BNSF Group Benefits Plan For Pre-Medicare Retirees

Claims Procedures — Medical and Vision Care Programs

CONTENTS

CLAIMS PROCEDURES

Medical and Vision Care Programs for Pre-Medicare Retirees

BNSF Group Benefits Plan

Effective Jan. 1, 2022

CLAIMS PROCEDURES FOR:

- **RETIREE MEDICAL AND VISION CARE BENEFITS**
- **HEALTH REIMBURSEMENT ACCOUNT (HRA)**[1]

Claims procedures are not provided here for the Health Savings Account (HSA)[1] as it is not a benefit under the BNSF Group Benefits Plan. The HSA is a bank account in your name. Procedures for paying expenses from your HSA are determined by the Account Administrator. To ask questions or get details, call the Account Administrator.

Medical Necessity, Compliance with Regulations and Delegation of Authority

A basic requirement of any claim under the Medical Program or Vision Care Program is that the service or supply must be medically necessary. Decisions on medical necessity are made on whether the claim is a pre-service claim, a concurrent care claim for an ongoing course of treatment, an urgent care claim or a post-service claim, as described in the *Defined Terms* section of this Claims Procedures chapter.

Under U.S. Department of Labor (DOL) regulations, if you make a claim under the Medical Program, Vision Care Program or any remaining balance in the HRA[1], you are entitled to full and fair review of your claim. The procedures described in this section are intended to comply with DOL regulations governing the filing of benefit claims, notification of benefit decisions and appeal of adverse benefit decisions.

Defined terms: For the meaning of terms in blue, click to see the *Defined Terms* section.

Previous view: Return to your previous page by right clicking and selecting the "previous view" option.

To add the handy "previous view" button to your toolbar, open your Adobe Reader tools and select Page Navigation, then Previous View.

[1] *Through December 2013, the company funded an HRA or HSA for enrolled participants.*

The Plan Administrator has delegated the discretionary authority to the Claims and Account Administrators listed in the *Administrative Information – Medical and Vision Care Programs for Pre-Medicare Retirees* chapter of this Summary Plan Description (SPD) to interpret the Medical Program and the HRA, and to make both initial claim determinations and final claim review decisions on ERISA appeals. The Vice President and Chief Human Resources Officer retains the discretionary authority to determine whether you or your dependents are eligible to enroll for coverage or to continue coverage under program terms, or over anything else for which the Plan Administrator has reserved final authority and discretion.

Filing a Claim

Any claim that you file *yourself* must be submitted to the Claims Administrator in writing using the appropriate claim form. Claim forms are available from the Claims Administrator. Your claim must include a description of the services provided and the diagnosis or other information establishing medical necessity. All claims should be reported promptly.

Deadlines for filing claims are:

- ***For benefits under the Medical and Vision Care Programs*** – 90 days after the date the services were provided. If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim still will be accepted if you file it as soon as possible. Unless you are legally incapacitated, late claims will not be accepted if they are filed more than 24 months after the date of service.
- ***For reimbursement of expenses from the HRA*** – Anytime, as long as you are a participant in the BNSF Medical Program for Pre-Medicare Retirees and funds remain available in your HRA. However, if your participation in the Medical Program for Pre-Medicare Retirees ends, any claims that you incur *before,* but that you file *after,* your participation ends must be submitted by March 31 following the calendar year in which participation in the Medical Program ends.

Automatic Filing of Medical and Vision Care Claims

If you use an in-network provider under the Medical Program or Vision Care Program, in most cases claims will be filed for you automatically. Some out-of-network providers also file claims for you. However, there may be situations where you must file claims yourself.

Claims to a Limited Purpose HRA

If you have a balance remaining in a *Limited Purpose HRA,* you may use the account only for eligible expenses, such as dental care expenses or vision care expenses that are not paid by the Vision Care Program or another plan. IRS Publication 502, available at irs.gov, provides further details. If you retired prior to Jan. 1, 2017, you may have a Health Savings Account (HSA) debit card from UMB Bank, and an HRA debit card from HealthEquity. If you retired on or after Jan. 1, 2017, you may have two separate debit cards from HealthEquity. Be sure to use your HealthEquity HRA debit card for any limited purpose expenses described above. This way, HRA dollars, which are not portable,[2] are the first to be used.

[2] *HRA balances are available to you as long as you remain covered by the Medical Program or Vision Care Program for Pre-Medicare Retirees or continue coverage under the BNSF Medicare-Eligible Retiree Medical Program (if eligible); otherwise, you forfeit any balance.*

Claims to a General Purpose HRA

If you have a balance remaining in a General Purpose HRA, you may use the account to pay for qualifying health care expenses, including medical, vision and dental expenses that are not paid by your BNSF coverage or another plan. You may use your HealthEquity debit card to access any remaining General Purpose HRA balance as long as you are eligible.

Claims When You Do Not Use the Debit Card – All Accounts

You may file an electronic or paper claim for reimbursement of eligible expenses from your Limited Purpose or General Purpose HRA. Log on to myhealthequity.com. Choose the Claims & Payments tab, then the Request Reimbursement link and follow the prompts to submit a claim for reimbursement.

If your HSA is with HealthEquity, use the same claims steps as described above but choose to be reimbursed from your HSA instead of your HRA. If your HSA is with UMB Bank, log on to hsa.umb.com to request reimbursement from your HSA.

Save Documentation of Expenses

For documentation of expenses that were claimed but not reimbursed under your medical or vision care benefits, be sure to save the Explanation of Benefits (EOB) provided by the Claims Administrator (or the deductible receipt for SurgeryPlus procedures) and related receipts. You will need these records in case you must provide proof of an expense to HealthEquity for HRA claims or to the IRS for HSA distributions.

Notification of Initial Benefit Determination

Except as noted for HRA *debit card* transactions, and for the Medical Program's SurgeryPlus benefit, each time a claim is submitted you or any representative designated by you will receive a written Explanation of Benefits (EOB) explaining how much was paid and whether the claim was denied, in whole or in part.[3] If any part of a claim is denied, the Claims Administrator will provide a written notice of the denial and the reason for the denial. The Claim Denial Notice will:

- Explain the specific reason(s) for the denial;
- Provide the specific reference to the program or HRA provisions that are the reason for the denial;
- Describe any additional information necessary to reverse the denial, or to complete an incomplete claim, and explain why this information is necessary; and
- Explain the program or HRA claim review procedures, any applicable time limits and your right to bring a civil action under Section 502(a) of ERISA following a final denial on appeal.

[3] *Does not apply to Health Savings Account (HSA) withdrawals. The HSA is a bank account that you own.*

If the Claims Administrator used internal guidelines, protocols or other information, the notice will describe this. If you request, the Claims Administrator will provide, free of charge, a copy of the rule, guideline, protocol or other information, as well as reasonable access to documents, records and other data on the claim.

If the claim denial was based on a professional opinion, including decisions on whether a service is experimental, investigational or not medically necessary or appropriate, the Claims Administrator will provide an explanation of the scientific or clinical opinion used in the decision, applying the terms of the program, and an explanation for the denial.

For urgent care claims, the notice will also describe the expedited review process.

For claims under the Medical Program, the notice will also include:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings;
- The reason for the denial, including the denial code and its corresponding meaning, as well as a description of the Medical Program's standard, if any, that was used in denying the claim;
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review process.

Debit Card Transactions

For HRA *debit card* transactions, a written EOB is not provided. If the processing of a debit card transaction was denied, you may call HealthEquity, the Account Administrator for the HRA, or log into your account at myhealthequity.com. In addition, you can see a list of completed HealthEquity debit card transactions for your HRA by accessing your account online at myhealthequity.com or by requesting a statement from the Account Administrator. If the processing of an HRA debit card transaction is denied, you may file a claim appeal as described in the section above titled *Filing a Claim*. If a claim is denied because you failed to provide appropriate documentation, you will need to reimburse HealthEquity for the amount of the claim. If you disagree, you have the right to appeal as explained in the following section.

SurgeryPlus Benefits

Notification of your approval for the 100% SurgeryPlus benefit (after you pay any remaining Medical Program annual deductible) will be provided by SurgeryPlus upon confirming that your prospective treatment or procedure has been accepted by a SurgeryPlus physician. For any deductible you pay, SurgeryPlus will provide a receipt for your records and notify the Medical Program Claims Administrator of the payment.

Timeframes for Deciding Initial Benefit Claims

Urgent Care Claims

The Claims Administrator will decide an initial urgent care benefit claim or appeal as soon as possible, but no later than 72 hours of receipt. With respect to your initial urgent care claim, if necessary information is missing or if you failed to follow the Medical Program's procedures for filing urgent care claims, the Claims Administrator will tell you within 24 hours what information is needed or the procedures to follow. You will be given at least 48 hours to respond to the Claims Administrator. The Claims Administrator will decide the claim within 48 hours after the earlier of the Claims Administrator's receipt of the requested information, or the end of the period of time given to you to provide the requested information. A request for an expedited appeal may be submitted orally or in writing and all necessary information, including the appeal determination, will be transmitted by telephone, facsimile or other similar method.

Timeline
For a timeline view, see Summary Timetable for Claims and Appeals later in this chapter.

Pre-Service Claims

The Claims Administrator will provide a written decision on the initial pre-service claim within 15 days or the appeal of a pre-service claim within 30 days, including requests for pre-determination (advance approval) for medical services. With respect to your initial pre-service claim, if more time is needed because of matters beyond the Claims Administrator's control, you will be notified within 15 days of the Claims Administrator receiving the claim. This notice will tell you the date a decision is expected, which will be no more than 30 days after the Claims Administrator received the claim.

If more time is needed to determine your initial pre-service claim because necessary information is missing, the Claims Administrator will tell you within 15 days or, if you failed to follow the Medical Program's procedures for filing urgent care claims, within five days. The Claims Administrator will tell you what information is needed or the procedures to follow. You must provide that information within 45 days of being notified. The Claims Administrator will notify you within 15 days after the end of that additional period or after receiving your information, whichever is sooner.

Post-Service Claims

The Claims Administrator will decide an initial post-service benefit claim within 30 days or appeal within 60 days of receipt. With respect to your initial post-service claim, if more time is needed to make a decision because of matters beyond the Claims Administrator's control, the Claims Administrator will tell you within 30 days of receiving the claim. This notice will include the date you can expect a determination, which will be no more than 45 days after the Claims Administrator received the claim.

If more time is needed to determine your initial post-service claim because necessary information is missing, the Claims Administrator will tell you within 30 days what is needed. You must provide that information within 45 days of being notified. The Claims Administrator will notify you within 15 days after the end of that additional period or after receiving your information, whichever is sooner.

Ongoing Course of Treatment (Concurrent Care) Claims

You will be notified of any reduction or termination of an approved ongoing course of treatment sufficiently in advance of the reduction or termination to allow you to appeal and receive a determination on appeal before the benefit is reduced or terminated. A request to extend approval of an ongoing course of treatment will be decided based on the type of claim – either urgent care, pre-service or post-service. If urgent care, the Claims Administrator will decide within 72 hours; if pre-service, the decision will be made within 15 days; and if post-service, the decision will be within 30 days. However, if your request is for urgent care and is made at least 24 hours before the approved time period or number of treatments expires, the Claims Administrator will decide within 24 hours.

If Your Claim Is Denied – *Claim Appeal Procedure*

Programs included in the BNSF Group Benefits Plan are subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA has special rules that you or any representative designated by you must follow to appeal a claim denial, as explained in the following sections.

Internal and External Review Processes for Medical Program Claims

The appeal process under the BNSF Medical Program consists of both an internal and an external review. Generally, the appeal first is processed through an internal review. However, if you are in an urgent care situation, you may be allowed to proceed with an expedited external review at the same time that the internal review process is conducted.

Only the internal review (appeal) process applies to other programs of the BNSF Group Benefits Plan.

Timeline

For a timeline view, see Summary Timetable for Claims and Appeals later in this chapter.

Request for Internal Review (Appeal) of Denied Claims

You or your representative may appeal any complete or partial claim denial, including any denial of a pre-service (pre-notification / pre-determination / advance claim review) claim. You or your representative should file a written appeal as soon as you receive a claim denial but *no later than 180 days* from the date you receive the denial. You will forfeit any right to an appeal or to file suit if you do not meet this 180-day deadline. In the case of a reduction or termination of a previously approved course of treatment, the appeal must be made within 30 days from the date you received the denial. If the claim is an urgent care claim, you may appeal and receive an expedited decision. Please see *Timeframes for Deciding Initial Benefits Claims and Appeals* in this chapter.

A person not involved in the initial decision, and who is not a subordinate of someone who made the initial decision, will decide your appeal. The review of your denied claim will not be influenced by the initial decision and will take into account all information submitted by you, regardless of whether it was considered in the initial decision.

Along with your written appeal request, you may submit any additional documents, issues and comments for consideration during the review of your denied claim. If appropriate, you also should include any clinical information from your health care professional supporting your appeal.

If you or your representative requests, the Claims Administrator will provide reasonable access to and copies of all documents, records and other information on your claim, free of charge, including:

- Information relied upon in making the denial;
- Information submitted, considered or generated during the denial decision, whether or not it was used in making the decision;
- Descriptions of the administrative processes and safeguards used in the denial decision;
- Statements of policy or guidance concerning the denied treatment option or benefit, without regard to whether such statement was relied upon in making the benefit determination; and
- The identity of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether or not the advice and consultation were relied upon in the denial decision.

In deciding an appeal of any claim denial that is based in whole or in part on a medical judgment, including determinations as to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional will not be the individual who was consulted in connection with the initial denial or a subordinate of such individual.

For claims under the Medical Program, you will be provided, free of charge, with any new or additional evidence considered by the Claims Administrator and any new or additional rationale for a denial, sufficiently in advance of the deadline for notification of the external review decision to give you a reasonable opportunity to respond prior to that deadline.

Your appeal should be addressed to the appropriate Claims Administrator. See the *Claims Administrators for the BNSF Group Benefits Plan* section of the chapter of this SPD titled *Administrative Information – Medical and Vision Care Programs for Pre-Medicare Retirees*.

Notification of Decision on Appeal

The Claims Administrator will notify you in writing of its final decision within 72 hours for an urgent care claim, 30 days for a pre-service claim, or 60 days for a post-service claim. The notification will include the following:

- The specific reasons for the appeal decision;
- A reference to the specific program provision(s) that is the basis of the decision;
- A statement that you may receive, upon request and without charge, reasonable access to or copies of all documents, records and other relevant to your claim;
- A statement that you may receive, upon request and without charge, a copy of any internal rule, guideline, protocol or similar data relied on in denying your appeal, and/or an explanation of the scientific or clinical judgment for a decision based on a medical necessity, experimental treatment or other similar exclusion or limit; and
- A statement that you have a right to bring a civil action in federal court under Section 502 of ERISA. Such civil action may be brought only if all administrative remedies have been exhausted.

For claims under the Medical Program, the notice will also include:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings;
- The reason for the denial, including the denial code and its corresponding meaning, as well as a description of the Medical Program's standard, if any, that was used in denying the claim and a discussion of the decision;
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review process.

Request for External Review of Denied Medical Claims *(Medical Program Only)*

You may request an external review of a claim denied under the Medical Program if:

- You are appealing a final claim denial or the Claims Administrator's confirmation of a previous claim denial;
- Your request for external review is made within four months of the claim denial; and
- Your claim meets the following eligibility requirements for external review:
  - The Claims Administrator does not strictly adhere to all claim determination and appeal requirements under federal law or;
  - The Medical Program's standard levels of appeal have been exhausted; ***and***
  - The coverage denial is based on medical judgment, including that the service or supply is not medically necessary, is experimental or investigational, resulted from the application of any utilization review, or is a rescission of coverage; or is an adverse determination for surprise bills (medical and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions).

Within five business days of receiving your request for external review, the Claims Administrator will conduct a preliminary review of your claim to determine if:

- You were eligible for benefits under the Medical Program at the time claimed expenses were incurred;
- You have exhausted (or deemed exhausted) the Medical Program's internal review process; and
- You have provided all of the information necessary for an external review.

Within one business day of completing its preliminary review, the Claims Administrator will advise you of its findings. If your request is not complete or not eligible for external review, the Claims Administrator will explain why your claim is not complete or not eligible and provide contact information for the Employee Benefits Security Administration (EBSA). In addition, if the request is not complete, the notification will describe information needed for completion and you will be allowed to provide the additional information within the four-month filing period or

within the 48-hour period following receipt of the notification.

If your request is eligible, an Independent Review Organization (IRO) will be assigned the external review of your claim and will advise you of its assignment and of your right, within 10 business days, to submit any additional information.

You will be notified of a decision to uphold or reverse the adverse determination within 45 days after receipt of the request for an external review.

If your physician confirms that a delay would jeopardize your health, an expedited external review will be completed within 72 hours after the date of receipt of the request for an expedited external review.

In addition to the information provided by you and the Claims Administrator, the IRO will consider:

- Your medical records;
- Your attending health care professional's recommendations;
- Reports from appropriate health care professionals;
- The terms of the Medical Program;
- Appropriate practice guidelines and clinical review criteria; and
- The opinion of the IRO's clinical reviewer(s).

The decision of the IRO is binding on the Claims Administrator, BNSF and the Medical Program. You will not be charged a professional fee for the review.

The external review process will comply with applicable state and/or federal law requirements. Contact the Claims Administrator if you need further details.

The Claims Administrator's decision on appeal is final and binding for all claims except Medical Program claims that are subject to external review. Benefits will be paid only if the Claims Administrator decides, in its sole discretion, that you are entitled to them. If you continue to disagree, you may exercise your ERISA rights. However, you first must exhaust all of your administrative remedies described in this SPD before filing suit for any benefits covered by ERISA. You may not begin a lawsuit later than one year after being notified of the Claims Administrator's final decision. See the chapter of this SPD titled *Your Rights Under ERISA – Medical and Vision Care Programs for Pre-Medicare Retirees*.

Summary Timetable for Claims and Appeals

The following chart shows a timetable view of the above timeframes for deciding *initial* benefit claims and appeals under the Medical Program. See the separate, following chart for claims under the SurgeryPlus benefit.

Type of Notice	Urgent Care Claim	Pre-Service Claim	Post-Service Claim	Ongoing Course of Treatment (Concurrent Care) Claim
Initial Claim Determination (Claims Administrator)	72 hours	15 days	30 days	72 hours if urgent care, 15 days if pre-service or 30 days if post-service[4]
⬇ Extensions	None	15 days	15 days	As appropriate to type of claim
⬇ Additional Information Request (Claims Administrator)	24 hours[5]	15 days[6]	30 days	As appropriate to type of claim
⬇ Response to Additional Information Request (Claimant)	48 hours	45 days	45 days	As appropriate to type of claim
⬇ Claim Determination After Additional Information Request (Claims Administrator)	48 hours	15 days	15 days	As appropriate to type of claim
⬇ Request for Appeal (Claimant)	180 days	180 days	180 days	As appropriate to type of claim
⬇ Appeal Determinations at Each Level of Appeal (Claims Administrator)	72 hours	30 days	60 days	As appropriate to type of claim
⬇ Extensions	None	None	None	

[4] *If you or your representative makes a concurrent care claim no later than 24 hours before the expiration of a previous claim's allowed length of stay or length of treatment and the claim involves urgent care, the Claims Administrator must make its decision within 24 hours of receiving the new claim. You will be notified of any reduction or termination of an approved ongoing course of treatment sufficiently in advance of the reduction or termination to allow you to appeal and receive a determination on appeal before the benefit is reduced or terminated.*

[5] *If claim is improperly filed, Claims Administrator must notify you within this 24-hour period.*

[6] *If claim is improperly filed, Claims Administrator must notify you by the fifth day of this 15-day period.*

SurgeryPlus Benefit	
Appeal of Pre-surgery Assessment (by Claimant)	At timing of the patient's choosing, patient may appeal non-acceptance by a SurgeryPlus physician who determines either the procedure is not medically necessary, or the patient is not suitable for proposed treatment, including necessary travel, by requesting a second opinion with another SurgeryPlus physician.
Appeal of 2nd Pre-surgery Assessment (by Claimant)	At timing of the patient's choosing, patient may appeal non-acceptance by the second SurgeryPlus physician due to the reasons stated above, by seeking services under the Medical Program's Blue Cross Blue Shield-administered coverage.
Post-service Claim for Procedure Outside SurgeryPlus Episode of Care (by Claimant)	For elective procedures not authorized by SurgeryPlus but performed during the episode of care, claimant may submit a claim for related expenses under the Medical Program's Blue Cross Blue Shield-administered coverage. To be considered, the claim normally must be submitted to BCBS within 90 days after the date the services were provided. (See Filing a Claim in this SPD chapter for more about deadlines.)

Coordination with Other Plans Except TRICARE

Some people have other health coverage in addition to coverage under the BNSF Medical Program or Vision Care Program. In these cases, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including BNSF's Medical and Vision Care Programs, have Coordination of Benefits (COB) rules.

Under the BNSF COB rules, the amount normally reimbursed through the BNSF programs may be reduced to take into account payments made by other plans.

Order of Benefit Determination

Here's how the order in which the various plans will pay benefits is decided:

1. A plan with no rules for coordination with other benefits will pay its benefits before a plan that contains these rules.
2. In the case of a dependent child whose parents are divorced or separated:
   - If there is a court decree stating that the parents shall share joint custody, without stating that one of the parents is responsible for the child's health care expenses, the rules provide that the primary plan will be the plan of the parent whose birthday falls earlier in the calendar year or, if both parents have the same birthday, the plan that has covered the parent for the longest amount of time.
   - If there is a court decree which makes one parent financially responsible for the child's health care expenses, the plan that covers the child as a dependent of this parent will pay benefits before any other plan that covers the child.
   - When there is no court decree: If the parent with custody of the child has not remarried, the plan that covers the child as a dependent of the parent with custody will pay benefits before the plan that covers the child as a dependent of the parent without custody.
   - If the parent with custody of the child has remarried, the plan that covers the child as a dependent of the parent with custody will pay benefits before the plan that covers the child as a dependent of the step-parent. The plan that covers the child as a dependent of the step-parent will pay benefits before the plan that covers the child as a dependent of the parent without custody.
3. A plan that covers the person as a retiree of an employer will pay benefits before any plan that covers that same person as a dependent.

4. A plan that covers the person as a laid-off or retired employee, or as a dependent of such a person, will pay benefits after any plan that covers the person as other than a laid-off or retired employee, or a dependent of such person. This does not apply if the other plan does not have a provision relating to laid-off or retired employees.
5. A plan that covers the person because of a federal or state law governing benefits continuation, such as COBRA, will pay benefits after any other plan that covers the person based on any other eligibility requirements.

   If the other plan does not have a provision regarding benefits continuation under federal or state law, the previous paragraph will not apply.

The general rule when the BNSF program is secondary is that the benefits otherwise payable under a BNSF program for all expenses incurred in a calendar year will be reduced by all "other plan" benefits payable for those expenses. When the COB rules of a BNSF program and another plan agree that the BNSF program pays benefits before the other plan, the benefits of the other plan will be ignored. When COB rules operate to reduce the total amount of benefits otherwise payable under these programs, each benefit will be reduced appropriately.

Other Health Care Plan

"Other health care plan" or "other plan" means any other plan of health care expense coverage under:

- Group insurance;
- Any other type of coverage for persons in a group (this includes both insured and uninsured plans); or
- No-fault auto insurance required by law but not provided on a group basis. Only the minimum level of benefits required will be considered.

Effect on Benefits of the Program

When the BNSF Medical Program or Vision Care Program is secondary, the maximum benefits payable, when combined with benefits already paid by other health care plans, will not be more than what the BNSF program would have paid had it been the only plan responsible for coverage. In other words, the total benefits normally payable under the BNSF program will be reduced by the amount of benefits paid by all other plans for the same services and supplies. Benefits payable under other plans include benefits that would have been paid if a proper claim had been made for them.

Example: Assume the BNSF Medical Program pays secondary at an 80% coinsurance rate, your deductible has already been met and you have a $1,000 hospital bill plus a $400 surgery bill, for a total of $1,400. The BNSF program will calculate benefits as though you had no other coverage, and then subtract the amount paid by the other plan from this benefits payable amount. If the other plan pays 80% of these bills, or $1,120, the BNSF program will pay nothing on these bills ($1,400 x 80% = $1,120 – $1,120 paid by other plan = $0). The total paid by both plans is the amount that would have been payable under the BNSF program.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under the BNSF programs and other plans. The Claims Administrator has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount that should have been paid under a BNSF program. If so, the Claims Administrator may reimburse that plan and treat the payment as a benefit paid under the BNSF program. The Claims Administrator will not have to pay that amount again. The term "payment made" includes reasonable cash value of the benefits provided in the form of services.

Coordination with TRICARE

If you are enrolled in TRICARE, the BNSF Medical and Vision Care Programs will provide coverage and pay benefits before your TRICARE benefits are calculated.

End Stage Renal Disease (ESRD)

If you or a covered dependent is Medicare-eligible due to End Stage Renal Disease (ESRD), the BNSF Medical Program will pay benefits before Medicare for the first 30 months after becoming eligible for Medicare based on ESRD.

SUBROGATION AND RIGHT OF RECOVERY

Subrogation

Immediately upon paying or providing any benefit, the BNSF Group Benefits Plan will be subrogated to all rights of recovery a covered person has against any responsible party with respect to any payment made by the responsible party to a covered person due to a covered person's injury, illness or condition to the full extent of benefits provided or to be provided by the Plan.

Reimbursement

In addition, if a covered person receives any payment from any responsible party or insurance coverage as a result of an injury**,** illness or condition, the BNSF Group Benefits Plan has the right to recover from, and be reimbursed by, the covered person for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount the covered person receives from any responsible party.

Constructive Trust

By accepting benefits (whether payment is made to the covered person or made on behalf of the covered person to any provider) from the BNSF Group Benefits Plan, the covered person agrees that if he or she receives any payment from any responsible party as a result of an injury, illness or condition, he or she will serve as a constructive trustee over the funds that constitute the payment. Failure to hold those funds in trust will be deemed a breach of the covered person's fiduciary duty to the BNSF Group Benefits Plan.

Lien Rights

The BNSF Group Benefits Plan will automatically have an equitable lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition for which the responsible party is liable. The lien will be imposed upon any recovery whether by settlement, judgment or otherwise related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the covered person; the covered person's representative or agent; the responsible party; the responsible party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First Priority Claim

By accepting benefits from the BNSF Group Benefits Plan (whether payment is made to the covered person or on behalf of the covered person to any provider), the covered person acknowledges the Plan's recovery rights are a first priority claim against all responsible parties and are to be paid to the Plan before any other claim for the covered person's damages. The Plan will be entitled to full reimbursement on a first-dollar basis from any responsible party's payments, even if that payment to the Plan will result in a recovery to the covered person that is insufficient to make the covered person whole or to compensate the covered person in part or in whole for the damages sustained. The Plan is not required to participate in, or pay court costs or attorney fees to, any attorney hired by the covered person to pursue the covered person's damage claim. The Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, attorney's fees, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

Applicability of All Settlements and Judgments

The terms of this entire Subrogation and Right of Recovery section will apply to all benefits paid by the Plan, and the BNSF Group Benefits Plan is entitled to full recovery regardless of:

- Whether any liability for payment is admitted by any responsible party; and
- Whether the settlement or judgment received by the covered person:
  - Identifies the benefits the BNSF Group Benefits Plan provided, or
  - Purports to allocate any portion of the settlement or judgment to payment of expenses other than medical expenses.

The BNSF Group Benefits Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

Cooperation

The covered person must fully cooperate with the BNSF Group Benefits Plan's efforts to recover its benefits paid. It is the duty of the covered person to notify the Plan within 30 days of the date any notice is given to any party, including an insurance company or attorney, of the covered person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the covered person. The covered person and his or her agents must provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of Plan coverage for the covered person or filing suit against the covered person.

The covered person must not do anything to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of these Subrogation and Right of Recovery provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The covered person acknowledges that the BNSF Group Benefits Plan has the right to conduct an investigation regarding the injury, illness or condition to identify any responsible party. The Plan reserves the right to notify any responsible party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this Subrogation and Right of Recovery provision is ambiguous, or if questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the BNSF Group Benefits Plan (whether the payment of the benefits is made to the covered person or on behalf of the covered person to any provider), the covered person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may choose. By accepting benefits, the covered person hereby submits to each jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Recovery of Overpayment

If you or a beneficiary receives a benefit payment from the BNSF Group Benefits Plan that exceeds the benefit payment that should have been made, the Claims Administrator may recover the excess paid from one or more of the persons it has paid or any other person or organization that may be responsible for the benefits or services provided. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services. If this recovery is not possible, you or the beneficiary will be required to return the excess amount. If the excess amount is not returned, the Claims Administrator and/or Plan Administrator reserve the right to deduct this amount from future benefits payable to you or a beneficiary under the BNSF Group Benefits Plan, or otherwise collect the excess amount.

Special Provision: Another way that plan overpayments are recovered from in-network providers is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Claims Administrator. Under this process, the Claims Administrator reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when the Claims Administrator recovers overpayments for other plans administered by the Claims Administrator. This right does not affect any other right of recovery the Plan may have with respect to overpayments.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. The BNSF Group Benefits Plan has the right to pay any health benefits to the service provider. This will be done unless you have told the Claims Administrator otherwise by the time you file the claim.

The Plan may pay up to $1,000 of any benefit to any of your relatives whom it believes are fairly entitled. This may be done if the benefit is payable to you and you are a minor or are otherwise unable to give a valid release. It also may be done if a benefit is payable to your estate.

Records of Expenses

You should keep complete records of health care expenses for each covered person. They will be required when a claim is made. Very important are:

- Names of physicians, dentists and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

WHO TO CALL ABOUT YOUR BENEFITS

For questions about your claims or claims procedures, call the Claims or Account Administrator for the benefit program in question. Phone numbers are listed in the chapter of this SPD titled *Administrative Information – Medical and Vision Care Programs for Pre-Medicare Retirees* and below.

- BCBS – 888-399-5945
- CVS/caremark (prescription drugs) – 800-378-7559
- UMB Bank (HSA if you retired prior to 2017) – 866-520-4472
- HealthEquity (HSA if you retired on or after Jan. 1, 2017 and HRA) – 866-346-5800
- EyeMed Vision Care – 866-723-0513

For questions about eligibility for benefits or enrolling in any of the programs of the BNSF Group Benefits Plan, call the BNSF Benefits Center at 833-277-8051. Benefits Center representatives are available Monday through Friday, 7 a.m. to 7 p.m. Central time.

DEFINED TERMS

About These Terms

The following definitions of certain words and phrases will help you understand the provisions to which the definitions apply.

Some definitions apply in a special way to specific benefits or provisions. So, if a term that is defined in another chapter of this SPD also appears as a defined term listed here, the definition in the other chapter will apply to that specific chapter rather than the definition below.

Previous view: Return to your previous page by right clicking and selecting the "previous view" option.

To add the handy "previous view" button to your toolbar, open your Adobe Reader tools and select Page Navigation, then Previous View.

Assignment – The transference of a right or interest from one person or entity to another.

BNSF, company, employer – Burlington Northern Santa Fe, LLC, 2301 Lou Menk Drive, Fort Worth, TX 76131, and participating subsidiary companies.

Claim – *As the term applies in the Subrogation and Right of Recovery section:* Any request for a benefit. A communication regarding benefits that is not made according to these procedures will not be treated as a claim. Routine requests for information regarding your benefits under a program or plan of the BNSF Group Benefits Plan and other similar inquiries will not be considered a benefit "claim" that requires processing under ERISA. If you wish to make a claim for benefits under a program or plan of the BNSF Group Benefits Plan in accordance with your rights under ERISA, you must do so in writing to the appropriate Claims Administrator as described in this SPD.

Claimant – An individual covered by the Medical (including HRA) or Vision Care Program. You become a claimant when you make a request for benefits.

Claims or Account Administrator – For identification of Claims Administrators, see the chapter of this SPD titled *Administrative Information – Medical and Vision Care Programs for Pre-Medicare Retirees*. If you retired prior to Jan. 1, 2017, the Health Savings Account (HSA) is administered by UMB Bank, telephone 866-520-4472. If you retired on or after Jan. 1, 2017, the Health Savings Account (HSA) is administered by HealthEquity, telephone number 866-346-5800. And regardless of when you retired, the Health Reimbursement Accounts (HRA) are administered by HealthEquity, telephone number 866-346-5800.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985.

Concurrent care claim – A claim approved by the Claims Administrator for an ongoing course of treatment over a period of time or for a specified number of treatments. There are two types of concurrent care claim review decisions:

- Where the Claims Administrator's reconsideration of an approved claim results in a reduction or termination of the original period of time or number of treatments.
- Where an extension of the approved period of time or number of treatments is requested.

Coordination of Benefits – The Claims Administrator's consideration of the benefits payable by all plans covering the person for a certain service or supply in the determination of any benefit payable by the BNSF Medical Program or Vision Care Program.

Covered person – A covered person under this section includes anyone on whose behalf the BNSF Group Benefits Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan participant or person entitled to receive any benefits from a program or plan under the BNSF Group Benefits Plan.

Discretionary authority – The power or right to decide or act according to one's own judgment and enforce that decision or action.

Episode of care – Applies only to the SurgeryPlus benefit. An episode of care is limited to approved services rendered by SurgeryPlus, and hospital- or facility-related expenses for your specific diagnosis. The episode of care begins on the day you first receive services from the SurgeryPlus provider and ends when you are discharged from the hospital or facility to return home.

ERISA – Employee Retirement Income Security Act of 1974, as amended.

Fiduciary – A person to whom property or power is entrusted for the benefit of another.

Improperly filed claim – Any request for benefits that is not made according to the claims procedures in this chapter.

Insurance coverage – Insurance coverage under this section refers to any coverage providing medical or vision care expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical or vision care payments coverage, Workers' Compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

Lien – The legal claim of one person upon the property of another person to secure the payment of a debt or the satisfaction of an obligation.

Medical necessity, Medically necessary – A service or supply that is commonly and customarily recognized by physicians in a particular medical specialty as appropriate for the diagnosis or treatment of the illness or injury, as determined by the Claims Administrator.

Plan Administrator – Vice President and Chief Human Resources Officer, BNSF Railway Company, 2301 Lou Menk Drive, Fort Worth, TX 76131.

Post-service claim – A claim that involves only the payment or reimbursement of the cost for care that already has been provided. A post-service claim is any claim that is not a pre-service claim, an urgent care claim or a concurrent care claim.

Pre-service claim (pre-notification / pre-determination / advance claim review) – A claim for benefits that may require approval before incurring expenses for care.

Responsible party – Responsible party under this section means any party actually, possibly or potentially responsible for making any payment to a covered person due to an injury, illness or condition. The term "responsible party" includes the liability insurer of that party or any insurance coverage.

Right of Recovery – Right of Recovery applies to the BNSF Group Benefits Plan's right to recover amounts that it pays in benefits for illnesses or injuries caused by someone not covered under the Plan.

Subrogation, Subrogated – Subrogation (or being subrogated to) means putting one person in the place of another. Under this section, it refers to the Claims Administrator taking your place if you are covered under the BNSF Group Benefits Plan and you have a right to recover your costs from someone else. This is done to recover amounts that the Plan paid for you but should have been paid by the person at fault. For example, say you are covered under the Plan and you are injured in an auto accident caused by someone else. The other person's auto insurance is obligated to pay some or all of your expenses for medical care. If the Plan pays your expenses, the Claims Administrator has the right to recover money paid by the Plan from the other insurer.

Surprise bill/surprise billing – A bill that happens when an individual unknowingly gets care from health care providers that are outside of his or her plan's network and can happen for both emergency and non-emergency care.

Urgent care claim – Any claim for care where normal response times could seriously jeopardize the claimant's life or health or ability to regain maximum function; or would, in the opinion of a knowledgeable health care professional, subject the claimant to severe pain that cannot be adequately managed without the requested care. A knowledgeable health care professional can establish a claim as an

urgent care claim. Otherwise, the Claims Administrator will make this determination. If the requested care already has been provided, the claim will be considered a post-service claim.