a state or federal court. 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 your Plan, you should contact the Plan Administrator. 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.

Our Commitment to Protecting Your Privacy

TRUSTMARK INSURANCE COMPANY
TRUSTMARK LIFE INSURANCE COMPANY

NOTICE OF PRIVACY PRACTICES

(We, Us, Our)

NOTICE OF PRIVACY PRACTICES
Effective date of this notice: July 2020

THIS NOTICE APPLIES EXCLUSIVELY TO OUR INSURANCE PRODUCTS AND DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

You do not need to respond to this notice in any way.

Our Responsibilities and Privacy Commitment
We understand the importance of protecting your personal information. Our highest priority is to maintain your trust and confidence. We will maintain our commitment to safeguarding your information now and in the future.

We are required by law to:

- Maintain the privacy of your personal information.
- Provide you with certain rights with respect to your personal information.
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your personal information.
- Follow the terms of the Notice that is currently in effect.

We are guided by our respect for the confidentiality of your personal information. We are providing you with this notice in accordance with privacy laws and because we want you to know that we value your privacy.

Information We Collect
Personal Information is any information we obtain about you in the course of issuing insurance and/or providing services. The information we may obtain includes, but is not limited to, your past, present, or future physical or mental health or condition, the provision of health care to you, payment for the provision of health care to you, your Social Security number, employment history, credit history, income information, and bank or credit card information.

We obtain this information from several sources, including but not limited to applications or other forms you complete, your business dealings with us and other companies, and consumer reporting agencies.

Our Privacy and Security Procedures
Our employees who have access to this information are those who must have it to provide products or services to you. Below are some examples of our guidelines for protecting information.

- Paper copies, when used, are viewed, discussed, and retained in private surroundings.
- Individuals viewing information stored in a computer must have passwords to gain access. Passwords are provided only to individuals who must have access to provide products or services to our insureds.
- Third parties are given access to information only for the purpose provided under our service agreements with them or as required or permitted by law.

Information We Disclose
We will not disclose any personal information about you, except as allowed by law, including the Fair Credit Reporting Act. We may share all of the information we collect with insurance companies, agents, companies that help us to conduct our insurance business, companies that are self-insured, or others as permitted by law. Below are examples of the times we may share information for business purposes.

- Underwriting (but not personal information that consists of the genetic information of an individual);
- Premium rating;
- Submitting claims;
- Reinsuring risk;
- Assessing quality;
- Business management and planning; and
- Sales, transfer, merger or consolidation of the business.

Your information may also be shared:

- For purposes of treatment, payment, and operations, including assessment of eligibility, case management activities, coordination of care, collection of premium, payment of benefits, and other claims administration.
- With a regulatory, law enforcement, or other government authority as required by law. This may include finding or preventing criminal activity, fraud, material misrepresentation or material nondisclosures in connection with an insurance issue.
- In response to an administrative or judicial order, including a search warrant or subpoena.
- With a medical care institution or professional, to verify coverage, conduct an audit of their activities, discuss a medical problem of which the insured may not be aware, discuss drug and disease management approaches, and other purposes permitted or required by law.
- To conduct actuarial or research studies. In this case, individuals are not identified in the research report. Material identifying an individual is destroyed as soon as it is no longer needed.
- To authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the national Security Act and implementing authority.
- To workers' compensation or other similar programs, established by law, that provides benefits for work-related injuries or illness without regard to fault as authorized by and to the extent necessary to comply with these programs.
- With third parties for use in auditing services or operations, auditing marketing services, performing various functions on our behalf, or to provide certain services.
- With a group policyholder for reporting claims experience, or for conducting an audit of our operations or services.
- To consult with outside health care providers, consultants and attorneys, and other health related services.
- With an authorized representative of your group health plan or employer, for purposes of benefit administration.
- As otherwise permitted or required by law.

We require those with whom we share information to implement appropriate safeguards regarding your personal information, as required by law. We use and disclose information as minimally necessary to perform

our business functions and activities. Information may be requested from other companies to assist us with our determination of coverage, eligibility, benefits or for the purpose of determining the rating of premiums. Companies used for this purpose retain this information and it may be made available to other companies for their determinations. We are prohibited from using or disclosing personal information that is genetic information of an individual for underwriting purposes.

Your written authorization is required for uses and disclosures of personal information for purposes other than those described above. We will not sell your personal information without obtaining your written authorization to do so. If you provide us authorization to use or disclose your personal information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information for the specific purpose contained in the authorization. We are required to retain any records we may have containing your personal information for the periods specified in document retention laws. If you revoke your authorization for payment or health care operations, you may jeopardize the administration of your benefits.

Your Rights

To be notified following a breach of unsecured protected health information. Upon written request, you have the right to:

- Inspect and copy certain protected health information. We may charge a reasonable fee for the costs of copying or mailing.
- Request confidential communication of protected health information.
- Receive an electronic copy of your protected health information when it is maintained electronically.
- Request restrictions on certain uses and disclosures of your protected health information, although we are not required to agree to a requested restriction.
- Request an amendment to your protected health information, although we are not required to agree to an amendment.
- Receive an accounting of impermissible protected health information disclosures or disclosures made in compliance with federal law for which an accounting is required.
- Request a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

We will respond to your request in a timely manner. The written request must reasonably describe the information. The information requested must be reasonably locatable and retrievable.

How to File a Complaint Regarding the Use and Disclosure of Personal Information
If you believe your privacy rights have been violated, you may file a complaint with us, your respective state insurance department, or with the Secretary of Health and Human Services. All complaints must be in writing.

You may not be retaliated against for filing a complaint.

How to Contact Us
You may contact our representative at the following address:

Privacy Officer
Privacy Request
Trustmark Companies
PO Box 7961
Lake Forest, IL 60045-7961
Email: privacysecurityoffice@trustmarkbenefits.com

We can change the terms of this notice, and the changes will apply to all personal information we have about you. Notification of a revised privacy notice will be provided through one of the following:

- U.S. Postal Service
- Internet E-mail

Any right a consumer, claimant, or beneficiary may have under this notice is not limited by any other privacy notice used by Trustmark Mutual Holding Company or its subsidiaries and affiliates. (Last Updated: July 1, 2020)

CERTIFICATE OF COVERAGE

TRUSTMARK INSURANCE COMPANY

Lake Forest, Illinois
(hereinafter called Trustmark)

Certifies that it has issued Group Policy No. 9000 based on the application made by

NATIONAL CARRIERS' CONFERENCE COMMITTEE
of Washington, D.C.

acting on behalf of the railroads and other employers participating in the Supplemental Sickness Benefit Plan for Railroad Yardmaster Employees. Such railroads are listed in Exhibit C to Group Policy 9000 and collectively constitute the Policyholder.

This booklet summarizes the principal provisions of the Group Policy as amended effective August 1, 2023. The Group Policy constitutes the entire contract between Trustmark and the Policyholder.

The Group Policy specifies the time when and circumstances under which Trustmark is liable for benefits.

Employees become covered under the Group Policy as provided on the foregoing pages. This booklet becomes the Employee's certificate of coverage while covered under the Group Policy.

The benefits and provisions described on the foregoing pages are subject in all respects to the specific terms and conditions of the Group Policy, which will control in the case of any conflict.

John Anderson

President

PROOF OF DISABILITY - ATTENDING PHYSICIAN'S STATEMENT

Return To: Trustmark Insurance Company
P.O. Box 7901
Lake Forest, IL 60045-7901
Phone 1.800.504.9052 • Fax 847.615.3866

Name of Patient	Date of Birth

HISTORY

(a) When did symptoms first appear or accident happen? | (b) Date patient ceased work because of disability? | (c) Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes", state when and describe.

(d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown | (e) Names and addresses of other treating physicians

DIAGNOSIS

(a) Diagnosis (Including complications) | (b) If pregnancy, est. date of delivery | (c) Subjective symptoms

(d) Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings)

TREATMENT

(a) List all dates of treatment for period of disability
o | (b) Frequency: ☐ Weekly ☐ Monthly ☐ Other (Specify)

(c) Nature of treatment (Including surgery and medications prescribed, if any)

(d) Specific restrictions and limitations

PROGRESS

(a) Has patient? ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed? | (b) Is patient? ☐ Ambulatory? ☐ House Confined? ☐ Bed Confined? ☐ Hospital Confined?

(c) Has patient been hospital confined? ☐ Yes ☐ No If yes, give name and Address of Hospital

Confined from_____ through_____

CARDIAC

(a) Functional Capacity (American Heart Association)

☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation)
☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)

(b) Blood Pressure (Last Visit)

_____
Systolic/Diastolic

IMPAIRMENTS

(a) Physical Impairments (*As defined in Federal Dictionary of Occupational Titles)

☐ Class 1 - No limitation of functional capacity; capable of heavy work*. No restrictions. (0-10%)
☐ Class 2 - Medium manual activity*. (15 - 30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work*. (35 - 55%)
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60 - 70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75 - 100%)

Remarks:_____

(b) Mental Impairments (If Applicable)
(a) Please define "stress" as it applies to this claimant.
(b) What stress and problems in interpersonal relations has claimant had on job?

☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks:

PROGNOSIS

(a) Is patient now totally disabled? PATIENT'S JOB ☐ Yes ☐ No ANY OTHER WORK ☐ Yes ☐ No | (b) Date patient became disabled due to present illness

(c) When do you expect a fundamental or marked change in the future?
☐ 1 Month ☐ 1 - 3 Months ☐ 3 - 6 Months ☐ Never Applies To: ☐ Patient's Job ☐ Other Work

REHAB

(a) Is patient a suitable candidate for occupational rehabilitation? PATIENT'S JOB ☐ Yes ☐ No ANY OTHER WORK ☐ Yes ☐ No | (b) Can present job be modified to allow for handling with impairment? ☐ Yes ☐ No

(c) When could trial employment commence? Date: _____ (PATIENT'S JOB) ☐ Full-Time ☐ Part-Time Date: _____ (ANY OTHER WORK) ☐ Full-Time ☐ Part-Time

REMARKS

Reason unable to work, in detail

Name (Attending Physician) Print	Degree	Telephone

Street Address	City or Town	State or Province	Zip Code

Signature	Tax identification #	Date

AUTHORIZATION TO DISCLOSE/RELEASE OR OBTAIN MEDICAL RECORDS

All disclosures are in compliance with Federal and State laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), governing the use and disclosure of Protected Health Information (PHI).

Patient Name:_____ Street Address:_____

City: _____ State: _____ Zip Code:_____ Date of Birth: _____

I authorize:_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

Release to: **Trustmark Insurance Company**
P.O. Box 7901
Lake Forest, IL 60045-7901

Specify Dates or date ranges:_____

Protected Health Information (PHI) includes individually identifiable health information that is created or received by my provider, my health plan or insurer, a data clearinghouse, a health authority, employer, school, or university. PHI can be maintained or transmitted in any form or medium. It relates to the past, present, or future:

- Condition of my physical or mental health;
- Healthcare provided to me; or
- Payment for the healthcare provided to me.

PHI does not include summary health information or information that has been de-identified according to the standards for de-identification provided in the HIPAA Privacy Rule.

I authorize any licensed physician, medical practitioner, medical professional, psychologist, counselor, hospital, clinic, including Veterans Administration, or other medically related facility, pharmacy, government agency, Social Security Administration, insurance company, insurance support organization, employer, or any other holder of my personal health information documents, to release to Trustmark Insurance Company (herein as referred to "the Company") or its authorized representative, all requested information or records. This shall include but not be limited to, any information and health history including all consultation, diagnosis, prescriptions, treatments,

tests as well as any information regarding drug and alcohol abuse. This shall also include any information pertaining to the treatment of mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics. In addition, I authorize any employer, former employer, insurance company or insurance support organization to give any information or record it has about me, my employment, my employment history and income earnings to the Company.

Redisclosure Notice: I understand the information used or disclosed based on this authorization may possibly be redisclosed by the recipient, and/or may no longer be protected by Federal Privacy standards. I understand this information will be used to determine my eligibility for benefits and may be reviewed by claims, underwriting, legal or other Company personnel. I authorize the Company to release any such information to the following persons or organizations: reinsuring companies, persons or organizations performing business, legal or medical services related to the policy or claim, or any other public or private entity as may be lawfully required. The information provided to Trustmark Insurance Company, its subsidiaries or representatives is to be used solely for the administration of claim(s). A simulated, faxed or copied image of this authorization shall be as valid as the original.

Right to Inspect or Copy the Health Information to Be Used or Disclosed: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form.

Right to Refuse to Sign This Authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for healthcare benefits, on my decision to sign this authorization. I understand that if I agree to sign this authorization, I will be provided with a copy upon request.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a crime or insurance fraud and may be subject to imprisonment and/or fines.

I declare that all of the above statements on this claim are true and complete to the best of my knowledge.

I understand that I have the right to revoke this authorization at any time. I understand this must be in writing and addressed to the privacy officer of the above named facility. This authorization will be valid until coverage expires.

_____ _____

Claimant Signature/Legal Representative Date

TRUSTMARK INSURANCE COMPANY

P.O. BOX 7901 ◆ LAKE FOREST, IL 60045-7901 ◆ 1-800-504-9052 ◆ FAX # 847-615-3866
Email: LDMAIL@ Trustmarkbenefits.com

NOTICE OF DISABILITY

SMART – Transportation Division (SMART-TD) Supplemental Sickness Benefit Plan for Railroad Yardmaster Employees

IMPORTANT INSTRUCTIONS – To apply for benefits, complete all sections of this form so your eligibility can be confirmed. You should also complete an "Application for Sickness Benefits" and send it to the U. S. Railroad Retirement Board for RUIA Sickness Benefits.

SECTION I. This section must be completed by or on behalf of the covered employee for all claims.

Name of Employee (Please Print)	Name of Employing Railroad	Employee No.	Social Security No.

Employee's Home Address (Number) (Street)	Division and Location Last Worked	Occupation

(City) (State) (Zip)	When did you become disabled? (Month) (Day) (Year) ☐ A.M. ☐ P.M.	Cause of Disability? ☐ On duty injury ☐ Off duty injury ☐ Sickness

Home Phone Number	Date Employed	Date of Birth	Age

Status in Month Before Disability Commenced: ☐ Worked ☐ On vacation with pay ☐ Other (explain)	Date You Last Worked Prior to Disability

Name of Doctor?	Date of First Treatment (Month) (Day) (Year)	Have you returned to work? ☐ Yes – If so, give date _____ ☐ No – If not, when do you expect to return to work? _____

Have you received vacation pay since the date you became disabled? ☐ Yes ☐ No
If "Yes", show dates between which you received vacation pay: From _____ To _____

SECTION II. This section must be completed by or on behalf of the covered employee for all claims.

Date of Accident (Month) (Day) (Year) ☐ A.M. ☐ P.M.	Were you working when the accident happened? ☐ Yes ☐ No If so, for whom?

Explain how accident happened?

Was a railroad off-track vehicle involved? ☐ Yes ☐ No	Did Injury result from a Traffic Accident? ☐ Yes ☐ No	Will a Liability Claim be made? ☐ Yes ☐ No

SECTION III. This section must be completed by or on behalf of the covered employee for all claims.

Benefits under the Railroad Unemployment Insurance Act:

Have you applied for sickness benefits under the Railroad Unemployment Insurance Act? . . . . . ☐ Yes ☐ No

If not, why not?

- ☐ Am not qualified under the Act.
- ☐ Have not had a disability lasting four consecutive days or more this benefit year.
- ☐ My benefits have been exhausted for this benefit year.
- ☐ Other (explain).

Other Income Benefits:

Are any of the "Other Income Benefits" listed below available to you while disabled? . . . . . ☐ Yes ☐ No

(If so, check each of the following which is applicable, and show monthly amounts payable.)

- ☐ Railroad Retirement Act – Disability Annuity . . . . . $ _____
- ☐ Social Security Act . . . . . $ _____
- ☐ Any other government or tax-supported plan, federal, state or local . . . . . $ _____
- ☐ Any other plan toward the cost of which any employer contributed . . . . . $ _____

If you received an Annuity on a retroactive basis for a part of a Period of Disability for which benefits were paid under this Plan, Trustmark will have the right to recover the amount of benefits paid you which are in excess of the amount you would have received had we known of the Annuity prior to our payment. Please contact Trustmark Insurance Company when you apply for an annuity.

Fraud Statement for Alaska Residents
A person who knowingly and with intent to injure, defraud or deceive an insurance company, files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Fraud Statement for Arizona Residents

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Fraud Statement for California Residents
For your protection, California law requires the following to appear: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Fraud Statement for Colorado Residents
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Statement for Florida Residents
Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Fraud Statement for Kansas, Oregon, and Vermont Residents
Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which may be a crime.

Fraud Statement for Kentucky Residents
A person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Fraud Statement for Arkansas, Louisiana, Texas, and West Virginia
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Statement for Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Statement for Minnesota Residents A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Fraud Statement for District of Columbia, Maine, Tennessee and Virginia
WARNING: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

Fraud Statement for New Hampshire Residents
Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided under RSA 638:20.

Fraud Statement for New Mexico and Pennsylvania Residents
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES ANY APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Fraud Statement for New Jersey Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Fraud Warning for Delaware, Idaho, Indiana, Ohio, and Oklahoma. As Well as for the Residents of All States Not Specifically Listed
WARNING: Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which is a felony.

Fraud Warning for NY Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The information that I have provided on this claim form is true and complete to the best of my knowledge and belief

Signature of Employee _____ Date _____

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Trustmark Insurance Company
P.O. Box 7901
Lake Forest, IL 60045

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