NATIONAL RAILWAY CARRIERS

AND

UNITED TRANSPORTATION UNION

(NRC/UTU)

HEALTH AND WELFARE PLAN

Effective January 1, 2000

TABLE OF CONTENTS

I
Important Notice

This booklet describes the Health Care Benefits provided for U.S. residents under the National Railway Carriers and United Transportation Union Health and Welfare Plan ("Plan"), effective January 1, 2000. Other benefits provided by the Plan are described in a separate Plan booklet entitled Life Insurance Benefits for U.S. Employees and Retirees and Accidental Death and Dismemberment Insurance Benefits for U.S. Employees (January 2000).

The Plan was established pursuant to collective bargaining agreements between the United Transportation Union (the "UTU") and six of the nation's larger freight railroads: the Burlington Northern Santa Fe, Conrail, CSX, Kansas City Southern, Norfolk Southern, and Union Pacific, along with their wholly-owned subsidiaries. For those employees eligible for coverage under it, the Plan will replace coverage under The Railroad Employees National Health and Welfare Plan.

Because certain employees sometimes work in train service and sometimes in engine service, the Plan has been designed to avoid switches back and forth – and the hardships they may cause to the employee and the employee's dependents – between eligibility under the Plan and eligibility under The Railroad Employees National Health and Welfare Plan during 2000. Thus, the Plan provides that the following employees of railroads participating in it are eligible for Plan coverage:

- employees who, as of September 1, 1999, had last worked under a UTU collective bargaining agreement;
- employees hired after September 1, 1999 under a UTU agreement, provided they did not first work under a collective bargaining agreement with the Brotherhood of Locomotive Engineers (the "BLE").
- employees moving after September 1, 1999, to a position covered by a UTU agreement, provided that as of the date of the move they had not last worked under a BLE agreement.

Eligibility for coverage under the Plan will be the first day of the month following the month in which the employee first worked under the UTU agreement, or January 1, 2000, whichever is later. Eligibility for coverage under the Plan will end if the employee subsequently works under any agreement other than a UTU or BLE agreement.

Employees not eligible for coverage under the Plan because of work under a BLE agreement will not become eligible for coverage at any time during the year 2000 even if they subsequently work under a UTU agreement. These employees may continue to be eligible for coverage under The Railroad Employees National Health and Welfare Plan.

The Plan's Health Care Benefits described in this booklet are the Comprehensive Health Care Benefit ("**CHCB**"), the Mental Health and Substance Abuse Care Benefit ("**MHSA**"), the Managed Pharmacy Services Benefit ("**MPSB**"), and the Managed Medical Care Program ("**MMCP**"). These Benefits are not insured. They are payable directly by the Plan.

Regence Life and Health Insurance Company ("REGENCE"), a wholly owned subsidiary of Regence BlueCross BlueShield of Oregon, and United HealthCare ("United HealthCare") administer separate programs under the Comprehensive Health Care Benefit. You may choose which of these two programs covers you if you elect to participate in the **CHCB**.

In areas where the **MMCP** administered by United HealthCare is available under The Railroad Employees National Health and Welfare Plan, you may choose under this Plan an **MMCP** administered either by United HealthCare or by REGENCE. In areas where the **MMCP** administered by Aetna U.S. Healthcare ("AUSHC") is available under The Railroad Employees National Health and Welfare Plan, you may choose under this Plan an **MMCP** administered either by AUSHC or by REGENCE.

This Plan does not provide the **MMCP** in any area where the Managed Medical Care Program under The Railroad Employees National Health and Welfare Plan is not available.

The **MMCP** administered by REGENCE is different in some ways from the **MMCP** administered by United HealthCare or by AUSHC. These differences are explained on pages 47 through 49 of this booklet.

ValueOptions, Inc. ("ValueOptions") and Magellan Behavioral Health, Inc. ("Magellan") administer separate programs under the Mental Health and Substance Abuse Care Benefit. If you choose an **MMCP** or **CHCB** program administered by REGENCE, your **MHSA** will be administered by Magellan; otherwise your **MHSA** will be administered by ValueOptions.

Merck-Medco Rx Services and PAID Prescriptions, LLC, subsidiaries of Merck-Medco Managed Care, LLC, administer different parts of the Managed Pharmacy Services Benefit.

Toll-free telephone service is available from all of these companies:

REGENCE:	1-888-977-2583
United HealthCare:	
CHCB service:	1-800-691-0013
MMCP service:	1-888-445-4379
AUSHC:	1-888-332-8742
Magellan:	1-888-724-5006
Merck-Medco:	1-800-842-0070
ValueOptions:	1-800-934-7245

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.

II
Highlights

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

Benefits are paid in connection with Covered Expenses. Covered Expenses are the actual cost to you of the **Reasonable Charges** for various **Medically Necessary** services and supplies. See pages 65 through 75 of this booklet for a detailed explanation of Covered Expenses.

Comprehensive Health Care Benefit (CHCB)

Maximum Benefit per Lifetime*	$1,000,000
Deductible per Calendar Year*	
Individual	$100
Family	$300
Out-of-Pocket Maximum per Calendar Year*	
Individual	$1,500
Family	$3,000

*The Individual and Family Deductibles and Out-of-Pocket Maximums are combined with the same Deductibles and Out-of-Pocket Maximums under the **Out-of-Network Services** portions of the **MHSA** and the **MMCP**. Benefits payable under the **CHCB**, for **Out-of-Network Services** under the **MMCP**, and for **Out-of-Network Services** for **Mental Health Care** under the **MHSA** are added together for purposes of applying the Maximum Benefit per Lifetime. In addition, the total amount that counted for purposes of applying your Maximum Benefit per Lifetime under The Railroad Employees National Health and Welfare Plan as of December 31, 1999, will count for

purposes of applying the Maximum Benefit per Lifetime under this Plan.

Covered Expenses Payable After Deductible is Satisfied	85%
Covered Expenses Payable After Out-of-Pocket Maximum is Reached	100%

These Benefits may be reduced if applicable medical management procedures are not followed. See pages 40 through 45.

Managed Medical Care Program (MMCP)

	In-Network Services	Out-of-Network Services
Maximum Benefit per Lifetime*	None	$1,000,000
Deductible per Calendar Year*		
Individual	None	$100
Family	None	$300
Out-of-Pocket Maximum per Calendar Year*		
Individual	None	$1,500
Family	None	$3,000

*The Individual and Family Deductibles and Out-of Pocket Maximums are combined with the same Deductibles and Out-of-Pocket Maximums under the **CHCB** and the **Out-of-Network Services** portion of the **MHSA**. Benefits payable under the **CHCB**, for **Out-of-Network Services** under the **MMCP**, and for **Out-of-Network Services** for **Mental Health Care** under the **MHSA** are added together for purposes of applying the Maximum Benefit per Lifetime. In addition, the total amount that counted for purposes of applying your Maximum Benefit per Lifetime under The Railroad Employees National Health and Welfare Plan as of December 31, 1999, will count for purposes of applying the Maximum Benefit per Lifetime under this Plan.

Office Visit Co-payment	$15	N/A
Urgent Care Center Co-payment	$15	N/A
Emergency Room Co-payment (See page 46)	$30	N/A
Covered Expenses Payable after Co-payments/ Deductibles are Satisfied	100%	75%**
Covered Expenses Payable after Out-of-Pocket Maximum is Reached	N/A	100%**

***These Benefits may be reduced if applicable medical management procedures are not followed. See pages 40 through 45.*

Mental Health and Substance Abuse Care Benefit (MHSA)

In-Network Services

Inpatient Benefits

Maximum Benefit per Lifetime	None
Covered Expenses Payable	100%

Outpatient Benefits

Maximum Benefit per Lifetime	None
Office Visit Co-payment	$15
Covered Expenses Payable After Co-payment	100%

Out-of-Network Services

Maximum Benefit for **Mental Health Care** per Lifetime*	$1,000,000

Maximum Benefit for **Substance Abuse Care** per Lifetime*	$100,000
Deductible per Calendar Year*	
Individual	$100
Family	$300
Out-of-Pocket Maximum per Calendar Year*	
Individual	$1,500
Family	$3,000

*The Individual and Family Deductibles and Out-of-Pocket Maximums are combined with the same Deductibles and Out-of-Pocket Maximums under the **CHCB** and the **Out-of-Network Services** portion of the **MMCP**. Benefits payable under the **CHCB**, for **Out-of-Network Services** under the **MMCP**, and for **Out-of-Network Services** for **Mental Health Care** under the **MHSA** are added together for purposes of applying the Maximum Benefit for **Mental Health Care** per Lifetime. In addition, the total amounts that counted for purposes of applying your Maximum Benefit for Mental Health Care per Lifetime and your Maximum Benefit for Substance Abuse Care per Lifetime under The Railroad Employees National Health and Welfare Plan as of December 31, 1999, will count for purposes of applying the Maximum Benefit for Mental Health Care per Lifetime and the Maximum Benefit for Substance Abuse Care per Lifetime under this Plan.

Covered Expenses Payable After Deductible is Satisfied	75%**
Covered Expenses Payable After Out-of-Pocket Maximum is Reached	100%**

***These Benefits may be reduced if the applicable medical management procedures are not followed. See pages 54 through 64.*

Managed Pharmacy Services Benefit (MPSB)

PRESCRIPTION DRUG CARD PROGRAM

In-Network Pharmacy (supply of 21 days or less)

Co-payment per **Generic Drug** Prescription	$2
Co-payment per **Brand Name Drug** Prescription Ordered by your Physician to be "Dispensed As Written" or Where There is no Equivalent **Generic Drug**	$6
Co-payment per **Brand Name Drug** Prescription Where There is a Generic Equivalent and Brand Name Was Not Ordered by your Physician to be "Dispensed As Written"	$6 plus the difference in cost between the equivalent **Generic Drug** and the **Brand Name Drug** dispensed
Covered Expenses Payable After Co-payment is Satisfied	100%

Out-of-Network Pharmacy (supply of 21 days or less)

Covered Expenses Payable	75%

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

MAIL ORDER PRESCRIPTION DRUG PROGRAM
(supply of 22 to 90 days)

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

III
Eligibility and Coverage

WHO IS ELIGIBLE FOR COVERAGE

Eligible Employees

You are an **Eligible Employee** and therefore eligible for coverage if you are employed by a participating employer, and

- as of September 1, 1999, you had last worked under a collective bargaining agreement with the United Transportation Union ("UTU");

or

- you were hired after September 1, 1999, under a UTU agreement and did not first work under a collective bargaining agreement with the Brotherhood of Locomotive Engineers ("BLE");

or

- after September 1, 1999, you moved to a position covered by a UTU agreement and as of the date of the move you had not last worked under a BLE agreement.

***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 25, 28-29, and 32 for details).*

A person who is a living donor of an organ or tissue to an **Eligible Employee** or **Eligible Dependent** will be considered an **Eligible Employee** for purposes of the Plan's Health Care Benefits, but benefits will be paid to that person only for Covered Expenses in connection with the donation of an organ or tissue to an **Eligible Employee** or **Eligible Dependent**.

Eligible Dependents

Your **Eligible Dependents** are:

- Your wife or husband.
- Your unmarried children under 19.
- Your unmarried children between 19 and 25 who:
  - are registered students in regular full-time attendance at school, and
  - are dependent for care and support mainly upon you and wholly, in the aggregate, upon themselves, you, your spouse, and scholarships and the like, and
  - have their legal residence with you.
- Your unmarried children 19 or over who:
  - are dependent for care and support mainly upon you and wholly, in the aggregate, upon you, your spouse, and governmental disability benefits and the like, and
  - have a permanent physical or mental condition that began prior to age 19, and
  - are unable to engage in any regular employment, and
  - have their legal residence with you.
- Your children who are Alternate Recipients under a Qualified Medical Child Support Order.

Children include:

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

spouse, scholarships and the like, and governmental disability benefits and the like.

WHEN COVERAGE STARTS

Employees

- If you are an **Eligible Employee** who would have been covered as an employee under The Railroad Employees National Health and Welfare Plan on January 1, 2000, had this Plan not been established, you become covered under this Plan effective January 1, 2000.

- If you are an **Eligible Employee** who was not covered as an employee under The Railroad Employees National Health and Welfare Plan on January 1, 2000, for any reason other than the establishment of this Plan, you become covered under this Plan on the first day of the calendar month after the month in which you first render or receive, in the aggregate, the **Requisite Amount of Compensated Service** or the **Requisite Amount of Vacation Pay** under a collective bargaining agreement with the UTU or the BLE.

- An **Eligible Employee** continues to be covered during the month following each month in which he or she renders or receives, in the aggregate, the **Requisite Amount of Compensated Service** or the **Requisite Amount of Vacation Pay** under a collective bargaining agreement with the UTU or the BLE.

Dependents

Your **Eligible Dependents** become covered on the same day you become covered, unless you are covered under this Plan as a **Disabled Employee** and your coverage for your **Eligible Dependents** under The Railroad Employees National Health and Welfare Plan ended in 1999.

WHEN COVERAGE STOPS

Coverage for all Health Care Benefits stops when:

- you first become covered under **Another Railroad Health and Welfare Plan** after your coverage under this Plan began;

- your employer or the UTU 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 section **"Continuation of Coverage After You Last Rendered Compensated Service,"** coverage for all Health Care Benefits 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** under a collective bargaining agreement with either the UTU or the BLE;

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

Coverage for an individual dependent stops sooner when one of the following happens:

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

- a dependent stops being an **Eligible Dependent**.

CONTINUATION OF COVERAGE AFTER YOU LAST RENDERED COMPENSATED SERVICE

Furloughed Employees

If you are placed on furlough and if you rendered compensated service for three months as an **Eligible Employee** under this Plan or under The Railroad Employees National Health and Welfare Plan, 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 before your coverage ends, you will continue to be covered during the month in which you return to work.

If you return to work 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 section below for Disabled Employees.

Suspended or Dismissed Employees

If you are suspended or dismissed, 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** under this Plan or under The Railroad Employees National Health and Welfare Plan,

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 before your coverage ends, you will continue to be covered during the month in which you return to work.

If you return to work 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 should refer to the section below for Disabled Employees.

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 before your coverage ends, you will continue to be covered during the month in which you return to work.

If you return to work 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**.

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 REGENCE or United HealthCare (if you are covered under the **CHCB**), or to the company that administers the **MMCP** for you (if you are covered under the **MMCP**). Failure to provide this proof of disability, when requested, will cause your coverage for Employee and Dependents Health Care Benefits to end. REGENCE or United HealthCare, as the case may be, with regard to the **CHCB**, or the company that administers the **MMCP** for you, will determine the date that coverage terminated based on the most current disability information available.

Your coverage ends if your employment relationship terminates for reasons other than retirement or dismissal.

Retired Employees

If you retire, you will be covered 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 page 140.

Deceased Employees

If you die while covered, Dependents Health Care Benefits will continue until the end of the fourth month following 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.

Returning Veterans

If you had been an **Eligible Employee** and if you returned 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

Solely for purposes of determining coverage for Employee and Dependents Health Care Benefits during the month immediately following any month in which you take a period of family or medical leave authorized and provided for under the federal Family and Medical Leave Act ("FMLA"), such period of authorized leave will be treated as if it were a period during which you rendered compensated service. FMLA leave will not be treated as compensated service (i) for purposes of measuring any continued coverage described under the heading **Continuation of Coverage After You Last Rendered Compensated Service**, beginning on page 13 of this booklet, or (ii) for any purpose whatsoever if you or your Dependents are not covered for Health Care Benefits under the Plan immediately prior to the beginning of the FMLA leave.

If you do not return to compensated service at the end of any period of family or medical leave, you will ordinarily be responsible for reimbursing your employer for its cost of continuing, during the period of leave, any Health Care Benefits under the Plan that were in fact continued for you or your Dependents during your leave.

Contact your employer for more information about family or medical leave under the federal statute.

SUMMARY OF CONTINUATION OF COVERAGE
IF YOU CEASE TO RENDER COMPENSATED SERVICE
(OTHER THAN CONTINUATION UNDER COBRA OR THE FAMILY AND MEDICAL LEAVE ACT)

Reason for Ceasing to Render Compensated Service	The Date Coverage Terminates (See Note 1) Coverage for Employee and Dependents Health Care Benefits
Disability - Inability to Perform Work in your Regular Occupation	Date your disability ends, but in any event when you have failed to render compensated service or receive **Vacation Pay** in a Calendar Year (2 Calendar Years for Employee Health Care Benefits)
Pregnancy	End of fifth month following the month in which you last rendered compensated service.

Reason for Ceasing to Render Compensated Service	The Date Coverage Terminates (See Note 1) Coverage for Employee and Dependents Health Care Benefits
Furlough 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 Disability	Date of termination of employment relationship. (See Note 3)
Termination of an **Eligible Employee**	If the **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.
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)

Notes:

1. Subject to information concerning continuation of coverage, including modifications of the provisions outlined above, see the section of this booklet entitled "Eligibility and Coverage" beginning on page 10. Under certain circumstances and provided the Plan is continued, benefits may be payable after coverage terminates. Information in this regard is also contained in the Eligibility for Benefits section on pages 25 through 29.
2. For a Furloughed Employee, **Vacation Pay** must be received prior to furlough. For a Dismissed Employee, **Vacation Pay** must be received prior to severance of the employment relationship.
3. For a **Retired Employee**, **Vacation Pay** must be received prior to the relinquishment of employment rights.

See page 140 for information as to other coverage available upon termination of your coverage under this Plan.

OPTIONAL CONTINUATION COVERAGE UNDER COBRA

Rights provided for under the federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, generally known as **COBRA**, are described in this section of your booklet.

If your Employee or Dependents Health Care Benefits would stop because of any of the following qualifying events:

- you cease to render the **Requisite Amount of Compensated Service** for any reason (except in the case of dismissal because of gross misconduct),
- you die,
- your marriage is dissolved, or
- your dependent child stops being an **Eligible Dependent**,

the individual(s) who would lose coverage may, as qualified beneficiaries, elect to continue Health Care Benefits, at their own expense, subject to the provisions below.

This **COBRA** coverage will continue for the period starting on the date of the qualifying event and ending at the earliest of the following:

- 18 months from the date you ceased to render (other than by reason of your death) the **Requisite Amount of Compensated Service**.
- 29 months from the date you ceased to render the **Requisite Amount of Compensated Service**, instead of the 18-month period stated above, for you or any dependent who is disabled at any time during the first sixty (60) days of such person's **COBRA** coverage. To be eligible for this additional 11 months of coverage, you must obtain a determination of such disability under Title II or Title XVI of the Social Security Act, or that the disabled person has a total and permanent disability entitling him or her to an annuity under the Railroad Retirement Act. This determination must be made before the end of the 18-month period stated above, and, you must notify United HealthCare of the determination within sixty (60) days from

the date it was made. The additional 11 months of coverage will apply not only to the disabled individual but also to any **Covered Family Members**.

- 36 months, with respect to Dependents Health Care Benefits, from the date you ceased to render the **Requisite Amount of Compensated Service**, instead of the 18-month period stated above, if during that 18-month period you die, your marriage is dissolved or your dependent child stops being an **Eligible Dependent**.

- 36 months after you die, your marriage is dissolved or your dependent child stops being an **Eligible Dependent**.

- the date you first become, after the date on which you elect to continue health care benefits pursuant to COBRA, entitled to **Medicare**; however, if you cease to render the **Requisite Amount of Compensated Service** within 18 months after you become entitled to **Medicare**, your **Eligible Dependents** may continue **COBRA** coverage for 36 months from the date you became entitled to **Medicare**.

- the date you first become, after the date on which you elect to continue health care benefits pursuant to COBRA, covered under another employer's group health plan, unless that plan has a pre-existing condition limitation that applies to you.

- the date you fail to provide the payment required to continue **COBRA** coverage.

- the date your employer ceases to provide any group health plan to any employee.

Election Period

A qualified beneficiary has 60 days to elect **COBRA**. The 60-day period begins on the later of:

- the date coverage under the Plan would have stopped due to the qualifying event, or

- the date an election form detailing the option to continue coverage is sent to the qualified beneficiary.

You may elect to continue coverage for yourself and your dependents who would also lose coverage because of the same qualifying event. If you do not elect to continue coverage for your dependents, they may elect to continue coverage on their own.

Notification Requirements

Your employer will notify United HealthCare if you die or cease to render the **Requisite Amount of Compensated Service**.

A dependent losing coverage must notify United HealthCare within 60 days after either of the following qualifying events:

- your marriage is dissolved.
- a dependent child stops being an **Eligible Dependent**.

The notice must be in writing and must be sent to:

United HealthCare
Railroad Administration (COBRA)
P.O. Box 150453
Hartford, CT 06115-0453

A form to use for this notice may be obtained by calling United HealthCare toll free at 1-800-691-0013. However, the call will not be accepted as notice. Notice must be sent in writing to the address shown above.

United HealthCare will send the appropriate election form to you or to the dependent eligible for **COBRA** coverage within 14 days after receiving this notice.

If a person who, while covered under the Plan pursuant to **COBRA**, has a newborn child or a child is placed with that person for adoption, the child may be added to the person's **COBRA** coverage. United HealthCare should be notified within thirty (30) days from the date of the child's birth or placement for adoption.

Other Continuation of Coverage Provisions

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

If in doubt as to whether or not there has been a qualifying event, call the United HealthCare toll free telephone number (1-800-691-0013).

ELIGIBILITY FOR BENEFITS

Employees of Non-Hospital Association Railroads

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

You are also eligible for Employee Health Care Benefits for pregnancy.

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

Benefits While You are Covered by the Plan

You are eligible for Employee and Dependents Health Care Benefits for **Covered 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 will continue to be payable 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 (as described below), 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 you stop being so disabled.
  - 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, it must be received before
    - you become covered under **Another Railroad Health and Welfare Plan**,
    - your employer or the United HealthCare stops participation in the Plan, or

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

- For Pregnancy:

  Benefits will continue to be payable for a pregnancy if conception occurred or the pregnancy commenced (as described below) before or while you were covered.

A sickness (including pregnancy) is considered to commence when the first expense for its treatment is incurred, or you first become disabled and unable to work in your occupation because of that sickness (or pregnancy), whichever happens first.

Dependents Health Care Benefits

If your **Eligible Dependent** is disabled on the date your coverage ends, Dependents Health Care Benefits will be payable while your **Eligible Dependent** continues to be disabled for 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 as a Pregnant Employee ends, Dependents Health Care Benefits will apply to the expenses of your newborn child only during the first fourteen days of age and only while the Plan is in full force and effect.

Dependents Health Care Benefits for a pregnancy of a dependent spouse will be payable for expenses incurred while the Plan is in full force and effect, if conception occurs before or while you are covered.

Dependent spouses covered as employees under a hospital association plan

Dependents Health Care Benefits under this Plan are limited with respect to spouses who are covered under this Plan as **Eligible Dependents** and who are also **Eligible Employees** who must look to a hospital association for employee health

care benefits. Dependents Health Care Benefits under this Plan will be payable for such a spouse only

- for her pregnancy if no benefits are paid under the hospital association plan,
- for any covered injury or sickness if he or she 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;
    - he or she is a member of the hospital association plan; and
    - non-hospital association facilities or services are not used when it is possible to use hospital association facilities or services.

If a spouse who is an **Eligible Dependent** is also an employee eligible for coverage under The Railroad Employees National Health and Welfare Plan, or a retiree eligible for coverage under The Railroad Employees National Early Retirement Major Medical Benefit Plan, who must look to a hospital association for active employee or 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.

- if any hospital association plan benefits are decreased or eliminated, benefits under this Plan, if any, will be determined as if there had been no decrease in or elimination of benefits under the hospital association plan.

Dependents covered under Another Railroad Health and Welfare Plan

If benefits are payable under **Another Railroad Health and Welfare Plan** for a person who is a dependent not only of an employee covered by that plan but also 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, 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)

Depending upon where you live, you and your **Eligible Dependents** -- or if you are an **Eligible Employee** of a hospital association railroad, only your **Eligible Dependents** -- may participate in **MMCP** instead of **CHCB**.

If you live in an area where the Plan has selected United HealthCare as a managed care vendor, you may choose the **MMCP** administered by United HealthCare or the **MMCP** administered by REGENCE. If you live in an area where the Plan has selected AUSHC as a managed care vendor, you may choose the **MMCP** administered by AUSHC or the **MMCP** administered by REGENCE. The Plan's **MMCP** is not available in any other area.

The **MMCP** administered by REGENCE is different from the **MMCP** administered either by United HealthCare or AUSHC. See the explanation under the "Obtaining Benefits..." headings at pages 47 through 49 of this booklet.

Also, if you enroll in the **MMCP** administered by REGENCE (or if you participate in the **CHCB** administered by REGENCE rather than the **MMCP**) your **MHSA** will be administered by Magellan. Otherwise, your **MHSA** will be administered by ValueOptions.

For purposes of the following eligibility rules, where you live 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.

Newly Hired Employees

Each **Eligible Employee** who first becomes covered under this Plan after January, 2000, and who lives in an area where the Plan's **MMCP** is available, will be enrolled, along with his/her **Eligible Dependents**, in the **MMCP** administered by REGENCE. Starting with the first day of the month following the month he/she first renders the **Requisite Amount of Compensated Service** and continuing 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**, the **Eligible**

Employee and his/her **Eligible Dependents** will be placed in an interim **MMCP** administered by REGENCE. This interim **MMCP** is identical to the **MMCP** except that the payments for **Out-of-Network Services**, as described on page 51, are 85% and 68% instead of 75% and 60%. If such an **Eligible Employee** lives in an area where the Plan's **MMCP** is not available, he/she will be enrolled, along with his/her **Eligible Dependents**, in the Plan's **CHCB** administered by REGENCE.

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, and their **Eligible Dependents**, will be enrolled in the program of Plan benefits (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 he/she comes back within the 24-month period, will be considered a newly hired employee for purposes of determining in which Plan program he/she and his/her **Eligible Dependents** will be enrolled.

Transferring Employees

Eligible Employees who move will be covered, and have options, as follows:

- If they were covered under the **CHCB** administered by REGENCE before the move, they will remain covered under the **CHCB** administered by REGENCE. However, if they move to an area where the Plan's **MMCP** is available, they may request enrollment in the **MMCP** and choose the company (REGENCE or AUSHC in some areas; REGENCE or United HealthCare in others) they wish to administer the program.

- If they were covered under the **CHCB** administered by United HealthCare before the move, they will remain covered under the **CHCB** administered by United HealthCare. However, if they move to an area where the

Plan's **MMCP** is available, they may request enrollment in the **MMCP** and choose the company (REGENCE or AUSHC in some areas; REGENCE or United HealthCare in others) they wish to administer the program.

- If they were covered under the **MMCP** administered by REGENCE before the move, they will remain covered under the **MMCP** administered by REGENCE provided it is available under the Plan at their new location. If the **MMCP** is not available under the Plan at the new location, they will be covered under the **CHCB** administered by REGENCE.

- If they were covered under the **MMCP** administered by either United HealthCare or AUSHC before the move:

  - If 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 the **MMCP** administered by the same company is not available in the new location, but the **MMCP** administered by the other company (either United HealthCare or AUSHC) is available in the new location, they will be transferred to the **MMCP** administered by the other company. In this event, the interim **MMCP** described under the heading **Newly Hired Employees** above 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 United HealthCare receives notice that the **Eligible Employee** has moved to the new network area.

  - If the **MMCP** is not available under the Plan at the new location, they will be covered under the **CHCB** administered by United HealthCare.

Employees of Hospital Association Railroads

The description of the coverage -- **MMCP** or **CHCB** -- applicable to Newly Hired Employees, Returning Employees and Transferring Employees applies only to the **Eligible Dependents** of **Eligible Employees** of hospital association railroads. If an **Eligible Employee** of a hospital association railroad loses hospital association coverage and becomes covered for Employee Health Care Benefits under the Plan,

he/she will have the same coverage -- **MMCP** (administered by the same company) or **CHCB** (administered by the same company) -- selected for his/her **Eligible Dependents**. If the **Eligible Employee** has no dependents, he/she will be covered just as if he/she was a newly hired employee.

Enrollment Changes

- Open Enrollment. In October of each year, or during any other open enrollment period announced by the Plan, all **Eligible Employees** enrolled in the **MMCP** may elect to be enrolled, along with their **Eligible Dependents**, in the **CHCB** administered by REGENCE or the **CHCB** administered by United HealthCare. Also, the **Employee** may elect to move to the **MMCP** administered by REGENCE from any other **MMCP** under the Plan or from the **MMCP** administered by REGENCE to the **MMCP** administered by United HealthCare or AUSHC if either of them has been selected by the Plan to be a managed care vendor in the area where the **Eligible Employee** lives. 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.

- Transfer to **MMCP**. At any time, **Eligible Employees** enrolled in the **CHCB** may request any company administering the **MMCP** in the area where they live to enroll them, along with their **Eligible Dependents**, in the **MMCP** administered by that company. Enrollment in that **MMCP** will become effective on the first day of the month following the month in which the **MMCP** enrollment process is completed.

Primary Care Physician (PCP) Election

If you are an **Eligible Employee** enrolled in an **MMCP** administered by either United HealthCare or AUSHC, you and each of your **Eligible Dependents** must choose a **Primary Care Physician (PCP)** from the list of **Primary Care Physicians** in your directory of **In-Network Providers**. If you do not choose a **PCP**, one will be chosen for you.

If you want to change your **PCP**, you can request to transfer to another **PCP** from the list of **Primary Care Physicians** in your directory by calling United HealthCare at 1-888-445-4379 or AUSHC at 1-888-332-8742, as the case may be.

If you are an **Eligible Employee** enrolled in the **MMCP** administered by REGENCE, you need not choose a **Primary Care Physician**.

IV
Employee and Dependents Health Care Benefits

The Plan provides the Comprehensive Health Care Benefit, the Managed Medical Care Program, the Mental Health and Substance Abuse Care Benefit, and the Managed Pharmacy Services Benefit. The **CHCB**, the **MMCP** and the **MHSA** provide payment for the Covered Expenses listed on pages 65 through 75. The Managed Pharmacy Services Benefit provides payment for Covered 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 a Covered Expense -- for example, a Covered Expense cannot exceed the **Reasonable Charge** for a given service or supply -- are explained at page 65.

COMPREHENSIVE HEALTH CARE BENEFIT

The Comprehensive Health Care Benefit (**CHCB**) pays a percentage of Covered Expenses for **Medical Care** in a calendar year that exceed the applicable deductible.

To receive the highest benefit level, you must comply with applicable medical management requirements (see pages 40 through 45).

Expenses for **Mental Health Care** or **Substance Abuse Care**, or 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 expenses, however, to the extent provided under the **MHSA** (see pages 54 through 64) and the **MPSB** (see pages 76 through 80).

Deductibles

There are two types of deductibles, Individual and Family. Any deductible satisfied under the Comprehensive Health Care Benefit will also be considered satisfied under the **Out-of-Network Services** portion of the Mental Health and Substance Abuse Care Benefit and of the Managed Medical Care Program.

The Individual Deductible is $100. It applies separately to each **Covered Family Member** each calendar year.

The Family Deductible is $300. 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 Covered Expenses which count toward a person's Individual Deductible count toward the Family Deductible.

Percentage of Covered Expenses Payable

The Comprehensive Health Care Benefit pays:

- 85% of Covered Expenses incurred until the Out-of-Pocket Maximum is reached, but only
- 68% of Covered Expenses if a required notice to the company (REGENCE or United HealthCare) administering the **CHCB** in which you participate is not given or if that company determines that the service or supply is not **Medically Appropriate**.

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

- 100% of Covered Expenses for the remainder of the calendar year, but only
- 80% of Covered Expenses if a required notice to the company (REGENCE or United HealthCare) administering the **CHCB** in which you participate is not given or if that company determines that the service or supply is not **Medically Appropriate**.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay in a calendar year. Any Out-of-Pocket Maximum satisfied under the Comprehensive Health Care Benefit will also be considered satisfied under the **Out-of-Network Services** portion of the Mental Health and Substance Abuse Care Benefit and of the Managed Medical Care Program.

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

- The Individual Out-of-Pocket Maximum is $1,500 each calendar year.
- The Family Out-of-Pocket Maximum is $3,000 each calendar year. This Family Out-of-Pocket Maximum applies no matter how many **Covered Family Members** you have. Only Covered Expenses which count toward a person's Individual Out-of-Pocket Maximum count toward the Family Out-of-Pocket Maximum.

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.
- Co-payments you make for **In-Network Services** under the **MMCP** or the **MHSA**.
- Co-payments you make and any other charges you pay under the Managed Pharmacy Services Benefit.
- Charges you pay towards the Individual Deductible under the **CHCB**, the **Out-of-Network Services** portion of the **MMCP**, and the **Out-of-Network Services** portion of the **MHSA.**
- Charges you pay as a result of the 20% reduction in benefits under the **Out-of-Network Services** portion of the **MMCP** if a required notice under the medical management

procedures of the company administering your **MMCP** is not given or if the company administering your **MMCP** determines that the service or supply is not **Medically Appropriate**.

- Charges you pay as a result of the 50% reduction in benefits under the **Out-of-Network Services** portion of the **MHSA** if required **Certification** from Magellan or ValueOptions, as the case may be, is not obtained.

Maximum Benefit

The lifetime maximum benefit payable for you or for any **Eligible Dependent** is $1,000,000. Any part of it you have used, up to $5,000, will be restored on each January 1.

This lifetime maximum benefit includes any amount paid under the Comprehensive Health Care Benefit, for **Out-of-Network Services** under the Managed Medical Care Program, and for **Out-of-Network Services** for **Mental Health Care** under the Mental Health and Substance Abuse Care Benefit. There is no lifetime maximum benefit under the Managed Pharmacy Services Benefit or under the **In-Network Services** portion of either the Managed Medical Care Program or the Mental Health and Substance Abuse Care Benefit. There is a separate lifetime maximum benefit of $100,000 for **Out-of-Network Services** for **Substance Abuse Care** under the Mental Health and Substance Abuse Care Benefit.

The amounts counted under The Railroad Employees National Health and Welfare Plan as of December 31, 1999, against the lifetime maximum benefit of $1,000,000 or the separate lifetime maximum of $100,000 for substance abuse care benefits shall also count against the similar lifetime maximum benefits provided under this Plan.

BlueCross BlueShield Participating Providers and United HealthCare Preferred Providers

REGENCE and United HealthCare have separate arrangements with certain health care providers regarding their charges – often discounted – for Covered Expenses under the **CHCB**. The providers that have such arrangements with REGENCE are called **BlueCross BlueShield Participating Providers**. Those with arrangements with United HealthCare are called **United HealthCare Preferred Providers**. There are considerably more **BlueCross BlueShield Participating Providers** than **United HealthCare Preferred Providers**. Some providers may have arrangements with both companies.

If **BlueCross BlueShield Participating Providers** or **United HealthCare Preferred Providers** are used, the amount of Covered Expenses for which you are responsible will generally be less than if other providers had been used. The percentage of Covered Expenses payable remains the same whether or not **BlueCross BlueShield Participating Providers** or **United HealthCare Preferred Providers** are used. However, because the Covered Expenses may be less when **BlueCross BlueShield Participating Providers** or **United HealthCare Preferred Providers** are used, the portion that you owe will be less.

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

Call REGENCE at 1-888-977-2583 for a directory of **BlueCross BlueShield Participating Providers**. Call United HealthCare at 1-800-691-0013 for a directory of **United HealthCare Preferred Providers**.

BlueCross BlueShield Participating Providers and **United HealthCare Preferred Providers** are responsible for filing your

claims directly with REGENCE or United HealthCare, as the case may be. You do not need to submit claims for **BlueCross BlueShield Participating Provider** or **United HealthCare Preferred Provider** services or supplies.

You must submit claims for services and supplies rendered by other providers, as described on pages 118 through 121 of your booklet.

If a **BlueCross BlueShield Participating Provider** bills you for any amount beyond the applicable deductible and the percentage of Covered Expenses you owe, call REGENCE at 1-888-977-2583. If the bill is from a **United HealthCare Preferred Provider**, call United HealthCare at 1-800-691-0013.

Medical Management

Notification

You must notify the company (REGENCE or United HealthCare, as the case may be) that administers the **CHCB** in which you participate as soon as possible after you know that you require any of the services shown below:

- confinement in a **Hospital, Hospice, Birth Center** or **Skilled Nursing Facility**.
- home health care.
- private duty nursing.
- certain outpatient surgical procedures and diagnostic tests. A list of the types of procedures and tests which require notification is shown on page 44.

The notice you give must be given in sufficient time to allow the company to which it must be given 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 if the service is **Medically Necessary** or **Medically Appropriate** before you incur expenses.

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

This notification requirement does not apply to injuries incurred by an **Eligible Employee** while on-duty for an employing railroad, but the services of whichever company administers the **CHCB** in which you participate are available to answer questions about proposed medical treatment.

How to Give the Required Notice

Notice should be given by telephone. REGENCE's toll-free number is 1-800-888-977-2583; United HealthCare's is 1-800-842-4555. Each company's working days are Monday through Friday, except for State and Federal holidays. Their usual hours of operation run from 8:00 a.m. to 6:00 or 7:00 p.m., in their particular time zone. However, you can call at any time, day or night. If you call outside a company's normal 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.

When to Give the Required Notice

- You must give the required notice as promptly as possible for all services that require notification. See the text under "Notification" above.

- If a listed outpatient surgical procedure or diagnostic test is not planned in advance, but is performed immediately as part of your **Physician's** office visit, you do not have to give notice. However, if your **Physician** does plan the procedure or test for a later time, you must notify REGENCE or United HealthCare, as the case may be, as soon as possible.

- For an **Emergency** which results in a confinement, you (or your representative or your **Physician**) must give the required notice within one day (excluding weekends and holidays) from the date the confinement begins.

- You should notify REGENCE or United HealthCare, as the case may be, promptly after you become aware that you are pregnant. You must give this notice of pregnancy,

however, only if and when the inpatient care for the mother or child is expected to continue beyond:

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

What Happens After You Give the Required Notice

REGENCE or United HealthCare, as the case may be, reviews the services for which you have given it notice and determines whether they are **Medically Necessary** and **Medically Appropriate**.

*The ultimate decision on your medical care must be made by you and your **Physician**. Review by REGENCE OR United HealthCare only determines whether the service or supply is **Medically Necessary** and **Medically Appropriate** for purposes of deciding what, if any, amounts are payable with respect to the service or supply under the Comprehensive Health Care Benefit of the Plan.*

Effects on Benefits

- Benefits are reduced if you do not give the required notice or if REGENCE or United HealthCare, as the case may be, determines that the service or supply is not **Medically Appropriate**. In either case, the benefit will be reduced from 85% to 68% of Covered Expenses. If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to 80%.
- No benefits are payable if the company administering the **CHCB** in which you participate determines that the service or supply is not **Medically Necessary**.

If that company determines that a service is not **Medically Necessary** or **Medically Appropriate**, you or your **Physician** can appeal that determination. To initiate this appeal, you should call the company that made the determination. Call REGENCE at 1-888-977-2583. Call United HealthCare at 1-800-842-4555.

If you are not satisfied after exhausting all of the appeal processes within the company administering the **CHCB** in

which you participate, you or your **Physician** may make a further appeal to an independent specialist **Physician** designated by the Plan. REGENCE or United HealthCare, as the case may be, will let you know how to make that appeal.

Case Management Services

REGENCE and United HealthCare also provide case management services in connection with your Comprehensive Health Care Benefit. These services focus on severe illnesses and injuries which could result in long-term hospital confinements. The company that administers the **CHCB** in which you participate will determine whether the services of case management are appropriate in your case.

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

Applicability Under MMCP

Medical management procedures apply not only under the Comprehensive Health Care Benefit, but also under the **Out-of-Network Services** portion of the Managed Medical Care Program. The company to which you must give the required notice -- and that will review the matter and make a determination as to whether a service or supply is **Medically Necessary** and **Medically Appropriate** for purposes of deciding what, if any, amounts are payable under the Plan's **MMCP** – is the company that administers the **MMCP** in which you participate. Regardless of what company is administering your **MMCP**, your right to appeal to an independent specialist physician designated by the Plan is also applicable. See pages 50 through 53 of this booklet.

Medical Management Determinations Made Under The Railroad Employees National Health and Welfare Plan

Determinations of **Medical Necessity** and of **Medical Appropriateness** made by Medical Management prior to January 1, 2000, under The Railroad Employees National Health and Welfare Plan will apply under this Plan.

List of Types of Procedures and Tests which Require that Medical Management be Notified in Advance:

You must give the required notice, and obtain advance approval from the company to which you must give the notice, for any of the services shown below:

Surgical Procedures

- Back surgery
- Ears, nose and throat
- Female pelvic surgery
- Foot surgery
- Gallbladder surgery
- Hand/wrist surgery
- Heart surgery
- Knee surgery
- Rectal surgery

Outpatient Diagnostic Tests for the following:

- Back
- Bladder or kidney
- Colon
- Stomach or intestines
- Heart

All expenses relating to organ/tissue transplants.

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*Exclusions applicable to the Comprehensive Health Care Benefit are set forth under the heading General Exclusions at pages 82 through 85. Also, your benefits may be reduced if you or your **Eligible Dependent** has health benefits under another plan. These benefit reductions are described under the heading Coordination of Benefits at pages 86 through 90. Other limitations with respect to Dependents Health Care Benefits are described on pages 28 through 29.*

MANAGED MEDICAL CARE PROGRAM

The Managed Medical Care Program (**MMCP**) provides payment for a wide range of expenses for **Medical Care**. The Covered Expenses section, starting on page 65 of this booklet, outlines what is covered under the **MMCP**.

Expenses for **Mental Health Care** or **Substance Abuse Care**, or for **Prescription Drugs** received from a pharmacy or by mail order, are not covered under the **MMCP**. The Plan does cover these expenses, however, to the extent provided under the **MHSA** (see pages 54 through 64) and the **MPSB** (see pages 76 through 80).

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

These two benefit levels are shown on page 5 of this booklet.

IN-NETWORK SERVICES

All Covered Expenses are paid at 100% for **In-Network Services**, except as follows:

- You must pay $15 for each office visit. This Office Visit Co-payment applies to each office visit to any **In-Network Provider**.
- You must pay $15 for each visit to an urgent care center listed in your directory of **In-Network Providers**.
- You must pay at least $30 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 $30 emergency room co-payment applies to Covered Expenses for charges made by the **Hospital** for **Emergency** care received in its emergency room. The co-payment does not apply if confinement as a **Hospital** inpatient is required.

A **Hospital** that is an **Out-of-Network Provider** may ask you to pay more than the $30 emergency room co-payment. The **Hospital** may even require payment in full at the time services are rendered. In such a case -- indeed, in any case without

regard to whether the **Hospital** is an **In-Network Provider** or an **Out-of-Network Provider** -- if the care you receive meets the Plan requirement for an **Emergency** (see definition on page 98), the Plan will reimburse you for the full amount of the **Hospital** charge except for $15. If the care you receive does not meet the Plan requirement for an **Emergency**, only those benefits provided for **Out-of-Network Services** (see pages 50 through 53) will be paid.

Obtaining Benefits Under the MMCP Administered by United HealthCare or AUSHC

To obtain benefits for **In-Network Services**, you or your **Eligible Dependent** must comply with all of the following requirements:

- You must contact your **Primary Care Physician (PCP)**
  - in advance of receiving any services covered by the **MMCP**, or
  - within one working day of first receiving such services in an **Emergency**.

  except that if you or your spouse is admitted for the delivery of a child, you need contact your **PCP** only if your (or your spouse's) confinement is expected to continue beyond:
  - 48 hours following a normal delivery, or
  - 96 hours following a cesarean section.
- You must receive the services from your **PCP**, another **In-Network Provider** to whom you were referred by your **PCP** for specified services, or through an **Out-of-Network Authorization**.

When you call your **PCP**, he/she will work with network medical management to determine what services you need. Your **PCP** will render the services himself/herself, or will refer you to other **In-Network Providers** for those services. If circumstances indicate that you need services not available from an **In-Network Provider**, your **PCP** may seek to obtain an **Out-of-Network Authorization**.

In addition, **In-Network Services** are obtained if you or your **Eligible Dependent** receives services from an urgent care center listed in your directory of **In-Network Providers**. You do not have to contact your **PCP** in advance of receiving these services.

Limit on Patient Liability (Balance Billing)

As long as you receive services from your **PCP**, another **In-Network Provider** to whom you were referred by your PCP for specified services, or through an **Out-of-Network Authorization** prior to receiving specified services from an **Out-of-Network Provider**, all of your Covered Expenses will be paid in full, except for any applicable co-payments.

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

Emergencies

You are not required immediately to contact your **PCP** in an **Emergency**, and the provider does not have to be an **In-Network Provider**. If your case falls within the Plan's definition of an **Emergency** (see page 98), the **MMCP** will pay benefits at the In-Network level. If, however, your case does not fall within the Plan's definition of an **Emergency**, the **MMCP** will pay benefits at the Out-of-Network level.

When an **Emergency** results in a confinement, you (or your representative or **Physician**) must call your **PCP** within one working day of the date the confinement begins (excluding weekends and holidays).

To receive the In-Network level of benefits after the **Emergency** has ended, you must comply with the requirements set forth on page 47 of this booklet, including contacting your **PCP** if applicable, before you receive any additional services.

Obtaining Benefits Under the MMCP Administered by REGENCE

To obtain benefits for **In-Network Services**, you or your **Eligible Dependent** must utilize an **In-Network Provider**. REGENCE calls them **BlueCross BlueShield Preferred Providers**. You are not required to choose a **Primary Care Physician**. Nor are you required to obtain a referral in order to receive benefits for specialist care.

Limit on Patient Liability (Balance Billing)

As long as you receive services from a **BlueCross BlueShield Preferred Provider**, all of your Covered Expenses will be paid in full, except for any applicable co-payments.

BlueCross BlueShield Preferred Providers also cannot charge you for any services that are not **Medically Appropriate** or **Medically Necessary**, unless you agree in advance to pay for them. The Plan does not cover them.

Emergencies

You are not required to choose a **Primary Care Physician (PCP)** or obtain a referral in order to receive benefits for **Emergency** care. If you have an **Emergency** and receive care from a **BlueCross BlueShield Preferred Provider** (see page 98 for **Emergency** definition), the **MMCP** will pay benefits at the In-network level. If, however, you receive care from other than a **BlueCross BlueShield Preferred Provider** and your situation does not fall within the Plan definition of an **Emergency**, the **MMCP** will pay benefits for Covered Expenses at the Out-of-Network level. To receive the In-Network level of benefits after the **Emergency** has ended, you must utilize **BlueCross BlueShield Preferred Providers**.

OUT-OF-NETWORK SERVICES

All Covered Expenses for **Out-of-Network Services** are paid at the percentages set forth on pages 5 through 6 of this booklet that exceed any applicable deductible if you or your **Eligible Dependents**:

- do not have an **Out-of-Network Authorization**,

or, if your **MMCP** is administered by United HealthCare or AUSHC, you or your **Eligible Dependents**:

- do not receive services from your **PCP**,
- do not receive a referral from your **PCP** before receiving services from an **In-Network Provider**.

*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 pages 40 through 45 of this booklet.) If United HealthCare administers your **MMCP**, call 1-888-445-4379. If AUSHC administers your **MMCP**, call 1-888-332-8742.*

Deductibles

There are two types of deductibles for **Out-of-Network Services**, an Individual Deductible and a Family Deductible. Any deductible satisfied under the **MMCP** will also be considered satisfied under the **CHCB** and the **Out-of-Network Services** portion of the **MHSA**.

- The Individual Deductible is $100. It applies separately to each **Covered Family Member** each calendar year.
- The Family Deductible is $300. 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 Covered Expenses which count toward a person's Individual Deductible count toward the Family Deductible.

Percentage of Covered Expenses Payable

All Covered Expenses for **Out-of-Network Services** are paid as follows:

Before the annual Out-of-Pocket Maximum is met, the **MMCP** pays:

- 75% of Covered Expenses, but only
- 60% of Covered Expenses (a 20% reduction in benefits) if a required notice under applicable medical management procedures is not given or if the company that administers your **MMCP** determines in performing its medical management function that the service or supply is not **Medically Appropriate**.

After the annual Out-of-Pocket Maximum is met, the **MMCP** pays:

- 100% of Covered Expenses for the remainder of the calendar year, but only
- 80% of Covered Expenses (a 20% reduction in benefits) if a required notice under applicable medical management procedures is not given or if the company that administers your **MMCP** determines in performing its medical management function that the service or supply is not **Medically Appropriate**.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay in a calendar year for **Out-of-Network Services**. Any Out-of-Pocket Maximum satisfied under the **Out-of-Network Services** portion of the **MMCP** will also be considered satisfied under the **CHCB** and under the **Out-of-Network Services** portion of the **MHSA**.

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

- The Individual Out-of-Pocket Maximum is $1,500 each calendar year.

- The Family Out-of-Pocket Maximum is $3,000 each calendar year. This Family Out-of-Pocket Maximum applies no matter how many **Covered Family Members** you have. Only Covered Expenses which count toward a person's Individual Out-of-Pocket Maximum count toward the Family Out-of-Pocket Maximum.

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.

- Co-payments you make for **In-Network Services** under the **MMCP** or the **MHSA**.

- Co-payments you make and any other charges you pay under the Managed Pharmacy Services Benefit.

- Charges you pay toward the Individual Deductible under the **CHCB**, the **Out-of-Network Services** portion of the **MMCP** and the **Out-of-Network Services** portion of the **MHSA**.

- Charges you pay as a result of the 20% reduction in benefits under the **Out-of-Network Services** portion of the **MMCP** if a required notice under applicable medical management procedures is not given or if the company that administers your **MMCP** determines in performing its medical management function that the service or supply is not **Medically Appropriate**.

- Charges you pay as a result of the 50% reduction in benefits under the **Out-of-Network Services** portion of the **MHSA** if required **Certification** from Magellan or ValueOptions, as the case may be, is not obtained.

Maximum Benefit

The lifetime maximum benefit payable for **Out-of-Network Services** for you or for any **Eligible Dependent** is $1,000,000. Any part of it you have used, up to $5,000, will be restored on each January 1.

This lifetime maximum benefit includes any amount paid under the Comprehensive Health Care Benefit, for **Out-of-Network Services** under the Managed Medical Care Program, or for **Out-of-Network Services** for **Mental Health Care** under the Mental Health and Substance Abuse Care Benefit. It also includes the total amount that counted for purposes of applying the same lifetime maximum benefit under The Railroad Employees National Health and Welfare Plan as of December 31, 1999.

There is no lifetime maximum benefit under the Managed Pharmacy Services Benefit or under the **In-Network Services** portion of either the Managed Medical Care Program or the Mental Health and Substance Abuse Care Benefit. There is a separate lifetime maximum benefit of $100,000 for **Out-of-Network Services** for **Substance Abuse Care** under the Mental Health and Substance Abuse Care Benefit.

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*Exclusions applicable to the Managed Medical Care Program are set forth under the heading General Exclusions at pages 82 through 85. Also, your benefits may be reduced if you or your **Eligible Dependent** has health benefits under another plan. These benefit reductions are described under the heading Coordination of Benefits at pages 86 through 90. Other limitations with respect to Dependents Health Care Benefits are described on pages 28 through 29.*

MENTAL HEALTH AND SUBSTANCE ABUSE CARE BENEFIT

The Mental Health and Substance Abuse Care Benefit (**MHSA**) pays for certain Covered Expenses (see pages 65 through 75 of this booklet) for **Mental Health Care** or **Substance Abuse Care**. This Benefit does not cover **Medical Care**; nor does it cover **Prescription Drugs** obtained as part of outpatient **Mental Health Care** or **Substance Abuse Care**. The Plan does cover these expenses, however, to the extent provided under the **CHCB** or **MMCP** as to **Medical Care** (see pages 35 through 53) and under the **MPSB** as to **Prescription Drugs** (see pages 76 through 81).

Different levels of benefits are paid under the **MHSA** depending upon whether you obtain **In-Network Services** or **Out-of-Network Services**. To receive the highest benefit level, you must use **In-Network Services**. To receive the maximum benefit that is payable when you use **Out-of-Network Services**, you must comply with the **Certification** or **Pretreatment Outpatient Assessment** requirements described at pages 61 through 63, below.

If you are enrolled in the **MMCP** or **CHCB** administered by REGENCE, your **MHSA** will be administered by Magellan. If you are enrolled in the **MMCP** or **CHCB** administered by United HealthCare, or in the **MMCP** administered by AUSHC, your **MHSA** will be administered by ValueOptions.

All questions about Plan benefits, rules and procedures with regard to **Mental Health Care** or **Substance Abuse Care**, including the names of **ValueOptions Providers** or **Magellan Providers** in your area, or any question about the Plan's definitions of **Mental Health Care** and **Substance Abuse Care** (see pages 106 and 114), or whether the Mental Health and Substance Abuse Care Benefit applies to a particular sickness or injury, should be directed to whichever of Magellan or ValueOptions administers your **MHSA**. Call Magellan at 1-888-724-5006. Call ValueOptions at 1-800-934-7245.

Percentage of Covered Expenses Payable

For **In-Network Services**, the Mental Health and Substance Abuse Care Benefit pays:

- 100% of the Covered Expenses for inpatient care. No co-payment by you or your **Eligible Dependent** is required.
- 100% of the Covered Expenses for outpatient care, other than **Prescription Drugs**, after you or your **Eligible Dependent** makes a $15 co-payment for each visit to the provider.

There is no annual deductible with respect to **In-Network Services**.

There is no annual Out-of-Pocket Maximum with respect to **In-Network Services**.

There is no lifetime limitation on the amount of benefits payable with respect to **In-Network Services**.

For **Out-of-Network Services**, the Mental Health and Substance Abuse Care Benefit pays:

- For inpatient care in a **Hospital**, 75% of the Covered Expenses incurred in a calendar year that exceed the applicable deductible, except that only 38% of the Covered Expenses will be paid if required **Certification** is not obtained.
- For outpatient care, other than at a **Treatment Center** or an **Outpatient Clinic**, rendered by a Doctor of Medicine (M.D.) or a **Psychologist**, 75% of the Covered Expenses, other than **Prescription Drugs**, incurred in a calendar year that exceed the applicable deductible, except that only 38% of the Covered Expenses will be paid if required **Certification** is not obtained.
- For **Treatment Center** and **Outpatient Clinic** Services, 75% of the Covered Expenses (see pages 73 through 75 for a description of what expenses for **Treatment Center** services are Covered Expenses) that exceed the applicable deductible, except that only 38% of the Covered Expenses will be paid if **Certification** is not obtained.

- For transportation to and from a **Treatment Center** in connection with each confinement for which benefits are payable, 75% of the Covered Expenses that exceed the applicable deductible, except that only 38% of Covered Expenses will be paid if **Certification** is not obtained. Moreover, no benefits will be paid for transportation to and from a **Treatment Center** other than the one that Magellan or ValueOptions, as the case may be, determines provides the most appropriate and economical treatment program, and the maximum benefit for transportation to and from a **Treatment Center** shall not exceed $500 per confinement.

*The Mental Health and Substance Abuse Care Benefit does not cover any outpatient **Out-of-Network Services** (other than **Treatment Center** and **Outpatient Clinic** services, see pages 73 through 75) that are rendered by a provider other than a Doctor of Medicine (M.D.) or a **Psychologist**.*

Deductibles

There are two types of deductibles for **Out-of-Network Services**, an Individual Deductible and a Family Deductible. Any deductible satisfied under the **Out-of-Network Services** portion of this Mental Health and Substance Abuse Care Benefit will also be considered satisfied under the Comprehensive Health Care Benefit and the **Out-of-Network Services** portion of the Managed Medical Care Program.

- The amount of the Individual Deductible is $100. It applies separately to each **Covered Family Member** each calendar year.

- The Family Deductible is $300. This is the most you and your **Eligible Dependents** will have to pay for Individual Deductibles under this Plan in any calendar year. This Family Deductible applies no matter how many **Covered Family Members** you have. Only Covered Expenses which count toward a person's Individual Deductible count toward the Family Deductible.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay in a calendar year for **Out-of-Network Services**. Any Out-of-Pocket Maximum satisfied under the **Out-of-Network Services** portion of the **MHSA** will also be considered satisfied under the Comprehensive Health Care Benefit and under the **Out-of-Network Services** portion of the Managed Medical Care Program.

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

- The Individual Out-of-Pocket Maximum is $1,500 each calendar year.
- The Family Out-of-Pocket Maximum is $3,000 each calendar year. This Family Out-of-Pocket Maximum applies no matter how many **Covered Family Members** you have. Only Covered Expenses which count toward a person's Individual Out-of-Pocket Maximum count toward the Family Out-of-Pocket Maximum.

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.
- Co-payments you make for **In-Network Services** under the **MMCP** or the **MHSA**.
- Co-payments you make and any other charges you pay under the Managed Pharmacy Services Benefit.
- Charges you pay towards the Individual Deductible under the **CHCB**, the **Out-of-Network Services** portion of the **MMCP**, and the **Out-of-Network Services** portion of the **MHSA**.
- Charges you pay as a result of the 20% reduction in benefits under the **Out-of-Network Services** portion of the **MMCP** if a required notice under applicable medical

management procedures is not given or if the company that administers your **MMCP** determines in performing its medical management function that the service or supply is not **Medically Appropriate**.

- Charges you pay as a result of the 50% reduction in benefits under the **Out-of-Network Services** portion of the **MHSA** if required **Certification** is not obtained.

When the annual Out-of-Pocket Maximum is met, the Plan pays 100% of Covered Expenses for the remainder of the calendar year, except that only 50% of Covered Expenses will be paid if required **Certification** is not obtained.

Maximum Benefit

The lifetime Maximum Mental Health and Substance Abuse Care Benefit payable for **Out-of-Network Services** for **Substance Abuse Care** for you or any **Eligible Dependent** is $100,000. Any part of it that you have used, up to $500, will be restored on each January 1.

There is also a lifetime maximum benefit of $1,000,000 with respect to all amounts paid under the Comprehensive Health Care Benefit, for **Out-of-Network Services** under the Managed Medical Care Program, and for **Out-of-Network Services** for **Mental Health Care** under the Mental Health and Substance Abuse Care Benefit. In addition, the total amount that counted for purposes of applying both of the lifetime maximum benefits described above under The Railroad Employees National Health and Welfare Plan as of December 31, 1999, will count for purposes of applying those maximum lifetime benefits under this Plan.

There is no lifetime maximum benefit under the Managed Pharmacy Services Benefit or under the **In-Network Services** portion of either the Managed Medical Care Program or the Mental Health and Substance Abuse Care Benefit.

Obtaining (Accessing) Benefits

In-Network Services

To obtain benefits for **In-Network Services** you or your **Eligible Dependent** must comply with all of the following requirements:

- Contact Magellan or ValueOptions, whichever administers your **MHSA**, to obtain a **Magellan** or **ValueOptions Provider** in your area
  - in advance of receiving any services covered by the Mental Health and Substance Abuse Care Benefit, or
  - within forty-eight hours of first receiving such services in an **Emergency**, and
- Receive **Certified** services from a **Magellan** or **ValueOptions Provider** or through an **Out-of-Network Authorization**.

Magellan and **ValueOptions Providers** have agreed that they will not charge you or an **Eligible Dependent** for any covered service or supply which Magellan or ValueOptions has **Certified**, except for the $15 co-payment, if applicable.

*If you or an **Eligible Dependent** agree to receive a **Non-Certified** service or supply from a **Magellan** or **ValueOptions Provider**, 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-Certified** service or supply.*

Out-of-Network Services

To obtain maximum benefits for **Out-of-Network Services**, you or your **Eligible Dependent** must comply with all of the following requirements:

- Contact Magellan or ValueOptions, whichever administers your **MHSA**

- in advance of receiving any services covered by the Mental Health and Substance Abuse Care Benefit, or
- within forty-eight hours of first receiving such services in an **Emergency**, and

- Receive **Certified** services from a **Non-Magellan** or **Non-ValueOptions Provider**, or obtain a **Pretreatment Outpatient Assessment** with respect to the first ten outpatient visits to the provider.

24 hours a day, seven days a week, you can contact Magellan by calling 1-888-724-5006 or ValueOptions by calling 1-800-934-7245.

*You are responsible for verifying that a provider is a **Magellan** or **ValueOptions Provider**. You should not assume that a referral from a **Magellan** or **ValueOptions Provider** will always be to another **Magellan** or **ValueOptions Provider**. You can verify that the provider is a **Magellan** or **ValueOptions Provider** by calling Magellan's or ValueOptions' toll-free number.*

The appropriate toll-free number must be called for a **Pretreatment Outpatient Assessment**, or for a **Certification**, with respect to services to be provided by a **Non-Magellan** or **Non-ValueOptions Provider**.

The requirement to obtain **Certification** in connection with **Out-of-Network Services** does not apply to injuries incurred by an **Eligible Employee** while on duty for an employing railroad, but Magellan or ValueOptions, whichever administers your **MHSA**, is available to answer questions about proposed **Mental Health Care** or **Substance Abuse Care** treatment.

Certification and Pretreatment Outpatient Assessment

In-Network Services

All **Certifications** with respect to **In-Network Services** will be handled directly with Magellan or ValueOptions, as the case may be, by the **Magellan** or **ValueOptions Provider** who provides the services. No benefits are payable if Magellan or ValueOptions, as the case may be, determines that the service or supply is not **Medically Necessary**.

You and your **Magellan** or **ValueOptions Provider** may initiate an appeal of a **Non-Certification**. Information on how to initiate an appeal will be provided in the **Non-Certification** letter you will get from Magellan or ValueOptions or may be obtained through the company's toll-free number.

Out-of-Network Services

Those inpatient admissions to and stays in **Non-Magellan** or **Non-ValueOptions Facilities** which are covered under the Mental Health and Substance Abuse Care Benefit are subject to prior and concurrent **Certification**.

*You are responsible for calling Magellan or ValueOptions, as the case may be, to start the **Certification** process.* Except in the case of an **Emergency**, you or your provider must call for **Certification** prior to an inpatient admission. Magellan or ValueOptions, as the case may be, must also be notified prior to any continued length of stay beyond the time previously **Certified** during the same admission.

Benefits will be reduced for any inpatient admission to or stay at a **Non-Magellan** or **Non-ValueOptions Facility** which has not been **Certified**.

You must call and advise Magellan or ValueOptions, as the case may be, prior to any outpatient visit to a **Non-Magellan** or **Non-ValueOptions Provider** which is covered under the Mental Health and Substance Abuse Care Benefit. During that call the company that you must call will provide you with a telephonic **Pretreatment Outpatient Assessment**. You are also responsible for seeing to it that your **Non-Magellan** or **Non-ValueOptions Provider** has forwarded to Magellan or

ValueOptions, as the case may be, a fully completed outpatient treatment report (OTR) form for proposed outpatient visits and a fully completed psychological testing report form for any psychological tests to be performed.

*If you receive services covered under the Mental Health and Substance Abuse Care Benefit from a **Non-Magellan** or **Non-ValueOptions Provider** without calling for a **Pretreatment Outpatient Assessment** (with respect to the first ten outpatient visits) or without obtaining **Certification** (with respect to all other care), benefits will be reduced by 50% 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.*

No benefits are payable if Magellan or ValueOptions, as the case may be, determines that the service or supply is not **Medically Necessary**.

When benefits for **Out-of-Network Services** *are reduced by 50% (from 75% to 38% of Covered Expenses), the amount of the reduction does not count towards any Out-of-Pocket Maximum.*

*Magellan and ValueOptions, only **Certify** a service or treatment for purposes of deciding what benefit amount, if any, is payable under the Plan. Any decision regarding the need to obtain the service or treatment involved, like any other medical decision, is your responsibility and that of your provider.*

You or your **Non-Magellan** or **Non-ValueOptions Provider** may initiate an appeal of a **Non-Certification**. Information on how to initiate an appeal will be provided in the **Non-Certification** letter you get from Magellan or ValueOptions, as the case may be, or may be obtained through the company's toll-free number.

If you are not satisfied after exhausting all of the appeal processes, you or your **Non-Magellan** or **Non-ValueOptions Provider** may make a further appeal to an independent specialist **Physician** designated by the Plan. Magellan or

ValueOptions, as the case may be, will let you know how to make that appeal.

Notice of Certification or Non-Certification

Magellan or ValueOptions, as the case may be, will provide notice of its **Certification** determinations directly to you, except when the patient is one of your **Eligible Dependents**, it is administratively feasible to notify him or her directly, and Magellan or ValueOptions, as the case may be, has been informed:

- that the patient is a minor living with a custodial parent or guardian who is not you; or
- of a specific situation and Magellan or ValueOptions, as the case may be, determines that it is otherwise appropriate to provide such **Certification** notice directly to the patient.

Emergencies

In an **Emergency**, you (or your representative) should call Magellan or ValueOptions, as the case may be, immediately. However, if the circumstances prevent an immediate call, then you should go or be taken to the nearest **Facility** for treatment.

Magellan or ValueOptions, as the case may be, must be contacted within forty-eight (48) hours of admittance to the **Facility** for a determination as to whether or not an **Emergency** exists, and if it does not, whether or not the treatment should be **Certified**. If such timely contact is made and Magellan or ValueOptions, as the case may be, determines that an **Emergency** does exist and that the treatment should be **Certified**, the Plan will pay the level of benefits for **In-Network Services** for any services covered under the Mental Health and Substance Abuse Care Benefit that are received during the **Emergency**.

If such timely contact with Magellan or ValueOptions, as the case may be, is made as required and the company determines that an **Emergency** does not exist, but that the treatment rendered should be **Certified**, the Plan will pay the level of benefits for **Out-of-Network Services** for any services covered under the Mental Health and Substance Abuse Care

Benefit rendered by a **Non-Magellan** or **Non-ValueOptions Provider**.

If such timely contact with Magellan or ValueOptions, as the case may be, is not made as required, or if the company involved determines that the treatment should not be **Certified**, the Plan will pay the level of benefits for any **Out-of-Network Services** covered under the Mental Health and Substance Abuse Care Benefit rendered by a **Non-Magellan** or **Non-ValueOptions Provider**, reduced by fifty percent (50%).

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*Exclusions applicable to this Mental Health and Substance Abuse Care Benefit are set forth under the heading General Exclusions at pages 82 through 85. Also, your benefits may be reduced if you or your **Eligible Dependent** has health benefits under another plan. These benefit reductions are described under the heading Coordination of Benefits at pages 86 through 90. Other limitations with respect to Dependents Health Care Benefits are described on pages 28 through 29.*

COVERED EXPENSES

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

Covered Expenses are the actual cost to you of the **Reasonable Charges** (defined on pages 111 through 109) for the **Medically Necessary** (defined on pages 104 through 105) services and supplies listed on pages 67 through 75 of this booklet. The service or supply must be needed because of:

- injury,
- sickness, or
- pregnancy.

Covered Expenses also include the actual cost to you of the **Reasonable Charges** for certain preventive services. (See pages 70 through 71.)

A service or supply is not **Medically Necessary** just because it is furnished by, or ordered by, your provider. The services and supplies you receive will be reviewed

- for the Comprehensive Health Care Benefit, by REGENCE or United HealthCare, whichever administers your **CHCB**,
- for the Managed Medical Care Program, by the company that administers your **MMCP**, and
- for the Mental Health and Substance Abuse Care Benefit, by Magellan or ValueOptions, whichever administers your **MHSA**,

to determine if they are **Medically Necessary**.

If you are uncertain whether a charge for proposed surgery is a **Reasonable Charge** or whether services or supplies ordered or recommended by your **Physician** are **Medically Necessary**, you may call for assistance:

- For expenses related to the Comprehensive Health Care Benefit or Managed Medical Care Program administered by REGENCE, call REGENCE toll free at 1-888-977-2583.

- For expenses related to the Comprehensive Health Care Benefit administered by United HealthCare, call United HealthCare toll free at 1-800-691-0013.
- For expenses related to the Managed Medical Care Program administered by United HealthCare, call United HealthCare toll free at 1-888-445-4379.
- For expenses related to the Managed Medical Care Program administered by AUSHC, call AUSHC toll free at 1-888-332-8742.
- For expenses related to the Mental Health and Substance Abuse Care Benefit, call the toll free number of the company that administers your **MHSA**. Magellan's number is 1-888-724-5006. ValueOptions' number is 1-800-934-7245.

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 or through any other medical management procedure for prescribing a length of stay not in excess of the above periods.

Note, however, that neither the Plan nor, generally, federal law prohibits the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Ambulatory Surgical Center Services

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

Anesthetics

Birth Center Services

Chemotherapy

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 or occupational therapy.
- Speech therapy to restore speech lost or impaired due to removal of vocal chords, cerebral thrombosis, or brain damage due to injury or organic brain lesion.
- **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 Managed Medical Care Program 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 Abuse Care**.

Services provided by a licensed pastoral counselor to a member of his/her congregation in the course of his/her normal duties as a pastor or minister will not be considered a Covered Expense.

Hospital Services

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

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

Jaw Joint Disorders

Up to a lifetime maximum payment of $1,250 for services for treatment in connection with the temporomandibular joint (jaw joint) 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).
- An appliance which replaced a lost body organ or part or helps an impaired one to work. An example is an artificial limb.
- Oxygen and charges for giving it. This includes rental of required equipment.
- Rental of a wheelchair, hospital-type bed or other durable medical equipment.
- Rental of a device to help breathing when paralyzed.
- Blood or blood plasma only if not donated or replaced.

Nursing Services

Services of a trained nurse or a **Nurse-Midwife**, except for outpatient **Out-of-Network Services** of a trained nurse or a **Nurse-Midwife** for **Mental Health Care** or **Substance Abuse Care**. Expenses for outpatient **Out-of-Network Services** of a trained nurse or a **Nurse-Midwife** for **Mental Health Care** or **Substance Abuse Care** are not Covered Expenses under the Plan.

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.

Physicians' Services

Prescription Drugs

Prescription Drugs other than those obtained from a pharmacy or by mail order.

Preventive Health Care

Expenses for the health care services listed below are covered under the **In-Network Services** portion of the Managed Medical Care Program when given (a) in accordance with accepted principles of practice in the United States at the time of service and, (b) if United HealthCare or AUSHC administers your **MMCP**, by your **PCP**. The $15 Co-payment 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.
- One routine well-woman exam every calendar year. (If United HealthCare or AUSHC administers your **MMCP**, the well-woman exam may be given by your **PCP** or any gynecologist listed in your directory of **In-Network Providers**. You do not have to contact your **PCP** in advance.) A well-woman exam includes the following:
  - Breast examination and/or mammogram.
  - Pelvic examination.
  - Pap smear.

Expenses in excess of any applicable deductible for the health care services listed below are covered under the Comprehensive Health Care Benefit and the **Out-of-Network Services** portion of the Managed Medical Care Program:

- Routine childhood (generally age 6 and under) immunizations for Diphtheria, Pertussis or Tetanus (DPT), measles, mumps, rubella and polio.
- One routine pap smear each calendar year.

- One baseline mammogram for women age 35 through 39.
- One mammogram for women age 40 through 49 every two years, or more frequently if recommended by a **Physician**.
- One annual mammogram for women age 50 or over.
- One annual digital rectal examination age 40 or over.
- One annual stool blood slide test after age 49.
- One proctosigmoidoscopy every three years after age 49.

Psychologists' Services

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

Radiation Therapy

Reconstructive Surgery

Reconstructive breast surgery following a **Medically Necessary** mastectomy, including:

- 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 (swelling associated with removal of lymph nodes).

in a manner determined in consultation with the attending physician and the patient.

Services of Magellan or ValueOptions Providers

(Applies only to the Mental Health and Substance Abuse Care Benefit)

Mental Health Care or **Substance Abuse Care** services provided by a **Magellan** or **ValueOptions Provider**.

Skilled Nursing Facility Care After Hospital Confinement

Services and supplies up to 31 days of confinement following each **Hospital** confinement are covered under the Comprehensive Health Care Benefit. Services and supplies up to 60 days of confinement per calendar year for both **In-Network Services** and **Out-of-Network Services**, combined, following a **Hospital** confinement are covered under the Managed Medical Care Program.

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, Covered Expenses will be limited to the facility's daily charge for a semi-private room.

Speech Therapy

These services must be given to restore speech. The speech must have been lost or impaired due to one of the following:

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

Transportation Services
(Applies only to the CHCB, MMCP and Mental Health Care under the MHSA)

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.

Treatment Center and Outpatient Clinic Services
(Applies only to Out-of-Network Services under the Mental Health and Substance Abuse Care Benefit)

Services and supplies for **Substance Abuse Care** on an inpatient or outpatient basis in a **Treatment Center** or an **Outpatient Clinic**.

- **Inpatient Benefits**
  - Room, board, care and treatment up to 30 days for each confinement.
  - Benefits will be paid for not more than 2 confinements during your or your **Eligible Dependent's** lifetime.
  - If you or your **Eligible Dependent** voluntarily discontinues an approved treatment program before it is completed, not more than $100 will be paid for each day of that confinement and benefits will not be paid for more than 30 days of that confinement.
  - If you or your **Eligible Dependent** used any part of this benefit while covered under The Railroad Employees National Health and Welfare Plan, benefits under this Plan will be determined as if those prior benefits had been used under this Plan.
- **Outpatient Benefits**
  - Services and supplies of a **Treatment Center** or **Outpatient Clinic**, where an overnight stay is not required, for treatment provided by a **Qualified Counselor**. Benefits will not be paid for more than 30 Episodes of Treatment during each benefit period and for more than 2 benefit periods during your or your **Eligible Dependent's** lifetime.
  - The first benefit period starts on the date you or your **Eligible Dependent** incurs the first expense for covered outpatient treatment. It ends 12 months later. The second benefit period starts on the date you or your **Eligible Dependent** incurs the first expense for covered outpatient treatment after the end of the first benefit period. It ends 12 months later.

- If you or your **Eligible Dependent** used any part of this benefit while covered under The Railroad Employees National Health and Welfare Plan, benefits under this Plan will be determined as if those prior benefits had been used under this Plan.

Episode of Treatment means a period in which service or treatment is rendered to the patient alone, to the patient and Immediate Family, or to the patient's Immediate Family alone, as part of a treatment program.

The Immediate Family means the patient's wife or husband and children, and in the case of a dependent child who is the patient, the parents, brothers and sisters of the patient.

Transportation service to or from a **Treatment Center** in your local area for **Substance Abuse Care** is also covered. If there are no local **Treatment Centers** equipped to provide the care needed, transportation service to the nearest **Treatment Center** outside your local area qualified to give the required treatment is covered. In any event, the transportation must be to a **Treatment Center** that is deemed by Magellan or ValueOptions, as the case may be, to provide the most appropriate, effective and economical treatment program for the **Eligible Employee** or **Eligible Dependent**.

Transportation to and from a **Treatment Center** in connection with each confinement covered by the **Out-of-Network Services** portion of the Mental Health and Substance Abuse Care Benefit is limited to a maximum payment of $500.

X-ray and Laboratory Tests

MANAGED PHARMACY SERVICES BENEFIT

The Managed Pharmacy Services Benefit (**MPSB**) covers **Prescription Drugs** that are **Medically Necessary** and that are given for the treatment of an injury, sickness or pregnancy. There are no deductibles, annual out-of-pocket maximums, or lifetime maximum benefits, applicable to the **MPSB**.

Prescription Drug Card Program

This program, administered by PAID Prescriptions, LLC., pays for outpatient **Prescription Drugs** filled at either an In-Network Pharmacy or an Out-of-Network Pharmacy. A greater portion of your **Prescription Drug** cost will be payable by the Plan if you use In-Network Pharmacies. 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 PAID Prescriptions Pharmacy Network. For more information on which pharmacies participate in the PAID Prescriptions Pharmacy Network, call the customer service number 1-800-842-0070.

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

Generic Drugs

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

Brand Name Drugs

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

- The **Brand Name Drug** is ordered by your **Physician** by writing "Dispense As Written" on the prescription.

- The **Brand Name Drug** is dispensed because there is no equivalent **Generic Drug**.

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

- a $6 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 Covered Expenses under any other benefit of the Plan.

Out-of-Network Pharmacy

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

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

Mail Order Prescription Drug Program

Under the Mail Order Prescription Drug Program, administered by Merck-Medco Rx Services, 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 Merck-Medco Rx Services. If you or your **Eligible**

Dependent is not covered under the Plan when a new prescription is received by Merck-Medco Rx Services, 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
- Merck-Medco Rx Services received the prescription before the end of the calendar month following the month coverage was lost.

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

You must pay a co-payment of $5 for each prescription filled by Merck-Medco Rx Services. The co-payment is not a Covered Expense under any other benefit of the Plan.

OBTAINING YOUR MAIL ORDER DRUGS

Mail your original prescription (no copies) or refill slip in the postage-paid order envelope provided by Merck-Medco Rx Services, along with a check or money order for $5 for each prescription or refill submitted.

Complete the information required on the order envelope. If you are submitting your first prescription, complete the Patient Profile Questionnaire as well.

The prescription must be written for a minimum 22-day supply of the drug and for a maximum 90-day supply. However, no prescription will be filled for a supply that is greater than the smallest of a 90-day supply, the supply the dispensing pharmacist deems appropriate in the exercise of his/her professional judgment, the supply recommended by the manufacturers, or the maximum supply permitted by applicable law.

If you need to order envelopes or Patient Profile Questionnaires, or if you have any questions on how to submit an order, contact Merck-Medco Rx Services at 1-800-842-0070.

LIMITATIONS UNDER THE MANAGED PHARMACY SERVICES BENEFIT

The Managed Pharmacy Services 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. *The Managed Pharmacy Services Benefit pays nothing at all for any prescription filled at an Out-of-Network Pharmacy for more than a 21-day supply of the drug.* Benefits for supplies of **Prescription Drugs** for more than 21 days are available under this Managed Pharmacy Services Benefit only if the supply is ordered by mail, and then is limited to a 90-day supply.

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.

You may obtain medicines (other than **Prescription Drugs**) under the Mail Order Prescription Drug program, but not under the Prescription Drug Card program or any other benefit of the Plan. Such medicines must be prescribed for you by a **Physician** and be **Medically Necessary**.

NOT COVERED

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

- Drugs not given for the treatment of an injury, sickness or pregnancy.
- Drugs which are not **Medically Necessary**, including any drugs given in connection with a service or supply which is not **Medically Necessary**.
- Drugs that are considered investigational because they do not meet generally accepted standards of medical practice in the United States.
- Drugs identified by the Food and Drug Administration (FDA) to be less than effective. These drugs are identified on the FDA's most recent list of "DESI Drug Products And Known Related Drug Products That Lack Substantial Evidence Of

Effectiveness And Are Subject To A Notice Of Opportunity For Hearing, And Those That Already Have Had Approval Withdrawn."

- Drugs to treat infertility, oral contraceptives or vitamin supplements, except when **Medically Necessary** and ordered under the Mail Order Prescription Drug program. Oral contraceptives are covered under the Mail Order Prescription Drug program only when ordered for non-contraceptive purposes.

- Nicotine suppressants, except for two courses of treatment per lifetime under the Mail Order Prescription Drug program.

- Allergy serum, immunization agents and biological sera.

- Prescribed devices or supplies of any type including colostomy supplies, contraceptive devices and supplies, hypodermic needles, and syringes. However, needles and syringes prescribed for the administration of insulin, and other prescribed needles and syringes ordered under the Mail Order Prescription Drug program, are covered.

- Drugs given by a **Physician** either in his or her office or as part of a home health care visit.

- Drugs given by a **Hospital** (including take-home drugs), **Skilled Nursing Facility, Home Health Care Agency** or similar place that is not a pharmacy, but has its own drug dispensary.

- Injectables other than insulin, unless they are ordered under the Mail Order Prescription Drug program.

- Progesterone suppositories.

- Dietary supplements.

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*Exclusions applicable to this Managed Pharmacy Services Benefit are set forth under the heading General Exclusions at pages 82 through 85. Also, your benefits may be reduced if you or your **Eligible Dependent** has health benefits under another plan. These benefit reductions are described under the heading*

Coordination of Benefits at pages 86 through 90. Other limitations with respect to Dependents Health Care Benefits are described on pages 28 through 29.

GENERAL EXCLUSIONS

The Plan does not cover any expense for services, supplies or treatment relating to, arising out of, or given in connection with, the following:

- 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 29;

- Cosmetic/Reconstructive Surgery - Cosmetic or reconstructive surgery or treatment, whether or not it is for psychological or emotional reasons, except for

  - surgeries for injury sustained while the patient is covered by the Plan,

  - surgery to restore a bodily function when the malfunction is a result of a birth defect, or

  - reconstructive breast surgery following a **Medically Necessary** mastectomy;

- Custodial - **Custodial Care** (see Definitions);

- Dental Services - care of and treatment to the teeth and gums 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 which happens while covered, and

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

- Dependent Children -

  - a dependent child's pregnancy or the resulting childbirth, abortion or miscarriage;

- a dependent child's expenses if the child is receiving benefits for the same expenses under the Plan as an **Eligible Employee**;

- Dependents' Work Related Injury or Sickness - services or supplies for which your **Eligible Dependent** is entitled to indemnity under any workers' compensation or similar law;

- Donor Expenses - expenses incurred by an organ donor except as provided under the definition of **Eligible Employee** (see pages 10 and 97 through 98).

- Family Members - treatment given by a member of your family (your spouse and the children, brothers, sisters and parents 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;

- **Hospital** Special Care Areas - services and supplies received in a **Hospital** during a confinement in an area of the **Hospital** which is used as a special care area. These areas include but are not limited to the following: **Skilled Nursing Facility**, **Hospice**, **Treatment Center**, adult or child day care center, half-way house, vocational rehabilitation center, **Ambulatory Surgical Center**, **Birth Center**, or any other area of a **Hospital** which renders care on an inpatient basis for other than acute care of sick, injured or pregnant persons. Benefits under the Plan may be available with respect to such services and supplies if they are received through covered facilities, other than **Hospitals**;

- **Medicare**

  - services and supplies received while you or your **Dependent** are a **Person Eligible Under Medicare** if benefits are provided for such expenses under **Medicare**, except to the extent necessary so that the sum of the benefits payable under this Plan and under **Medicare** equal the benefits which would have been payable under the Plan alone;

- services and supplies which are partially or wholly covered under **Medicare** during any period of time for which you or your spouse has rejected this Plan as primary provider of health benefits;

- No Legal Obligation - services and supplies for which you are not legally required to pay or for which you would not have been charged but for the existence of coverage under the Plan. 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;

- Ecological or environmental medicine, diagnosis and/or treatment, such as -

  - chelation therapy except to treat metal poisoning,

  - chemical analysis of hair or nails,

  - gastrogram,

  - Heidelberg capsule,

  - cytotoxic, sublingual or wrinkle allergy testing, and

  - environmental chemical screening for toxins and allergins.

- Specific Services/Supplies -

  - in vitro fertilization, embryo transfer procedure, artificial insemination, immunotherapy for treatment of infertility, sex-change surgery, sterilization (except to avoid a life threatening condition), reversal of sterilization, liposuction, abdominoplasty, rhytidectomy, nutritional counselling, weight reduction or control;

  - 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 sustained while covered;

  - ear examinations, hearing aids or cochlear implants for diagnosis or treatment of hearing loss except to the extent needed for repair of damages caused by bodily injury sustained while covered;

- preventive care, including newborn well baby care, except as specifically provided by the Plan; or
- speech therapy, except as specifically provided by the Plan.

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**,
- **Medicare**, but see pages 131 through 132 with respect to the special rules when **Medicare** and Coordination of Benefits both apply,
- an individual health insurance policy which a person may purchase with his/her own funds, or
- health benefit plans paid for through payroll deductions unless the plan is an employer-sponsored plan.

How Does Coordination Work

One of the plans involved will pay benefits first. (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.

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 Wife and Husband Work for a Participating Employer

If a husband or wife 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 as follows:

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

If Husband or Wife Is Covered Under The Railroad Employees National Early Retirement Major Medical Benefit Plan or as an Employee Under The Railroad Employees National Health and Welfare Plan

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

For the secondary plan, benefits will be determined as follows:

- First determine the **Reasonable Charges** for covered services.
- 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 this Plan is primary, this Plan will

- Determine the **Reasonable Charge** for Covered Services.
- Pay its regular benefit.
- Estimate the benefit that would have been paid by the secondary plan had that plan been primary.
- Subtract the amount this Plan pays from the **Reasonable Charge**.
- Pay the difference, provided the difference is no more than the estimated amount the primary plan would have paid without this provision.

Prescription Drugs

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

- You must pay the full price of the prescription at the pharmacy whether it is an In-Network Pharmacy or an Out-of-Network Pharmacy.

- You must submit the claim to your or your **Eligible Dependent's** primary medical plan.

- Attach the Explanation of Benefits form received from the primary health plan and a copy of the itemized receipt to PAID Prescription's Coordination of Benefits (COB) claim form and return them to PAID Prescriptions, LLC., P.O. Box 702, Parsippany, NJ 07054, (call 1-800-842-0070 to request a form).

You will be reimbursed for the difference, if any, between what the primary health plan paid and 75% of the **Reasonable Charge** for the drug.

The provisions "If Both Wife and Husband Work for a Participating Employer" (see page 88) and "If Husband or Wife is Covered Under The Railroad Employees National Early Retirement Major Medical Benefit Plan or as an Employee Under The Railroad Employees National Health and Welfare Plan" (see page 89 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.

RELEASE OF MEDICAL INFORMATION

As a condition for receiving Health Care Benefits under the Plan, each **Covered Family Member** specifically authorizes:

- any health care provider to 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, and

- any company that administers Health Care Benefits under the Plan to release medical information 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.

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.

V
Definitions

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

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.
- Where licensing is not required, it meets all of the following requirements:
  - It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) and permits a surgical procedure to be performed only by a **Physician** who, at the time the procedure is performed, is privileged to perform the procedure in at least one **Hospital** in the area.
  - It provides at least one operating room and at least one post-anesthesia recovery room.
  - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
  - It has trained personnel and necessary equipment to handle emergency situations.
  - It has immediate access to a blood bank or blood supplies.
  - It provides the full-time services of one or more registered nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room.

Another Railroad Health and Welfare Plan

A health and welfare plan established pursuant to agreement between a railroad or railroads and a labor organization or labor organizations other than this Plan, The Railroad Employees National Health and Welfare Plan, and The Railroad Employees National Early Retirement Major Medical Benefit Plan. 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.

BlueCross BlueShield Participating Provider

A provider who has agreed to negotiated charges for covered services under the Comprehensive Health Care Benefit administered by REGENCE and for **Out-of-Network Services**, other than pursuant to an **Out-of-Network Authorization**, under the Managed Medical Care Program administered by REGENCE.

BlueCross BlueShield Preferred Provider

A provider who has agreed to negotiated charges for covered services as an **In-Network Provider** under the Managed Medical Care Program administered by REGENCE.

Brand Name Drug

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

Certification, Certifies, or Certified

A decision by Magellan or ValueOptions, as the case may be, to approve as **Medically Appropriate** an inpatient admission, an inpatient length of stay, or inpatient or outpatient treatment.

CHCB

The Plan's Comprehensive Health Care Benefit.

COBRA

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

Covered Family Members

You and your **Eligible Dependents** who are covered under the Plan.

Custodial Care

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

- Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.

- Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

Care that meets one of the conditions above is custodial care regardless of any of the following:

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

Eligible Dependent

- Your wife or husband.
- Your unmarried children under 19.
- Your unmarried children between 19 and 25 who:
    - are registered students in regular full-time attendance at school, and
    - are dependent for care and support mainly upon you and wholly, in the aggregate, upon themselves, you, your spouse, and scholarships and the like, and
    - have their legal residence with you.
- Your unmarried children 19 or over who:
    - are dependent for care and support mainly upon you and wholly, in the aggregate, upon you, your spouse, and governmental disability benefits and the like, and
    - have a permanent physical or mental condition that began prior to age 19, and
    - are unable to engage in any regular employment, and
    - have their legal residence with you.
- Your children who are Alternate Recipients under a Qualified Medical Child Support Order.

Children include:

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

Eligible Employee

An **Eligible Employee** is an employee who is employed by a participating employer, who resides in the United States, and who

- as of September 1, 1999, had last worked under a collective bargaining agreement with the UTU;

or

- was hired after September 1, 1999, under a UTU agreement and did not first work under a collective bargaining agreement with the BLE;

or

- after September 1, 1999, had moved to a position covered by a UTU agreement and as of the date of the move had not last worked under a BLE agreement.

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 25 and 32 for details).*

A person who is a living donor of an organ or tissue to an **Eligible Employee** or **Eligible Dependent** will be considered an **Eligible Employee** for the purposes of the Health Care Benefits under the Plan, but benefits will be paid to that person only for Covered Expenses in connection with the donation of an organ or tissue to an **Eligible Employee** or **Eligible Dependent**.

Emergency

For purposes of the Comprehensive Health Care Benefit and the Managed Medical Care Program, the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's health would be placed in serious jeopardy.
- Bodily function would be seriously impaired.
- There would be serious dysfunction of a bodily organ or part.

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

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

Facility

For purposes of the Comprehensive Health Care Benefit and the Managed Medical Care Program, an **Ambulatory Surgical Center** or a **Hospital**.

For purposes of the Mental Health and Substance Abuse Care Benefit, a **Magellan Facility**, a **Non-Magellan Facility**, a **ValueOptions Facility**, or a **Non-ValueOptions Facility**.

Full Medicare Coverage

Coverage for all the benefits provided under **Medicare** Hospital Insurance (Part A) and Medical Insurance (Part B). For purposes of coverage under this Plan, each **Person Eligible Under Medicare** shall be deemed to have **Full Medicare Coverage**.

Full Medicare Coverage will include any benefits which could have been provided under the provisions of **Medicare**, but which are not provided under **Medicare** for any of the following reasons:

- The person is not enrolled in **Medicare**.
- The person is enrolled in a Medicare+Choice Plan.
- The person has received services from a provider who has elected to opt-out of **Medicare**.
- The person is enrolled in a plan with a Medicare Savings Account.
- **Medicare** benefits are reduced because of any benefits paid in accordance with:
    - any plan of insurance regulated by or through action of any automobile reparations act of any government,
    - any policy or plan which includes automobile medical payments benefits, or
    - the provisions of any liability insurance policy or plan.

If a **Person Eligible Under Medicare** receives services from a Veterans Administration facility or other facility of the federal government, **Full Medicare Coverage** shall include benefits which would have been paid by **Medicare** if the services had been provided by a non-government facility.

Generic Drug

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

Home Health Care Agency

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

- It is approved under **Medicare**.
- It is established and operated in accordance with applicable licensing and other laws.
- 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.
    - 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.
- It is approved by **Medicare** as a hospital.
- It meets all of the following criteria:
    - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of **Physicians**;
    - 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 Managed Medical Care Program, a provider participating in the managed medical care network of the company that administers your **MMCP**. If that company is United HealthCare or AUSHC, your **PCP** is an **In-Network Provider**.

In-Network Providers under the **MMCP** administered by REGENCE are referred to as **BlueCross BlueShield Preferred Providers**.

For purposes of the Mental Health and Substance Abuse Care Benefit, a **Magellan Provider** if Magellan administers your **MHSA**, and a **ValueOptions Provider** if ValueOptions administers your **MHSA**.

In-Network Services

For purposes of the Managed Medical Care Program, **Medically Appropriate** covered services received (a) from a provider participating in the managed medical care network of the company that administers your **MMCP** or (b) pursuant to an **Out-of-Network Authorization**.

For purposes of the Mental Health and Substance Abuse Care Benefit, **Medically Appropriate** covered services received (a) from an **In-Network Provider** or (b) pursuant to an **Out-of-Network Authorization**.

Level of Care

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

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

Magellan Facility

A state licensed or authorized institution, program or other health facility which has entered into an agreement with Magellan as an independent contractor to provide covered services to you or your **Eligible Dependents**.

Magellan Provider

A Magellan Facility or Magellan Therapist.

Magellan Therapist

A licensed or certified psychiatrist, **Psychologist**, psychiatric **Social Worker**, or other licensed or certified mental health or substance abuse practitioner who has entered into an agreement with Magellan as an independent contractor to provide covered services to you or your **Eligible Dependents**.

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 IV published by the American Psychiatric Association, or published in the International Classification of Diseases, Ninth 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.

Medically Appropriate

A covered service which has been determined

- by whichever of United HealthCare or REGENCE that administers your **CHCB** with respect to the Comprehensive Health Care Benefit,
- by the company that administers your **MMCP** with respect to the Managed Medical Care Program, or
- by whichever of Magellan or ValueOptions administers your **MHSA** with respect to the Mental Health and Substance Abuse Care Benefit,

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.

Medically Necessary

A service or supply which has been determined (a) by whichever of United HealthCare or REGENCE that administers your **CHCB** with respect to the Comprehensive Health Care Benefit, (b) by the company that administers your **MMCP** with respect to the Managed Medical Care Program, (c) by whichever of Magellan or ValueOptions administers

your **MHSA** with respect to the Mental Health and Substance Abuse Care Benefit, or (d) by PAID Prescriptions, LLC. or Merck-Medco Rx Services, as the case may be, with respect to the Managed Pharmacy Service Benefit, to be:

- a therapeutic response provided for and consistent with the symptoms or proper diagnosis and treatment for the specific covered individual's illness, disease or condition;
- given in accordance with generally accepted principles of **Medical Care**, **Mental Health Care** or **Substance Abuse Care** practice in the U.S. at the time given;
- either:
  - safe and effective according to accepted clinical evidence generally recognized by **Medical Care**, **Mental Health Care**, or **Substance Abuse Care** professionals or publications; or
  - provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to that defined by the National Institutes of Health for a life threatening or seriously debilitating condition. The treatment must be considered safe with promising efficacy as demonstrated by accepted clinical evidence reported by generally recognized medical professionals or publications;
- the appropriate **Level of Care**, unless the service or supply requires prior approval under applicable medical management procedures, or **Certification** under the **MHSA**.
- not primarily for the convenience of the covered individual, his/her family, or the provider.

A determination that a service or supply is not **Medically Necessary** may apply to the entire service or supply or to any part of the service or supply.

Some examples of services and supplies that are not **Medically Necessary** are:

- 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.
- Treatment or consultations provided via telephone.

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 IV published by the American Psychiatric Association, or its equivalent code published in the International Classification of Diseases, Ninth Edition, Clinical Modification, published by the United

States Department of Health and Human Services, 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, autism and mental retardation.
- 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.

MHSA

The Plan's Mental Health and Substance Abuse Care Benefit.

MMCP

The Plan's Managed Medical Care Program.

MPSB

The Plan's Managed Pharmacy Services Benefit.

Non-Certification or Non-Certified

A decision by Magellan or ValueOptions, as the case may be, not to approve as **Medically Appropriate** an in-patient admission, an inpatient length of stay, or inpatient or outpatient treatment.

Non-Magellan Facility

A **Hospital** or **Treatment Center** that is not a **Magellan Facility**.

Non-Magellan Provider

A **Non-Magellan Facility** or a **Non-Magellan Therapist**.

Non-Magellan Therapist

A licensed or certified psychiatrist or other Doctor of Medicine (M.D.), or a **Psychologist**, who is not a **Magellan Therapist**.

Non-ValueOptions Facility

A **Hospital** or **Treatment Center** that is not a **ValueOptions Facility**.

Non-ValueOptions Provider

A **Non-ValueOptions Facility** or a **Non-ValueOptions Therapist**.

Non-ValueOptions Therapist

A licensed or certified psychiatrist or other Doctor of Medicine (M.D.), or a **Psychologist**, who is not a **ValueOptions Therapist**.

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

- With respect to the Mental Health and Substance Abuse Care Benefit, by whichever of Magellan or ValueOptions administers your **MHSA**, or
- With respect to the Managed Medical Care Program, by the company that administers your **MMCP**,

that covered 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 Managed Medical Care Program, a provider not participating in the managed medical care network of the company that administers your **MMCP**.

For purposes of the Mental Health and Substance Abuse Care Benefit, a **Non-Magellan** or **Non-ValueOptions Provider**.

Out-of-Network Services

Covered 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 Abuse Care** and meets all of the following requirements:

- It is licensed, certified or approved as a substance abuse 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.

Person Eligible under Medicare

You or your **Eligible Dependent** if **Medicare** benefits are primary to Plan benefits (see Important Notice about the Plan and Medicare on pages 127 through 132).

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.).

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**.

Pretreatment Outpatient Assessment

The telephonic pretreatment assessment performed at the time a call is made to Magellan or ValueOptions, as the case may be, by an **Eligible Employee** or **Eligible Dependent** (or his/her representative) with respect to any **Mental Health Care** or **Substance Abuse Care** problem. This telephonic pretreatment assessment will be made by Magellan or ValueOptions, as the case may be, with respect to all

outpatient **Out-of-Network Services** and will include a discussion and evaluation of proposed outpatient therapy.

Primary Care Physician (PCP)

(applicable only with respect to the MMCP administered by United HealthCare or AUSHC)

A **Physician** in general practice or who specializes in pediatrics, family practice or internal medicine, and who has agreed with United HealthCare or AUSHC, as the case may be, to act as the entry point to the health care delivery system and as the coordinator of care. The **PCP** is not an agent or employee of the Plan or of United HealthCare or AUSHC, as the case may be.

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.

Reasonable Charge

- For services rendered by a provider who has a negotiated arrangement with a benefits administrator (i.e., AUSHC, Magellan, PAID Prescriptions, REGENCE, United HealthCare, or ValueOptions), an amount that does not, as determined by the benefits administrator, exceed the negotiated amount. Examples of providers who have these arrangements are:
  - BlueCross BlueShield Participating Providers
  - BlueCross BlueShield Preferred Providers
  - In-Network Providers
  - Magellan Providers
  - United HealthCare Preferred Providers

- providers who render services pursuant to an **Out-of-Network Authorization.**

- For all other services, an amount measured and determined by the appropriate benefits administrator by comparing the actual charge with the charges made 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.

Assistant Surgeon Services

Where **Medically Necessary**, the services of an assistant surgeon are limited to one-fifth of the amount of Covered Expenses for the surgeon's charge for the surgery.

Multiple Surgical Procedures

When more than one surgical procedure is performed during the same operative session, Covered Expenses are limited as follows:

- Covered Expenses for the second procedure will be limited to 50% of the **Reasonable Charges** for that procedure had it been performed alone.

- Covered Expenses for any subsequent procedure are limited to 25% of the **Reasonable Charges** for each subsequent procedure had it been performed alone.

Requisite Amount of Compensated Service

Compensated service rendered on an aggregate of at least seven (7) calendar days during a calendar month. This seven-day rule 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 seven (7) calendar days during a calendar month. This seven-day rule 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.

Speech Therapist

A person who is licensed as a speech therapist.

Substance Abuse Care

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

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

Therapist

A **Magellan Therapist**, a **ValueOptions Therapist**, a **Non-Magellan Therapist** or a **Non-ValueOptions Therapist**.

Treatment Center

A facility that provides a program of effective medical and therapeutic treatment for **Substance Abuse Care** and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.

- It provides a program of treatment approved by a **Physician**.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A part of a **Hospital** that meets the criteria set forth above and provides **Substance Abuse Care** that is similar to that which is ordinarily provided by a **Treatment Center**, will be considered a **Treatment Center** for the purposes of this Plan.

United HealthCare Preferred Provider

A provider who has agreed to negotiated charges for covered services under the Comprehensive Health Care Benefit administered by United HealthCare.

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.

ValueOptions Facility

A state licensed or authorized institution, program or other health facility which has entered into an agreement with ValueOptions as an independent contractor to provide covered services to you or your **Eligible Dependents**.

ValueOptions Provider

A **ValueOptions Facility** or **ValueOptions Therapist**.

ValueOptions Therapist

A licensed or certified psychiatrist, **Psychologist**, psychiatric **Social Worker**, or other licensed or certified mental health or substance abuse practitioner who has entered into an agreement with ValueOptions as an independent contractor to provide covered services to you or your **Eligible Dependents**.

VI
Claim Information

How to File a Claim for Comprehensive Health Care Benefits If REGENCE Administers Your CHCB:

If you receive services from a **BlueCross BlueShield Participating Provider**, all you need to do is present your REGENCE identification card. The Provider will bill REGENCE or the local BlueCross BlueShield Plan directly. REGENCE will pay the Provider and send you copies of the payment record. The Provider will bill you for any charges not covered by the **CHCB**, for any applicable deductible amount, and for the coinsurance amount payable by you.

If you receive services from a provider other than a **BlueCross BlueShield Participating Provider**, you will receive a bill for them. To claim your benefits, send a copy of the bill to:

Regence Life and Health Insurance Company
P.O. Box 1071
Portland, OR 97201-1071

and be sure it includes all of the following information:

- the name of the enrolled person who was treated;
- your name and your group and identification numbers;
- a description of the symptoms that were observed or a diagnosis; and
- a description of the services and the dates on which they were given.

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 Comprehensive Health Care Benefits If United HealthCare Administers Your CHCB:

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

United HealthCare
P.O. Box 30985
Salt Lake City, UT 84130

Your claims will be processed in the United HealthCare Regional Claim office designated for your state. The Salt Lake City address is for claim submission purposes only.

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

- the name and social security number of the **Eligible Employee**,
- the patient's name and relationship to the **Eligible Employee**,
- The plan number assigned by United HealthCare: GA-690100,
- the diagnosis,
- an itemized statement of the services rendered, and the charges for those services.

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

How to File a Claim for Mental Health and Substance Abuse Care Benefits:

In-Network Services

When you or your **Eligible Dependent** receives **In-Network Services** covered under the Mental Health and Substance Abuse Care Benefit, 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 Mental Health and Substance Abuse Care Benefit, you or your **Eligible Dependent** is responsible to ensure that the claim is filed with Magellan or ValueOptions, whichever is administering your **MHSA**. Please ask your provider to give you a universal claim form. You may use it to submit your claim. If your provider does not give you the form, call the company administering your **MHSA** and one will be sent to you. The form should be fully completed by you and your provider.

The Magellan address is:

Magellan Behavioral Health
P.O. Box 5234
Columbia, MD 21046-5234

The ValueOptions address is:

ValueOptions
Railroad Unit
Attn: Claims
P.O. Box 1002
Merrifield, VA 22116

How to File a Claim for Managed Medical Care Program Benefits If United HealthCare or AUSHC Administers Your MMCP:

You do not need to file a claim form when you go to your **PCP** or receive services from an **In-Network Provider** upon the referral from your **PCP**. To be reimbursed for **Out-of-Network Services**, however, you must complete and submit a claim.

If you are covered under the **MMCP** administered by United HealthCare, you should provide the same information and follow the same mailing instructions that are set forth on page 118 for filing claims under the CHCB administered by United HealthCare.

If you are covered under the **MMCP** administered by AUSHC, you must complete and submit a claim form and send itemized bills to:

Aetna U.S. Healthcare
P.O. Box 7064
Dover, DE 19903-1512

Be sure to include the employee's name and social security number with each claim submission. To obtain a claim form from Aetna U.S. Healthcare, contact Member Services at 1-888-332-8742.

How to File a Claim for Managed Medical Care Program Benefits If REGENCE Administers Your MMCP:

If you receive services from a **BlueCross BlueShield Preferred** or **Participating Provider**, all you need to do is present your REGENCE identification card and the Provider will bill REGENCE or the local BlueCross BlueShield Plan directly. REGENCE will pay the Provider and send you copies of the payment record. With respect to **In-Network Services**, the Provider will bill you for any charges not covered by the **MMCP** and for any co-payment payable by you. With respect to **Out-of-Network Services**, the Provider's bill to you will include any applicable deductible amount and the coinsurance payable by you.

If you receive **Out-of-Network Services** from a provider other than a **BlueCross BlueShield Preferred** or **Participating Provider**, you will receive a bill for them. To claim your benefits, send a copy of the bill to:

Regence Life and Health Insurance Company
P.O. Box 1011
Portland, OR 97207-1011

and be sure it includes all of the following information:

- the name of the enrolled person who was treated;
- your name and your group and identification numbers;
- a description of the symptoms that were observed or a diagnosis; and
- a description of the services and the dates on which they were given.

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 PAID Prescriptions, LLC. You can obtain a claim form by calling 1-800-842-0070. You must complete the claim form and send it to the following address:

PAID Prescriptions, LLC.
P.O. Box 702
Parsippany, NJ 07054

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

TOLL-FREE TELEPHONE SERVICE

Toll-free service is available as follows:

Comprehensive Health Care Benefit

REGENCE:	1-888-977-2583
United HealthCare:	1-800-691-0013

Medical Management

REGENCE:	1-888-977-2583
United HealthCare:	1-800-842-4555
AUSHC:	1-888-332-8742
Magellan:	1-888-724-5006
ValueOptions:	1-800-934-7245

Managed Medical Care Program

AUSHC:	1-888-332-8742
REGENCE:	1-888-977-2583

United HealthCare: 1-888-445-4379

Mental Health and Substance Abuse Care Benefit
Magellan: 1-888-724-5006
ValueOptions: 1-800-934-7245

Managed Pharmacy Services Benefit
PAID Prescriptions:
For the Prescription Drug Card Program 1-800-842-0070

Merck-Medco Rx Services:
For the Mail Order Prescription Drug Benefit 1-800-842-0070

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 pages 15 through 16), or
  - you believe your child meets the requirements set forth for a disabled child in the definition of an **Eligible Dependent** (see pages 11 and 96), and
  - you or an **Eligible Dependent** is eligible for benefits after coverage ends (see pages 26 through 27).
- require proof of student status if you believe your child meets the requirements for a student in the definition of an **Eligible Dependent** (see pages 11 and 96).
- require periodic information whether a spouse or child is employed and is covered under another plan (see **Coordination of Benefits** section beginning on page 86).

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 Managed Pharmacy Services Benefit, under the **CHCB** administered by REGENCE, and under the **MMCP** administered by REGENCE) and the **Eligible Employee** will receive an Explanation of Benefits.

- If the benefits are for **In-Network Services** covered under the Managed Medical Care Program or the Mental Health and Substance Abuse Care Benefit, 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 REGENCE or United HealthCare, as the case may be (with regard to the Comprehensive Health Care Benefit), the company that administers your **MMCP** (with regard to the Managed Medical Care Program), PAID Prescriptions, LLC. (with regard to the Prescription Drug Card Program), or Magellan or ValueOptions, as the case may be, (with regard to the Mental Health and Substance Abuse Care Benefit) 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 (**CHCB**, **MMCP**, **MHSA** or the Prescription Drug Program) 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.

How to Appeal a Claim Denial

Informal Claim Review

If you do not agree with a claim denial, you may request that an informal review of your claim be made by Magellan or ValueOptions, as the case may be, with respect to the Mental Health and Substance Abuse Care Benefit, by REGENCE or United HealthCare, as the case may be, with respect to the Comprehensive Health Care Benefit, by the company that administers your **MMCP** with respect to the Managed Medical Care Program, and by PAID Prescriptions, LLC., or Merck-Medco Rx Services, as the case may be, with respect to the Managed Pharmacy Service Benefit. The Explanation of Benefits will set forth the reasons for the claim denial and the name, address and telephone number of the appropriate office that will conduct an informal review of the claim denial if you request one.

Formal Appeals from Claim Denials

If you are not satisfied with the informal review of your claim denial, you may make a formal written appeal to CORE, Inc., in Boston, Massachusetts.

The office that handled the informal review of your claim denial will tell you how to make 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. This request must be submitted within sixty (60) days after the informal review of your claim has been completed. If you do not seek informal review within sixty (60) days after the claim was denied, your request for a formal appeal must be submitted before the earlier of sixty (60) days after your claim was denied or one hundred twenty (120) days after your claim was filed if it has not been acted upon by then.

You may submit additional information with your written request for formal appeal and you may request and receive

copies of pertinent documents, although in some cases approval may be needed for the release of confidential information such as medical records. You may also submit issues and comments in writing.

A decision will be made upon your formal appeal within sixty (60) days of receipt of your written request for the appeal. If additional information is required of you, the decision will be made within sixty (60) days of receipt of the required information. You will be notified of the decision in writing and this notice will specify the reasons for the decision and will be written in a manner calculated to be understood by you. The decision will be final.

Actions

You may not sue on your claim more than three years from the time proof of claim is required. However, if any applicable law requires that you have more time to bring suit, you will have the time allowed by that law.

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 Comprehensive Health Care Benefit, the Managed Medical Care Program, the Mental Health and Substance Abuse Care Benefit, and the Managed Pharmacy Services Benefit is subject to the following conditions:

- The Plan, by virtue of payment of benefits, automatically acquires the right to be reimbursed by you, if you or your **Eligible Dependent** recovers from the third party tortfeasor, damages for 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 shall equal but not exceed the amount of such benefits, less the proportionate amount of legal fees and expenses incurred by you or your **Eligible Dependent** in making recovery.

- Except in a case involving an injury incurred while on duty for your employer, the Plan shall be subrogated to and succeed to your right of recovery against any third party

tortfeasor, and in its discretion may exercise such right to the extent of such benefits paid.

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.)**

VII
Additional Information

Important Notice about the Plan and Medicare

MEDICARE ELIGIBILITY

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

1. on the first day of the month the person attains age 65,

2. on the first day of the 29th month following the day the person is found to be totally and permanently disabled under either the Railroad Retirement Act or the Social Security Act,

3. for persons with end stage renal disease, on the earliest of:

    - the first day of the third month after the month the person begins a course of maintenance dialysis treatments, or

    - the first day of the month the person is admitted to an approved hospital for a kidney transplant or procedures preliminary to a transplants, or

    - the first day of the month the person participates in a self-dialysis training program in a **Medicare**-approved training facility, or

4. when the person meets the eligibility requirements of a disabled child.

The Railroad Retirement Board or the Social Security Administration can provide details about **Medicare** eligibility. You may also want to refer to a Health Care Financing Administration booklet called Medicare & You, which gives valuable information about **Medicare**.

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:

- the Plan is primary while the **Eligible Employee** is rendered compensated service,
- **Medicare** is primary during any period when the person is still covered under the Plan but the **Eligible Employee** is not rendered compensated service.

If a person is eligible for **Medicare** while the **Eligible Employee** is rendering compensated service, the person can reject the Plan as primary payer of health benefits. If Plan benefits are rejected, 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, Covered Expenses under the Plan are limited to services and supplies wholly uncovered by **Medicare**. The person must notify United HealthCare in writing to reject Plan benefits.

Medicare Eligibility due to End Stage Renal Disease

If the person is eligible for **Medicare** due to end stage renal disease, the Plan is primary 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, and also due to end stage renal disease), the end stage renal disease rule applies.

*If **Medicare** benefits are 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, Plan benefits will be determined as if the person has enrolled. A person failing to enroll will not receive **Medicare** benefits, and Plan benefits will not be increased to make up for this 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:*

United HealthCare
Railroad Administration
P.O. Box 150453
Hartford, CT 06115-0453

*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 ENROLLMENT

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 or 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 end stage renal disease, see the Special Rule described below.

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 its benefits by that estimated amount. Therefore, when **Medicare** is primary, the person should enroll for Part B **Medicare** when he or she 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 an 8-month period that begin in the month in which the **Eligible Employee** ceases to render compensated service. 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.

*This delay in **Medicare** coverage, and this premium surcharge, will occur even if the person continues to be covered by the Plan after the **Eligible Employee** ceased to render compensated service.*

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 End State Renal Disease

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.

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.

MEDICARE AND COORDINATION OF BENEFITS

If a person is eligible for **Medicare** and is also covered under another employer-sponsored health benefit plan, benefits will be paid in the following order.

- If **Medicare** is secondary to both plans, the normal Coordination of Benefits rules will apply (see pages 86 through 90). **Medicare** will be the third payer.

- If **Medicare** is primary to both plans, **Medicare** will pay first. Then the normal Coordination of Benefits rules will apply. The primary plan will pay second, and the secondary plan will pay third.

- If **Medicare** is secondary to the plan that is primary, and is primary to the plan that is secondary, then benefits are paid as follows:

  - the primary plan will pay first,

  - **Medicare** will pay second, and

  - the secondary plan will pay third.

- If **Medicare** is primary to the plan that is primary, and is secondary to the plan that is secondary, then benefits are paid as follows:

  - the plan that is primary to **Medicare** will pay first (even though under normal Coordination of Benefits rules it would be secondary),

  - **Medicare** will pay second, and

  - the plan that is secondary to **Medicare** will pay third (even though under normal Coordination of Benefits rules it would be primary).

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** premium 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,

- 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:

United HealthCare
Railroad Administration
P.O. Box 150453
Hartford, CT 06115-0453

MEDICARE+CHOICE

The Balanced Budget Act of 1997 included changes to the Medicare Program. Beginning January 1, 1999, Medicare has offered new health plan choices as an alternative to Medicare Parts A and B discussed on pages 129 through 131. These new health plan choices are called Medicare+Choice.

If you are eligible for Medicare, you may enroll in Medicare Parts A and B, or you may select one of the Medicare+Choice Plans. Regardless of the choice you make, the relationship between Medicare and the Plan, as described on these previous pages, will not change.

If you are eligible for a refund of Medicare premiums, as described on page 132, the Plan will reimburse you the premium required for Medicare Part B (and also Medicare Part A if you are required to pay a premium for this coverage). The Plan will not reimburse you for any additional premium required for any of the choices available under Medicare+Choice.

You may obtain more information about Medicare+Choice from the Health Care Financing Administration publication Medicare & You, or by calling any office of the Railroad Retirement Board of Social Security Administration.

Information Required by the Employee Retirement Income Security Act of 1974 ("ERISA")

- Name of Plan:

  National Railway Carriers and United Transportation Union Health and Welfare Plan

- Plan Identification Numbers:

  Employer Identification Number (EIN): 52-2174651
  Plan Number (PN): 510

- Plan Administrator:

  National Carriers' Conference Committee
  Suite 500
  1901 L Street, N.W.
  Washington, D.C. 20036
  (Telephone (202) 862-7200)

  jointly with

  United Transportation Union Health and Welfare Committee
  14600 Detroit Avenue
  Lakewood, Ohio 44107
  (Telephone (216) 228-9400)

  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. Services 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 certain railroads and the United Transportation Union. The railroads and the United Transportation Union are represented in connection with the establishment and maintenance of the Plan by the National Carriers' Conference Committee and by the United Transportation Union Health and Welfare Committee, respectively. The two Committees administer the Plan. When acting as Plan Administrator, the Committees form a single Committee, called the Governing Committee.

- You may obtain a complete list of the railroads that, together with the UTU, sponsor the Plan. You may also obtain a copy of any collective bargaining agreement pursuant to which the Plan was established or is maintained. If you wish to obtain such a list or a copy of any such collective bargaining agreement, you should make your request in writing addressed to either the National Carriers' Conference Committee or the United Transportation Union Health and Welfare Committee. A reasonable charge may be made for the list or copy of an agreement that you request.

- The list of sponsoring railroads and of the collective bargaining agreements will also be made available for examination upon your written request at the office of the National Carriers' Conference Committee, at the office of the United Transportation Union Health and Welfare Committee, at the headquarters office of the UTU, at each employer establishment in which at least 50 employees covered by the Plan customarily work, and at the meeting hall or office of each UTU local in which there are at least 50 members covered by the Plan.

- You may receive, without charge, from the Plan Administrator, upon written request to either address, information as to whether a particular railroad (or other employer) is a sponsor of the Plan, (and if so, its or their addresses), and as to whether such railroad is a participating employer with respect to one or more groups of its employees who are represented by the UTU. However, the Plan Administrator cannot inform you whether you as an individual employee are covered as a participant, because that information is subject to schedule agreements between the railroads and the UTU, to which the Plan Administrator is not a party and as to which it is not informed.

- Type of administration for the Health Care Benefits provided by the Plan: 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

provides a description of your Plan benefits that are available under it. In connection with benefits, the Plan Documents give the various entities that administer the Plan's different Health Care Benefits pursuant to contracts with the Plan Administrator the discretion to construe and interpret the terms of the Plan. If you do not agree with a determination made by any of those entities, you may request a review of your claim (see "How to Appeal a Claim Denial" on page 124).

- Trustee:

  Morgan Guaranty Trust Company of New York
  522 Fifth Avenue
  New York, N.Y. 10036
  (Telephone (212) 483-2323)

- Source of contributions to the Plan:

  Employer contributions.

  Each employer's monthly contribution is calculated by multiplying 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 by the applicable payment rate per employee.

- 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.

See Section VI of this booklet, pages 121 through 122, for information about claim procedures.

- Plan Termination:

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

  An employer or the UTU 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 UTU 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 will terminate as to an employer effective as of the first day of the calendar month beginning after the month during which the employer failed to pay in full all amounts required by the Plan to be paid. An employer will have at least ten (10) days from the date notice of termination is transmitted to the employer from the Plan Administrator or its designee to remedy such failure to pay.

- As a participant in the Plan you are entitled to certain rights and protections under ERISA. ERISA provides that you are entitled, without charge, to examine - at the office of the National Carriers' Conference Committee or the United Transportation Union Health and Welfare Committee, at the headquarters office of the UTU, 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 UTU local in which there are 50 or more members covered by the Plan - all Plan documents, including the collective bargaining agreements pursuant to which the Plan was established and is maintained, and copies of all documents filed by the Plan with the U.S. Department of

Labor, such as detailed annual reports and Plan descriptions.

- You are also entitled to obtain copies of all Plan documents and other Plan information upon written request either to the National Carriers' Conference Committee or to the United Transportation Union Health and Welfare Committee. A reasonable charge may be made for each copy of any document that you request.

- 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 financial report.

- In addition to creating rights for Plan participants, ERISA imposes duties upon the persons who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries," 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 to prevent you from obtaining a benefit provided by the Plan or from exercising your rights under ERISA.

- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

- If you are denied a benefit under the Plan, either in full or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. You also have the right to file suit in a federal or a state court. If plan fiduciaries are misusing the Plan's money, or if you are being discriminated against for asserting your rights, you have the right to file suit in a federal court or request assistance from the U.S. Department of Labor. 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.

- If you have any questions about this statement or your rights under ERISA and the Plan, you should contact the National Carriers' Conference Committee or the Health and Welfare Committee, United Transportation Union, or your employing officer, your UTU representative, or the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Miscellaneous

Options After Coverage Ends

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

- Health Care Benefits may be continued under this Plan for a limited period of time under the provisions of **COBRA** (see pages 21 and 22).
- Retired employees who are over 61 with 30 or more years of railroad service may be eligible for coverage under The Railroad Employees National Early Retirement Major Medical Benefit Plan.
- Employees and surviving dependents may enroll for health coverage under Group Policy GA-23111 issued by United HealthCare.

Information about these options can be obtained by writing to United HealthCare's home office at the following address:

United HealthCare
Railroad Administration
P.O. Box 150453
Hartford, CT 06115-0453

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 applicable toll free number shown on pages 3 and 121 through 122 of this booklet.