BNSF Group Benefits Plan For Pre-Medicare Retirees Medical Program

CONTENTS

BNSF MEDICAL PROGRAM FOR PRE-MEDICARE RETIREES

The Big Picture

An Overview of the Medical Program Options

Effective Jan. 1, 2022

MEDICAL PROGRAM OPTIONS IN BRIEF

	Option 1	Option 2
Deductible[1]	$1,500 you only coverage or $3,000 all other coverage tiers[2]	$3,000 you only coverage or $6,000 all other coverage tiers[2]
Maximum HSA Contributions	• Up to $3,650 you only coverage or $7,300 family coverage, or the Internal Revenue Service maximum for the calendar year. • You may also make additional, tax-deductible catch-up contributions of up to $1,000/year.[3]	
Medical Coinsurance (BNSF / You)	Expenses paid after annual deductible: • In-network: 80% / 20% • Out-of-network: 60% / 40%	
Prescription Drug Benefit *See expanded summary.*	• For most prescription drugs: Benefits are paid after your covered medical and prescription drug expenses meet the annual deductible. You then pay a fixed copayment (copay) or coinsurance percentage. • Special benefit for specific preventive medications targeting certain risk factors: No deductible applies. You pay a fixed copayment or coinsurance percentage. • Certain preventive products: Covered at 100%. • Brand-name drugs: If you choose to use a brand-name drug when a generic is available, you will pay the cost difference (unless your doctor requires that the brand name is necessary). The difference will not apply toward your deductible, coinsurance maximum or out-of-pocket expense maximum. • Mail order: Up to 90-day supply available, usually at lower cost than retail. • Specialty drugs: Those included on Archimedes' Specialty Drug List are covered when pre-authorized by the prescription drug Claims Administrator and purchased in-network.	

[1] *The deductible applies to all medical and prescription drug expenses, except preventive care services and specific preventive medications targeting certain risk factors.*

[2] *If you choose coverage for any dependents, you must meet the full family deductible before the program begins paying benefits for anyone in the family. (The deductible does not apply to preventive care services and specific preventive medications targeting certain risk factors.)*

[3] *Your spouse age 55 or older may also make catch-up contributions to his or her own separate HSA.*

	Option 1	Option 2
Your Coinsurance Maximum[4]	• In-network: $2,000 you only coverage or $4,000 for all other coverage tiers. • Out-of-network: $4,000 you only coverage or $8,000 for all other coverage tiers.	
Your Out-of-Pocket Maximum[5]	• In-network: $3,500 you only coverage or $7,000 for all other coverage tiers. • Out-of-network: $5,500 you only coverage or $11,000 for all other coverage tiers.	• In-network: $5,000 you only coverage or $10,000 for all other coverage tiers.[6] • Out-of-network: $7,000 you only coverage or $14,000 for all other coverage tiers.

[4] *Coinsurance maximum assumes you have met the deductible.*

[5] *If you choose coverage for any dependents, your portion of all covered expenses must reach the family out-of-pocket maximum before the program begins paying 100%. Eligible expenses for all enrolled members of the family are paid at 100% for the remainder of the calendar year.*

[6] *An individual in-network out-of-pocket maximum as determined annually by HHS ($8,700 for 2022) applies to retirees with any level of family coverage. For example, in 2022, if any one person within the family pays in-network expenses equal to $8,700, in-network expenses for that person will be paid at 100% for the remainder of the plan year. The rest of the family members must reach the remainder of the in-network family out-of-pocket maximum before the family's expenses are paid at 100%.*

MEDICAL EXPENSES – WHAT'S COVERED UNDER THE MEDICAL PROGRAM FOR PRE-MEDICARE RETIREES IN BRIEF

The Medical Program for Pre-Medicare Retirees offers broad coverage of health care expenses, including those listed below. The *Schedule of Benefits* shown later in this chapter provides a detailed listing of the program's coverage.

Please note that certain limitations, exclusions and penalties may apply to coverage of some of these expenses. For specific information, refer to the sections of this Medical Program chapter titled *Important Rules and Administrative Information in Brief* and *General Exclusions*.

- Physician expenses:
  - Doctor office services
  - Surgeon services
  - Anesthesiologist services
  - Radiologist services
  - Pathologist services
- Prescription drug expenses:
  - Retail pharmacy services
  - Mail-order pharmacy services (in-network only)
- Inpatient hospital expenses:
  - Semi-private room and board
  - Ancillary hospital services
  - Physician services
- Outpatient facility expenses:
  - Services and supplies
  - Laboratory and X-ray testing
  - Therapy
  - Surgery, including charges by a surgery center
  - Emergency room services
  - Urgent care center services
  - Physician services
- Convalescent or skilled nursing facility expenses:
  - Semi-private room and board
  - Services and supplies
- Home health care expenses
- Preventive care expenses:
  - Physician services
  - Laboratory testing
  - Immunizations

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

Links: Click on *blue italic* items to link directly to the section or chapter indicated.

Previous view: Return to the 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.

- Skilled nursing or private-duty nursing care expenses
- Hospice care expenses
- Contraception expenses
- Infertility diagnosis and treatment
- Fertility treatment expenses
- Treatment of gender dysphoria
- Outpatient short-term rehabilitation expenses
- Chiropractor care expenses
- Durable medical and surgical equipment expenses
- Complex imaging expenses
- Other medical expenses:
  - Diagnostic lab and radiology services
  - Radiation and other therapy
  - Professional ambulance service
  - Artificial limbs and eyes

How Your Medical Program Coverage Works in Brief

Financial Protection

Health care benefits at BNSF help shield you from the unexpected burden of major medical expenses. A good way to control your share of medical expenses is to take full advantage of the Medical Program's preventive care benefits, such as those for annual physical exams and preventive medications.

In addition, using in-network providers helps you control expenses since your in-network coinsurance is significantly less than your out-of-network coinsurance. Also note that eligible out-of-network expenses are limited to the reasonable and customary amount set by the Claims Administrator. You are responsible for paying any charges over that amount.

Shared Cost

You and BNSF share in the cost of your coverage. The Medical Program for Pre-Medicare Retirees is self-insured by BNSF, meaning the company pays its share of costs from its general revenues. You pay your part through monthly billing or regular automatic deductions from your BNSF Retirement Plan pension.

Your cost of coverage is based on the deductible option you select, and the family members you include under your coverage. See *How Medical Program Coverage Works* in this chapter for more information.

Deductible, Coinsurance and Copayments

The covered medical expenses that you have paid on your own for doctor visits, prescription drugs and other expenses first must reach the annual deductible before the Medical Program begins paying benefits.[7]

Once you meet the deductible, the Medical Program begins paying a portion of your covered medical expenses and you pay a smaller portion. This is called coinsurance. *Note that if your coverage includes any dependents, you must meet the full family deductible before coinsurance kicks in.* This amount may be reached by one family member or a combination of family members' expenses.

A copayment (or copay) is a fixed amount that you pay for a service. Under the Medical Program, only generic prescription drugs have a copay.

Coinsurance Maximum and Out-of-Pocket Maximum

The Medical Program limits your overall financial risk for covered expenses. If you have met your deductible, and the amount of copays and coinsurance you have paid reaches the coinsurance maximum, you have also reached the annual out-of-pocket maximum. At that point, your Medical Program coverage begins paying 100% of your remaining eligible expenses (including prescriptions) for the rest of the calendar year, provided you stay in-network.

Note that if your coverage includes any dependents, you must meet your full family deductible, and your copays and coinsurance must reach the full family coinsurance maximum before the program begins paying expenses at 100%.[8]

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[7] *Not subject to the deductible are: (1) Eligible preventive care expenses, which are covered at 100%, and (2) Specific preventive medications targeting certain risk factors, for which you pay only a fixed copay or coinsurance. Your share of covered expenses for specific preventive prescription drugs counts toward your annual out-of-pocket maximum.*

[8] *In Option 2, an individual in-network out-of-pocket maximum as determined annually by HHS ($8,700 for 2022) applies to retirees with any level of family coverage. For example, in 2022, if any one person within the family pays in-network expenses equal to $8,700, in-network expenses for that person will be paid at 100% for the remainder of the plan year. The rest of the family members must reach the remainder of the in-network family out-of-pocket maximum before the family's expenses are paid at 100%.*

Health Savings Account (HSA) and Leftover Health Reimbursement Account (HRA) Balances

Your Medical Program coverage, which qualifies as a high-deductible health plan under Internal Revenue Service (IRS) rules, allows you to open a Health Savings Account (HSA),[9] which is an account you own. You may choose to make tax-deductible contributions to your HSA, up to the annual limit set by the IRS, then reimburse yourself from the account for eligible out-of-pocket expenses, including your copays, your coinsurance and other expenses that count toward your deductible. The tax savings help reduce your cost for health care, and the HSA is yours to keep, even after your BNSF coverage for pre-Medicare retirees ends.

When you are enrolled in the Medical Program with an HSA, certain limits apply to your use of any balance remaining in a BNSF Health Reimbursement Account (HRA). (Certain participants accrued HRA balances under previous program provisions.) Under federal and Medical Program rules, that leftover HRA is a Limited Purpose HRA, which can be used only for reimbursement of eligible dental, orthodontia and vision care expenses.[9, 10]

> ***HSA Unavailable to Certain Participants***
> Due to IRS rules, retirees enrolled in a government-sponsored health plan such as TRICARE or VA cannot participate in an HSA. If this applies to you, and you have a balance remaining in a BNSF HRA, you may continue to use that balance for eligible expenses as long as you are covered by a BNSF Medical Program.

For more information about the cash accounts, see the chapter of this Summary Plan Description (SDP) titled *Overview of Medical Options and Cash Accounts for Pre-Medicare Retirees*.

Freedom to Use In-Network or Out-of-Network Providers

When you go to a physician (medical doctor), hospital or other medical care provider, you may have the freedom to choose either an in-network or out-of-network provider. In-network providers have agreed to the network Claims Administrator's standards of care and to charge fees negotiated by the Claims Administrator. This usually results in lower overall costs for you.

For most types of out-of-network care, you pay a greater coinsurance percentage. In addition, an out-of-network provider is not limited to the Claims Administrator's negotiated fee schedule. To the extent permitted by ERISA, you will be responsible for paying the portion of any charge that exceeds the reasonable and customary limit.

You are free to see a specialist without a referral from an in-network doctor.

In-network Physician

You are not required to designate an in-network primary care physician (PCP) from the network. However, it's to your advantage to choose one to provide your preventive and primary care. By getting to know you and your health profile, your PCP is well positioned to see the whole picture of your health care needs and to coordinate appropriate treatment and medications. In addition, your in-network physician can assist you with referrals to in-network specialists.

Preventive Care

Routine medical tests and immunizations are key to maintaining good health and preventing potential health problems. That's why the Medical Program offers periodic physical exams and certain preventive products at no cost to you. In addition, the Medical Program covers expenses for specific preventive medications targeting certain risk factors. See the *Preventive Care Services* section of this Medical Program chapter for details.

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[9] *Unless you are also enrolled in TRICARE or Veterans Administration (VA) coverage. See HSA Unavailable to Certain Participants on this page.*

[10] *These limitations do not apply to HRA balances of participants who are also enrolled in a government-sponsored health plan such as TRICARE or VA. For those participants, the account is a General Purpose HRA.*

Prescription Drugs (Rx)

Coverage of prescription drugs is integrated into your Medical Program coverage. As a result, the prescription expenses you pay are credited to the deductible that applies to all other medical expenses. Once your share of expenses for all eligible medical services – including prescription drugs and supplies – reaches your deductible, benefits begin (see the following exception for specific preventive medications).

In-network coverage is provided through the CVS/caremark network of retail pharmacies. In addition, prescriptions for up to three months of maintenance medications can be filled through local CVS pharmacies and the CVS/caremark mail-order service. If your doctor prescribes a specialty drug (one that requires special handling or ongoing monitoring and assessment by a health care professional), your doctor will send the prescription through Archimedes and then it will be filled by CVS. Details are in the *Prescription Drugs (Rx)* section, later in this Medical Program chapter.

Special Benefit for Specific Preventive Medications

The Medical Program provides special coverage of specific preventive medications targeting certain risk factors, such as listed drugs for asthma, diabetes, heart disease, control of cholesterol and blood pressure, osteoporosis, stroke prevention and tobacco cessation. You pay only a fixed copay or coinsurance percentage, and no deductible applies. (See the *Schedule of Benefits* in this Medical Program chapter.) Amounts you pay for these specific preventive medications count toward your annual out-of-pocket expense maximum.

Formulary Exclusions

CVS/caremark, the prescription drug Claims Administrator, periodically evaluates and excludes certain medications from Medical Program coverage when generic and/or brand-name medications that are judged to be effective and safe are available to treat the same condition. This helps maintain a competitive cost structure. These medications, known as formulary exclusions, are not covered, so you may be required to pay the full cost if you choose to use them. Any such amounts you pay will not count toward your annual deductible, coinsurance maximum or out-of-pocket expense maximum.

Benefit Claims

An advantage of using in-network providers is that the provider usually will file your claim for you automatically, saving you time and effort. You may have to file your own claims if you use an out-of-network provider.

SurgeryPlus Benefit

In addition to your medical coverage, the cost of certain surgeries is 100% covered, after you meet or pay the Medical Program's annual deductible, under the voluntary SurgeryPlus benefit, described later in this document. SurgeryPlus offers personal service to help you find a participating surgeon, plan and schedule your procedure, and coordinate claims payment.

AccessHope Benefit

In addition to your medical coverage, AccessHope offers a cancer support line and second opinion resources to assist you and your dependents if facing a cancer diagnosis.

Rules for Filing Claims and Appeals

The Medical Program has rules for the filing of claims, such as time limits and the information required. It also includes a process for you to appeal claims decisions. Details are in the chapter of this SPD titled *Claims Procedures – Medical and Vision Care Programs for Pre-Medicare Retirees*.

IMPORTANT RULES AND ADMINISTRATIVE INFORMATION IN BRIEF

Requirement to Request Advance Approval of Coverage/ Confirmation of Benefits Payable

To be sure you will receive full benefits under the Medical Program for ***any hospital or facility admissions, as well as certain procedures, services and treatments, you must follow the BCBS pre-notification process before expenses occur***.

Your health care provider may assist you by requesting pre-notification. However, ***it is always <u>your</u> responsibility*** to confirm that BCBS has approved your pre-notification. If you are not certain that your provider has done this, call the Member Services number on your ID card to ask.

For details of these processes, see the section of this Medical Program chapter titled *Pre-notification and Pre-determination of Expenses*.

Benefits Under Other Plans

Due to IRS dual coverage rules, when you participate in medical coverage that allows you to open an HSA (such as the BNSF Medical Program), you – the retiree – cannot simultaneously participate in another plan that pays for medical expenses and contribute to HSA, unless the other plan also qualifies as a high deductible health plan.

This means retirees who have any other medical coverage through a non-governmental plan are not eligible for coverage under the Medical Program, unless the other plan is also a qualified high deductible health plan. Other medical coverage includes your enrollment in your spouse's employer-sponsored medical coverage as well as in a spouse's Health Care Flexible Spending Account (HCFSA). The BNSF Medical Program will not coordinate its benefits for the retiree with the other plan's benefits unless the other plan is a qualified high deductible health plan or is TRICARE, VA or Medicaid coverage.

However, your dependents can be covered by both the BNSF Medical Program and other medical coverage, and the Medical Program will coordinate benefits. For details, see *Coordination with Other Plans Except TRICARE* and *Coordination with TRICARE* in the chapter of this SPD titled *Claims Procedures – Medical and Vision Care Programs for Pre-Medicare Retirees*.

Expenses Owed by Other Parties

Occasionally, other parties are responsible for your medical expenses – for example, if you are injured in an auto accident and another driver is at fault. Your BNSF Medical Program has the right to recover amounts that others are obligated to pay. The related provisions are described under *Subrogation and Right of Recovery* in the chapter of this SPD titled *Claims Procedures – Medical and Vision Care Programs for Pre-Medicare Retirees*.

When Coverage Begins

Coverage under the Medical Program begins at different times, based on various factors, including the timing of your request for coverage and the individuals to be covered. Refer to the chapter of this SPD titled *Who Is Eligible and How to Enroll* for specific information.

When Coverage Ends

Coverage ends for a dependent when he or she is no longer eligible. Your coverage under this Medical Program for Pre-Medicare Retirees ends when you become eligible for Medicare or die. If a covered dependent loses coverage due to his or her loss of dependent eligibility, he or she may choose to continue coverage by paying the full cost. For more information, please see the chapters of this SPD titled *When Coverage Ends – Medical and Vision Care Programs for Pre-Medicare Retirees* and *COBRA – Medical and Vision Care Programs for Pre-Medicare Retirees*.

General and Administrative Information

This SPD contains detailed information, including your privacy rights, which may assist you in using your Medical Program coverage. Refer to the *General Information About Your Right to Benefits* and *Administrative Information – Medical and Vision Care Programs for Pre-Medicare Retirees* chapters of this SPD for details.

Your ERISA Rights

A federal law, ERISA, gives you important rights that are described in the chapter of this SPD titled *Your Rights Under ERISA – Medical and Vision Care Programs for Pre-Medicare Retirees*.

Coverage Details

Medical Program Options

SCHEDULE OF BENEFITS

Note that the "All other coverage tiers" are for coverage levels of you + spouse, you + child(ren) and you + family, and those rows apply to the entire family.

BENEFITS	Option 1		Option 2	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Medical Program Lifetime Maximum Benefit	Unlimited		Unlimited	
Deductible[11] *(per calendar year)*				
• **You only coverage**	$1,500		$3,000	
• **All other coverage tiers**	$3,000		$6,000	
Preventive Care Services *(when provided by physician; see preventive care prescription benefit below)*	100% (no deductible, no coinsurance)		100% (no deductible, no coinsurance)	
Coinsurance (You Pay)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Coinsurance Maximum[12] *(per calendar year)*				
• **You only coverage**	$2,000	$4,000	$2,000	$4,000
• **All other coverage tiers**	$4,000	$8,000	$4,000	$8,000
Out-of-Pocket Maximum *(per calendar year)*				
• **You only coverage**	$3,500	$5,500	$5,000	$7,000
• **All other coverage tiers**	$7,000	$11,000	$10,000[13]	$14,000
You Pay:				
Surgery Under SurgeryPlus Benefit	$0 after deductible		$0 after deductible	
Inpatient Hospital and Facility Admissions and Services[14, 15]	20% after deductible	40% after deductible	20% after deductible	40% after deductible

[11] *Deductible expenses count toward satisfying both the in-network and out-of-network deductibles simultaneously.*

[12] *Coinsurance maximum assumes you have met the deductible. The copays and coinsurance you pay for out-of-network services count toward both the in-network and out-of-network coinsurance maximum. Copays and coinsurance you pay for in-network services count only toward the in-network coinsurance maximum.*

[13] *In Option 2, an individual in-network out-of-pocket maximum as determined annually by HHS ($8,700 for 2022) applies to retirees with any level of family coverage. For example, in 2022, if any one person within the family pays in-network expenses equal to $8,700, in-network expenses for that person will be paid at 100% for the remainder of the plan year. The rest of the family members must reach the remainder of the in-network family out-of-pocket maximum before the family's expenses are paid at 100%.*

[14] *Other than qualifying SurgeryPlus services.*

[15] *Pre-notification required.*

BENEFITS	Option 1		Option 2	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
You Pay:				
Outpatient Procedures and Treatments [16]	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Emergency Hospital, Physician and Ambulance	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Urgent Care Facility	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Physician Office Visit *(except eligible preventive care covered at 100%, no deductible)*	20% after deductible	40% after deductible	20% after deductible	40% after deductible
24-Hour Telemedicine (Teladoc)	20% after deductible (approximately half the cost of an office visit)		20% after deductible (approximately half the cost of an office visit)	
Chiropractor Care *(limited to 60 visits per calendar year)*	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment (DME)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Occupational / Physical / Speech Therapy *(limited to 60 visits per therapy per calendar year)*[16]	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Applied Behavior Analysis (ABA) Therapy	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Cardiac Rehabilitation (*limited to 36 days per calendar year)* [16]	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Convalescent or Skilled Nursing Facility Care *(limited to 60 days per year)*[16]	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Skilled Nursing Care *(private duty nursing limited to 70 shifts/visits per year)*[16]	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Home Health Care *(limited to 40 visits per year)*[16]	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Maternity Care *(prenatal, delivery, postpartum care of mother)*[17]	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Infertility Diagnosis and Treatment	20% after deductible	40% after deductible	20% after deductible	40% after deductible

[16] *Pre-notification required for certain outpatient procedures and treatments.*

[17] *Pre-notification required for certain outpatient procedures and treatments. If a plan member acts as a surrogate mother, typical maternity benefits would apply.*

BENEFITS	Option 1		Option 2	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Fertility Treatment Expenses[18]	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Family Planning Expenses • Tubal ligation and associated ancillary services for females	$0 (no deductible, no coinsurance)	40% after deductible	$0 (no deductible, no coinsurance)	40% after deductible
• Other	20% after deductible	40% after deductible	20% after deductible	40% after deductible
You Pay:				
Medical Pharmaceuticals	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Other Covered Service[19]	20% after deductible	40% after deductible	20% after deductible	40% after deductible

[18] *Coverage of fertility treatment expenses is limited as noted in the following sections of this Medical Program chapter: Fertility Treatment Expenses, Prescription Drug Limitations and Expenses That Are Not Covered.*

[19] *Pre-notification may be required for certain expenses.*

Prescription Drugs **Benefits apply to BOTH Options 1 and 2**		
	In-Network (CVS/caremark)	**Out-of-Network**
Specific Preventive Medications Targeting Certain Risk Factors *(retail and mail order)*	No deductible. You pay only copay or coinsurance amounts shown below.	No deductible. You pay amounts shown below.
Other Prescription Drugs ***Retail*** • **Generic** – Up to 34-day supply	After you meet the annual deductible, you pay: ⬇ ⬇ ⬇ $7.50 (or actual cost, if less)	After you meet the annual deductible, you pay the following amounts **plus** any difference between the actual out-of-network charge and the amount that would have been charged by an in-network pharmacy: ⬇ $7.50 (or actual cost, if less)
– Up to 90-day supply if purchased at CVS pharmacies	$15 (or actual cost, if less)	N/A
• **Formulary brand**[20] – Up to 34-day supply	25% (min. $30, max. $120)	25% (min. $30, max. $120)
– Up to 90-day supply if purchased at CVS pharmacies	25% (min. $60, max. $240)	N/A
• **Non-formulary brand**[20] – Up to 34-day supply	40% (min. $50, max. $150)	40% (min. $50, max. $150)
– Up to 90-day supply if purchased at CVS pharmacies	40% (min. $100, max. $300)	N/A
Mail order *(up to 90-day supply)* • Generic	After you meet the annual deductible, you pay: $15 (or actual cost, if less)	Not covered
• Formulary brand[20]	25% (min. $60, max. $240)	
• Non-formulary brand[20]	40% (min. $100, max. $300)	
Specialty Drugs (Archimedes' Specialty Drug List) • Up to 30-day supply[21]	After you meet the annual deductible, you pay: 25% ($175 max.)	Not covered

[20] *If you choose to use a brand-name drug when a generic is available, you will pay the cost difference (unless the brand-name drug is required by your doctor). The difference will not apply to your deductible or out-of-pocket maximum.*

[21] *When pre-authorized by the prescription drug Claims Administrator, Archimedes.*

How Your Medical Program Coverage Works

Your Contributions for Coverage

The contributions required for each Medical Program option are included with your annual enrollment or newly eligible enrollment materials. The amount of your contribution is determined by:

- The coverage level you choose:
  - You only,
  - You + spouse,
  - You + child(ren), or
  - You + family.
- The deductible option you select.

You make your contributions through regular automatic deductions from your BNSF Retirement Plan pension (unless your pension benefit is not sufficient to cover the required contributions, in which case you will be billed monthly). BNSF regularly reviews the overall cost of medical benefit claims and may adjust the required retiree contributions each year.

Annual Deductibles

The annual deductible is the amount of eligible expenses that you must pay each year before your coverage begins paying benefits. You may use money from your HSA to pay expenses that satisfy the deductible. (If you have a balance remaining in a General Purpose HRA because you are enrolled in a government-sponsored health care plan such as TRICARE or VA, you may use that account to pay expenses that satisfy your deductible.)

The deductible does not apply to certain preventive care services that are covered at 100% or to expenses for specific preventive medications targeting certain risk factors.

Your deductible will differ depending on the medical coverage option you select and whether you cover yourself only or yourself plus one or more eligible dependents (family coverage). The same deductible applies to both in-network expenses and out-of-network expenses. Any portion of an expense that exceeds the Claims Administrator's reasonable and customary limits does not count toward the deductible.

See deductible amounts in the *Schedule of Benefits* of this Medical Program chapter.

Family Deductible

When you cover one or more dependents, federal tax rules that apply to the Medical Program require you to ***satisfy the full family deductible before the program can begin paying benefits for any family member***. That means your combined family expenses must reach $3,000 under Option 1 or $6,000 under Option 2 before program benefits are payable for any family member.[22]

Copayment (Copay)

A copayment (or copay) is the fixed amount you pay for each generic prescription. The copay amounts are shown in the *Prescription Drug Benefit* section of this Medical Program chapter.

[22] *Exception: Certain preventive care services and products and specific preventive medications targeting certain risk factors are covered with no deductible.*

Coinsurance

Coinsurance is the share of expenses that you and the program each pay after you meet your annual deductible. Coinsurance amounts are shown in the *Schedule of Benefits* in this Medical Program chapter. For example, if coinsurance is 80% / 20% for a particular service, the program pays 80% and you pay 20% of each covered charge after you have met your deductible. Your share of coinsurance usually is higher for out-of-network care In addition, charges by out-of-network providers are not limited to the Claims Administrator's negotiated fee schedule. You will have to pay the portion of any provider's charge that exceeds the reasonable and customary limit.

Annual Coinsurance Maximum

If you have met deductible, the annual coinsurance maximum is a limit on the amount of coinsurance (including copays for generic drugs) you could pay each calendar year. This maximum amount is shown in the *Schedule of Benefits* in this Medical Program chapter. There is a separate, higher annual coinsurance maximum for out-of-network expenses compared with in-network expenses. Any portion of an expense that exceeds the Claims Administrator's reasonable and customary limits does not count as coinsurance.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is a limit on the combined amount of deductible expenses and coinsurance (including copays for generic drugs) you could pay each calendar year. This maximum amount is shown in the *Schedule of Benefits* in this Medical Program chapter. There is a separate, higher annual out-of-pocket maximum for out-of-network expenses compared with in-network expenses. Once the share of expenses you have paid reaches your applicable annual out-of-pocket maximum, the program pays 100% of your eligible expenses for the remainder of the year.

Deductible and Out-of-Pocket Limit Exceptions

The following do not count toward the annual deductible or out-of-pocket maximum:

- Charges in excess of the reasonable and customary amount (applicable to out-of-network expenses only).
- The difference in cost of a prescription filled at an out-of-network pharmacy over the same prescription filled at an in-network pharmacy.
- The difference in cost between a brand-name drug over its generic equivalent when you voluntarily choose the brand-name drug.
- Charges for services and supplies not covered under the Medical Program.
- Charges that exceed the applicable annual maximum for a covered expense.
- Expenses that you did not pay, such as drug manufacturer coupons, rebates and other forms of copay assistance.

Annual and Lifetime Maximums

There are no dollar limits on benefits the Medical Program will pay on an annual basis, or over a lifetime, other than those for infertility treatment. (See *Fertility Treatment Expenses* in this Medical Program chapter.) For certain services, there are calendar year limits on the number of services or days of services.

BCBS Network

BCBS has contracted with a broad range of health care providers, including hospitals, physicians and labs, and brought them together into the BCBS Preferred Provider Organization (PPO) network.

These in-network providers, which BCBS calls participating providers, have agreed to offer you quality health care at negotiated contract rates. Using the network saves money for both you and BNSF. While you are free to use any licensed provider, your cost usually will be lower if you use in-network providers.

In addition, certain non-network providers have agreed to accept BCBS' reasonable and customary rates. These providers, which BCBS calls par providers, will be reimbursed at the lower out-of-network percentage.

Out-of-Network Charges for Certain Services

Charges for certain services furnished by an out-of-network provider in an in-network facility while you are receiving in-network services at that in-network facility: (i) are payable at the in-network cost-sharing level; and (ii) the allowable amount used to determine the Plan's benefit payment is the amount agreed to by the out-of-network provider and Claims Administrator, or as required by applicable state or Federal law.

You are responsible for applicable in-network cost-sharing amounts (any deductible, copay or coinsurance). You are not responsible for any charges that may be made in excess of the allowable amount. If the out-of-network provider bills you for a amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact your Claims Administrator at the phone number on your ID card.

Provider Directory

You can search for in-network providers at bcbsil.com/bnsf. If an out-of-network provider is erroreously listed as an in-network provider in the directory and you rely on that information, you will only be responsible for the in-network cost sharing rate and such amounts will be applied to your in-network deductible and out-of-pocket maximum.

Continuity of Care

You may have to find a new health care provider or facility when the Plan's network changes and the health care provider or facility you have is not in the new network or when you are already enrolled in the Plan and your health care provider or facility stops participating in the Plan's network.

In some cases, you may be able to keep going to your current health care provider or facility to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. A continuing care patient is an individual who is undergoing treatment for one of the following: a serious and complex condition, institutional or inpatient care, pregnancy, terminal illness, or a scheduled non-elective surgery.

Routine procedures, minor illnesses, and elective surgical procedures generally are not covered under this continuity of care provision.

If you qualify as a continuing care patient, the Plan will notify you, and you will be given the opportunity to submit a request for continuity of care. If your request is approved, you will generally be entitled to continue your care, subject to the same terms and conditions that applied when your health care provider or facility was in the Plan's network, until the earlier of: (1) the end of a 90-day period that begins on the date you receive notice that you qualify as a continuing care patient, or (2) the date on which you are no longer a continuing care patient with respect to that health care provider or facility.

Two Steps of Pre-approval Required for Admissions and Certain Services and Treatment

The Claims Administrator has two steps of approvals that need to be completed before you incur expenses for admissions and certain services and treatment. Both steps apply whether you use in-network providers or out-of-network providers.

For details of this two-step process, see the section of this Medical Program chapter titled *Pre-notification and Pre-determination of Expenses*.

Retiree Cannot Have Dual Coverage

Due to IRS dual coverage rules, when you participate in medical coverage that includes an option to make contributions to an HSA (such as the BNSF Medical Program for Pre-Medicare Retirees), you – the retiree – cannot simultaneously participate in another plan that pays for medical expenses, unless the other plan also qualifies as a high deductible health plan.

This means retirees who have any other medical coverage are not eligible for coverage under the Medical Program, unless the other plan also qualifies as a high deductible health plan. Other medical coverage includes your enrollment in your spouse's employer-sponsored medical coverage as well as in a Health Care Flexible Spending Account (HCFSA). The BNSF Medical Program will not coordinate its benefits for the retiree with the other plan's benefits unless the other plan qualifies as a high deductible health plan or is TRICARE, VA or Medicaid.

However, your dependents can be covered by both the BNSF Medical Program and other medical coverage, and the Medical Program will coordinate benefits. See *Coordination with Other Plans Except TRICARE* and *Coordination with TRICARE* in the *Claims Procedures – Medical and Vision Care Programs for Pre-Medicare Retirees* chapter of this SPD for details.

HEALTH SAVINGS ACCOUNT (HSA)

You May Make Tax-advantaged Contributions to an HSA

Your Medical Program coverage includes access to a Health Savings Account (HSA) to which you may choose to make tax-advantaged contributions. (If you are also enrolled in a government-sponsored health plan such as TRICARE or VA, your coverage cannot include an HSA due to the "dual coverage" restrictions noted in the previous section.)

For Medical Program claims and administrative purposes, you are considered to be an HSA participant even if you do not have an account with the HSA Administrator.

For more information about the HSA, see:

- *How Your Medical Program Coverage Works in Brief* earlier in this Medical Program chapter.
- The *Cash Accounts Overview* section of the chapter in this SPD titled *Overview of Medical Options and Cash Accounts for Pre-Medicare Retirees*.

COMPREHENSIVE MEDICAL COVERAGE – COVERED EXPENSES

Covered Expenses

Covered Expenses are expenses incurred by a person while covered under this Plan for the charges listed below for:

- Preventive care services, and
- Services or supplies that are medically necessary for the care and treatment of an illness or injury, as determined by the Claims Administrator.

As determined by the Claims Administrator, covered expenses may also include all charges made by an entity that has directly or indirectly contracted with the Claims Administrator to arrange, through contracts with providers of services and/or supplies, for the provision of services and/or supplies listed below.

Any applicable copayments, coinsurance, deductibles or limits are shown in the Schedule of Benefits.

In-network Physician

You are encouraged (but not required) to select an in-network primary care physician (PCP).

Your in-network PCP will provide preventive, basic and routine care, and will refer you to in-network specialists and facilities when medically necessary. Note that a referral to a specialist is not required, but is recommended, to ensure consistent use of network providers.

Medically Necessary

Although a specific service or supply may be listed as a covered expense, it will not be covered unless it is medically necessary for the prevention, diagnosis or treatment of an illness or injury.

Inpatient Hospital Expenses[23]

Charges for hospital room and board, and other hospital services and supplies, are covered when you are confined as a full-time inpatient.

In-network Care

- If a private room is used, the daily room and board charge will be covered if:
  - Your in-network provider requests the private room, and
  - The request is approved by the Claims Administrator.
- If the above requirements are not met, any part of the daily room and board charge that exceeds the semi-private rate is not covered and does not count toward your annual deductible or out-of-pocket expense.

Out-of-network Care

Expenses are covered up to the amount the Claims Administrator considers to be reasonable and customary.

Limitation

No benefit is paid for any out-of-network charge for daily room and board in a private room over the semi-private rate.

[23] *Other than services qualifying under the SurgeryPlus benefit.*

Outpatient Hospital Expenses

Hospital services and supplies also are covered when you are not confined as a full-time inpatient, as shown below.

Outpatient Surgery

Outpatient surgical services are covered to the extent shown below. This includes services:

- From a surgery center, the outpatient department of a hospital, or a physician's or dentist's office.
- By a physician.
- On behalf of a salaried staff physician by the outpatient department of a hospital.
- For outpatient services and supplies furnished in connection with a surgical procedure performed in a surgery center, hospital, or physician's or dentist's office. The procedure must meet these tests:
  - It is not expected to result in extensive blood loss, require major or prolonged invasion of a body cavity, or involve any major blood vessels; and
  - It can safely and adequately be performed in a surgery center, in a hospital or in an office-based surgical facility of a physician or dentist; and
  - It is not normally performed in the office of a physician or dentist.

Outpatient Services and Supplies

Coverage includes:

- Services and supplies furnished by the surgery center, hospital or office of a physician or dentist on the day of the procedure.
- Services of the operating physician for performing the procedure and for:
  - Related pre- and post-operative care, and
  - Administering an anesthetic.
- Services of any other physician for related post-operative care and for administering an anesthetic. This does not include a local anesthetic.

Limitations

No benefit is paid for:

- The services of a physician who renders technical assistance to the operating physician.
- Outpatient charges while you are confined as a full-time inpatient in a hospital.
- Facility charges for office-based surgery.

Convalescent or Skilled Nursing Facility Expenses

The following services and supplies are covered if furnished while you are confined in a convalescent or skilled nursing facility to recover from a disease or injury:

- Room and board. This includes services related to room occupancy (for example, general nursing care). Not included are daily room and board in a private room if the charge exceeds the semi-private rate.
- Use of special treatment rooms.
- X-ray and lab work.
- Restorative physical, occupational or speech therapy.

- Oxygen and other gas therapy.
- Other medical services usually given by a convalescent facility. This does not include private or special nursing, or physician's services.
- Medical supplies.

Limitations

- Benefits are paid for up to 70 visits during any one calendar year.

Home Health Care Expenses

Home health care services are covered if:

- The charge is made by a home health care agency,
- The care is given under a home health care plan, and
- The care is provided in your home.

Coverage includes charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aide services for patient care.
- Restorative physical, occupational or speech therapy.
- The following, to the extent they would have been covered under the Medical Program if you had been confined in a hospital or convalescent facility:
  - Medical supplies,
  - Drugs and medicines prescribed by a physician, and
  - Lab services provided by or for a home health care agency.

Limitations

- Up to 40 home health care visits are covered during a calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to four hours by a home health aide is one visit.
- These home health care services are not covered:
  - Services or supplies that are not a part of the home health care plan.
  - Services provided by someone who usually lives with you or who is a member of your family or your spouse's family.
  - Services of a social worker.
  - Transportation.
  - Services that are considered custodial care.
  - Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.

Preventive Care Services

Preventive care means routine health care that includes screenings, check-ups and patient counseling to prevent illnesses, diseases or other health problems, as determined by the Claims Administrator. Women's health services such as prenatal doctor's office visits, support and counseling, and certain contraceptives also are covered as preventive care services.

Preventive services typically are covered only when conducted and billed as part of an annual physical exam, periodic well-woman exam or periodic well-child check-up. Preventive services for women may be performed in one visit, or in several. Regardless of your age, the Medical Program will cover screenings, preventive immunizations and covered counseling recommended by your doctor due to your individual risk factors.

The Medical Program's preventive care benefits are intended to comply with the requirements of the Affordable Care Act of 2010. For more information, go to healthcare.gov/what-are-my-preventive-care-benefits/.

Routine Physical Exam Expenses

The Medical Program covers an annual routine physical exam (preventive care services) at 100% of eligible expenses with no deductible.[24] A routine physical exam is a medical examination given by a physician for a reason other than to diagnose or treat a suspected or identified injury or illness.

Additional Preventive Health Services

In addition to other services described in this Preventive Care Services section, these services are covered at 100% of eligible expenses with no deductible:

- Screenings and counseling services for:
  - Preventing or reducing the use of alcohol and controlled substances,
  - Sexually transmitted diseases and HIV infection, and
  - Weight reduction due to obesity.
- Women's health services including:
  - Well-woman visits, including Pap smears;
  - Gestational diabetes screening;
  - Human Papillomavirus (HPV) DNA testing;
  - FDA-approved contraception methods and contraceptive counseling (certain contraception methods may be subject to costs, for example, in cases of obtaining a brand-name drug when a generic drug is available or if not prescribed for preventive purposes);
  - Prenatal care office visits; and
  - Domestic violence screening and counseling.

Immunizations

Routine childhood immunizations are covered at 100% with no deductible, as are certain periodic adult re-immunization and immunizations recommended by your doctor due to qualifying personal risk factors as determined by the Claims Administrator.

[24] *Note that if you combine a preventive care office visit with non-preventive services, only 50% of the eligible non-preventive services will be considered. That amount will be subject to your annual deductible and coinsurance.*

It is important to talk with your doctor about any immunizations or screenings that you or a dependent may need based on your personal risk factors, such as personal and family history, and potential exposure to diseases.

Preventive Products

In addition, certain preventive pharmaceutical products are covered at 100% with no deductible, as noted in the *Prescription Drug Benefit* section.

Specific Preventive Medications Targeting Certain Risk Factors

See the *Prescription Drug Benefit* section of this Medical Program chapter for information about special no-deductible coverage of specific preventive medications that are prescribed to target certain health risk factors.

Tobacco Use Cessation

The program encourages quitting the use of tobacco products through coverage of certain tobacco cessation medications prescribed by your doctor, including those covered at 100% or with only a copay or coinsurance with no deductible.

Preventive Care for Children

In addition to the services described above and those in compliance with the Affordable Care Act of 2010, the Medical Program covers routine examinations and childhood immunizations at appropriate ages and frequency as determined by the Claims Administrator and as recommended by the child's doctor.

Coverage of exams includes:

- Physician charges for routine examination;
- X-rays, laboratory, and other screenings and tests done in connection with the exam;
- Counseling of the patient (or child's parents/guardians);
- Guidance to teens and preteens on issues such as tobacco and alcohol use, injury prevention, nutrition, physical activity and sexual health; and
- Immunizations for infectious disease and testing for tuberculosis. However, immunizations for travel or work are not covered under the preventive care benefit.

Age for Well-Child Check-ups
• 7 exams from birth through age 12 months.
• 3 exams in 13th through 24th month.
• 3 exams in 25th through 36th month.
• 1 exam annually thereafter.

Requirements of Exams for All Children

For a dependent child, the physician's exam must include at least:

- A review and written record of the child's complete medical history,
- A check of all body systems, and
- A review and discussion of the exam results with the child or with the parent or guardian.

Preventive Care Limitations – All Participants

Benefits will ***not*** be paid as preventive care for:

- Services covered to any extent under any other part of this Medical Program or other group plan offered or sponsored by BNSF.
- Services for diagnosis or treatment of a suspected or identified injury or disease.
- Exams given while you are confined in a hospital or other place for medical care.
- Services not given by, or under the direction of, a physician.
- Medicines, drugs, appliances, equipment or supplies, except specific preventive medications targeting certain risk factors and certain preventive pharmaceutical products covered at 100% under the program. See the *Prescription Drug Benefit* section of this Medical Program chapter for details.
- Psychiatric, psychological, personality or emotional testing or exams.
- Exams in any way related to employment.
- Premarital exams.
- Dental, vision and hearing exams, except when included as part of routine exams summarized in Preventive Care for Children above.
- A physician office visit related to immunization or testing for tuberculosis. (Note that immunization and testing for tuberculosis are covered as an office visit. Testing is covered as preventive care if it is part of a regular physical exam.)
- Expenses that exceed the reasonable and customary charge for routine preventive care services received from out-of-network providers, including office visit, lab and facility charges.
- A physician office visit and any associated services that is not coded by the provider as preventive.

Skilled Nursing Care Expenses

Coverage includes skilled nursing services from an R.N. or L.P.N. or a nursing agency. Skilled nursing services means private duty nursing by an R.N. or L.P.N. if skilled nursing care is required and visiting nursing care is not adequate.

Limitations

Benefits for skilled nursing services during a calendar year are limited to 70 shifts/visits. Each visit of up to eight hours is one shift.

Benefits are not paid for the following skilled nursing services:

- Any nursing care that does not require the education, training and technical skills of an R.N. or L.P.N., such as transportation, meal preparation, charting of vital signs and companionship activities.
- Any private duty nursing care given while you are an inpatient in a hospital or other health care facility.
- Care provided to help you in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting.
- Any service provided solely to administer oral medicines, except where applicable law requires that these medicines be administered by an R.N. or L.P.N.

- Care provided solely for skilled observation. However, skilled observation of up to one four-hour period per day for up to 10 consecutive days after any of the following occurs is not excluded:
  - A change in patient medication,
  - The need for treatment of an emergency medical condition by a physician,
  - The onset of symptoms indicating the likely need for these services,
  - Surgery, or
  - Release from inpatient confinement.

Aside from the above, benefits are not paid for other charges made by an R.N. or L.P.N. or a nursing agency.

Hospice Care Expenses

The following charges are covered for hospice care when given as a part of a hospice care program:

Facility Expenses

Inpatient Care

Room and board, and other services and supplies are covered while you receive full-time inpatient care at a hospice facility, hospital or convalescent facility for the following items:

- Pain control, or
- Other acute and chronic symptom management.

Not covered are daily room and board charges for a private room to the extent they exceed the semi-private rate.

Outpatient Care

Coverage includes:

- Services and supplies furnished to you by a hospice facility, hospital or convalescent facility while you are not confined as a full-time inpatient.
- Charges by a hospice care agency for:
  - Part-time or intermittent nursing care by an R.N. or L.P.N. for up to eight hours per day.
  - Medical social services under the direction of a physician. These include:
    - Assessment of your social, emotional and medical needs; and the home and family situation;
    - Identification of the community resources available to you; and
    - Assisting you to obtain the resources needed to meet your assessed needs.
  - Psychological and dietary counseling.
  - Consultation or case management services by a physician.
  - Physical and occupational therapy.
  - Part-time or intermittent home health aide services, primarily to care for you, for up to eight hours per day.

- Medical supplies.
- Drugs and medicines prescribed by a physician.

▶ Outpatient care from the following providers, but only if the provider is not an employee of a hospice care agency, and the agency retains responsibility for your care:

- A physician for consultant or case management services.
- A physical or occupational therapist.
- A home health care agency for:
  - Physical and occupational therapy;
  - Part-time or intermittent home health aide services, primarily to care for you, for up to eight hours per day;
  - Medical supplies;
  - Drugs and medicines prescribed by a physician; and
  - Psychological and dietary counseling.

Limitations

Not covered are:

▶ Bereavement counseling.

▶ Funeral arrangements.

▶ Pastoral counseling.

▶ Financial or legal counseling. This includes estate planning and the drafting of a will.

▶ Homemaker or caretaker services. These are services that are not solely related to your care, such as sitter or companion services either for you or other members of the family, transportation, house cleaning and maintenance of the house.

▶ Respite care. This is care furnished when your family or usual caretaker cannot, or will not, attend to your needs.

Family Planning Expenses

Coverage includes services by a physician and/or hospital for voluntary sterilization by vasectomy, or by tubal ligation, including associated ancillary services.

Limitation

Reversal of a sterilization procedure is not covered.

Contraception Expenses

Coverage includes:

▶ Contraceptive drugs and devices approved by the FDA that by law require a physician's prescription. See *Prescription Drug Benefit* and *Preventive Products Covered at 100%*.

▶ Related outpatient contraceptive services such as:

- Consultations,
- Exams,
- Procedures, and
- Other medical services and supplies.

Infertility Diagnosis and Treatment

Coverage includes diagnosis and treatment of a covered female for the underlying medical condition for infertility (the inability to conceive a child after one year of unprotected sexual intercourse, or the inability to sustain a successful pregnancy).

Fertility Treatment Expenses

In addition, after you meet your deductible, the Plan will pay 80% of the following in-network services (or 60% of the following out-of-network services) up to $20,000, with or without diagnosis of an infertility condition.

- In vitro fertilization.
- Gamete intrafallopian tube transfer and zygote intrafallopian tube transfer (only if less costly procedures have not been successful and limited to four completed oocyte retrievals and two more oocyte retrievals after a live birth).
- Uterine embryo lavage.
- Artificial insemination.
- Low tubal ovum transfer.

For example, if you undergo in-network fertility treatment: You will pay the first out-of-pocket expenses until your deductible is satisfied. Then the Plan will pay 80% of the remaining allowed amount up to the $20,000 lifetime maximum; and you are responsible for the remaining fertility treatment expenses. Any claims coming in after the lifetime maximum is met will not be considered a covered expense, or count toward deductibles or out-of-pocket maximums, so you would have full responsibility.

Limitations

Benefits for fertility treatment and all related services and supplies (except outpatient prescription drugs) are subject to a lifetime maximum of $20,000 per covered person. Coverage of prescription medications for fertility treatment is limited to a separate benefit of $5,000 per covered person per lifetime. (See *Covered Prescription Drugs* in this chapter.)

Not covered are:

- Fertility services rendered to a surrogate mother who is not a participant in the Medical Program.
- Cryopreservation and storage of sperm, eggs or embryos, except for procedures using a cryopreserved substance.
- Non-medical costs of an egg or sperm donor.
- Fertility services when the infertility is caused by or related to voluntary sterilization.
- Any experimental, investigational or unproven fertility procedures or therapies.

Treatment of Gender Dysphoria

Coverage includes medically necessary treatment for an individual with gender dysphoria when pre-approved by the Claims Administrator. See the Pre-notification and Pre-determination of Expenses section of this SPD for the pre-approval process.

- Mental health services.
- Hormonal therapy.
- Laboratory testing to monitor prescribed hormonal therapy.

- Age-related, gender-specific services, including but not limited to preventive health, as appropriate to the individual's biological anatomy.
- Chest/top reassignment surgery for female-to-male transitions.
- Genital reassignment surgery and eligible primary and/or secondary sexual characteristic (masculinizing or feminizing) gender reassignment surgeries for an individual age 18 or older.

Outpatient Short-term Rehabilitation Expenses

Coverage includes short-term rehabilitation services by a physician or a licensed or certified physical, occupational or speech therapist for treatment of acute conditions. A short-term rehabilitation service means therapy that is expected to result in the restoration of a body function (including the restoration of previous speech function), which has been lost or impaired due to:

- Injury,
- Disease, or
- Congenital defect.

The following services are covered if:

- You are not confined as an inpatient in a hospital or other facility for medical care, and
- The therapy includes:
  - Physical therapy,
  - Occupational therapy, or
  - Speech therapy.

Limitations

Benefits for short-term rehabilitation services are limited to 60 visits per therapy, per year.

Not covered are:

- Any services that are covered to any extent under any other plan sponsored by BNSF.
- Services not performed by a physician or under his or her direct supervision.
- Services rendered by a physical, occupational or speech therapist who resides in your home or who is a part of your family or your spouse's family.
- Services for the treatment of delays in speech or other developmental delays, unless resulting from:
  - Disease,
  - Injury, or
  - Congenital defect that can be corrected through surgery, such as cleft lip/palate.
- Services for the treatment of diagnoses that are considered developmental and/or chronic, including Down syndrome and cerebral palsy.
- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired.

- Services that also would be eligible under the Medical Program's Chiropractor Care benefit, whether or not benefits for the maximum number of Chiropractor Care visits have been paid.
- Services that are not considered restorative.

In addition, no service is covered unless it follows a specific treatment plan that details the treatment to be given and its frequency and duration.

Applied Behavior Analysis (ABA) Therapy

Coverage includes Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder (ASD) Diagnosis when determined to be medically necessary by the Claims Administrator.

Outpatient Cardiac Rehabilitation

Coverage includes cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when determined to be medically necessary by the Claims Administrator. Program must be physician directed with active treatment and EKG monitoring.

Limitations

Benefits for outpatient cardiac rehabilitation services are limited to 36 visits per year.

Autism Habilitation Coverage

The medical options will cover generally recognized services prescribed for autism spectrum disorder in children diagnosed prior to age 10, which may include:

- Evaluation and assessment services
- Applied behavior analysis
- Behavior training and behavior management
- Speech therapy
- Occupational therapy
- Physical therapy
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder

In addition, no service is covered unless it follows a specific treatment plan that details the treatment to be given and its frequency and duration.

Chiropractor Care Expenses

Coverage includes treatment of spinal subluxation or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Limitations

Benefits for Chiropractor Care visits are limited to 60 visits in a calendar year. However, this maximum does not apply to services:

- While you are a full-time inpatient in a hospital.
- For treatment of scoliosis.
- For fracture care.

- For surgery, including pre- and post-surgical care given or ordered by the operating physician.

Durable Medical and Surgical Equipment (DME) Expenses

Coverage includes:

- Rental of durable medical and surgical equipment.
- Initial purchase of durable medical and surgical equipment and accessories needed to operate it only if the Claims Administrator is shown that:
  - Long-term use is planned, and
  - The equipment cannot be rented, or it is likely to cost less to buy it than to rent it.
- Repair or replacement of purchased durable medical and surgical equipment and accessories. Replacement is covered only if the Claims Administrator is shown that:
  - It is needed due to a change in your physical condition, or
  - It is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.
- Charges for oxygen.

Limitations

Not included are:

- More than one item of equipment for the same or similar purpose.
- Equipment that is:
  - Normally of use to persons who do not have a disease or injury,
  - For use in altering air quality or temperature, or
  - For exercise or training.

Complex Imaging Expenses

Complex Imaging Services are covered when provided on an outpatient basis in a:

- Physician's office,
- Hospital outpatient department or emergency room, or
- Licensed radiological facility.

Only Complex Imaging Services determined to be medically necessary by the Claims Administrator are covered. These may include:

- Computerized axial tomography (CAT) scans,
- Magnetic resonance imaging (MRI), and
- Positron emission tomography (PET) scans.

Other Medical Expenses

Coverage also includes:

- Physician services unless otherwise excluded.
- Diagnostic lab work and X-rays.
- X-rays, radium and radioactive isotope therapy.
- Anesthetics and oxygen.

- Acupuncture services provided by a physician if the service is performed as a form of anesthesia in connection with a covered surgical procedure.
- Professional ambulance service to transport you from the place where you are injured or stricken by disease to the closest hospital where adequate treatment can be given.
- Artificial limbs and eyes.
- Wigs for covered medical conditions, as determined by the Claims Administrator, limited to one per lifetime.
- Walk-in clinic visits for unscheduled, non-emergency illnesses and injuries, and the administration of certain immunizations administered within the scope of the clinic's license.
- Dialysis performed at an in-network facility.
- Bariatric surgeries performed in-network at designated surgical facilities, if determined to be medically necessary, based on the clinical guidelines of the Claims Administrator, on an inpatient or outpatient basis by a hospital or a physician for the surgical treatment of morbid obesity. *You must contact the Claims Administrator in advance of this procedure to ensure that you have met all requirements necessary for this procedure to be covered.*
- Acquired brain injury therapy and rehabilitation services, including cognitive rehabilitation therapy; cognitive communication therapy; biofeedback therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment; neurofeedback therapy; remediation (to restore or improve a specific function); and post-acute transition and/or or community reintegration services including outpatient day treatment. Maximum 60 visits per calendar year for outpatient cognitive therapies.

Limitations

The Medical Program does not cover:

- Eyeglasses.
- Vision aids.
- Hearing aids.
- Communication aids.
- Orthopedic shoes, foot orthotics or other devices to support the feet, unless necessary to prevent complications of diabetes, based on the clinical guidelines of the Claims Administrator.

Transplant Expenses

The Medical Program covers in-network and out-of-network expenses for many types of human organ, stem cell, bone marrow and tissue transplants under its provisions for physician, inpatient hospital and other related expenses described elsewhere in this Medical Program SPD.

Special Transplant Network Coverage

For the following specific human organ and tissue transplants, *in-network coverage* is provided exclusively through the Claims Administrator's transplant network. Any services that you receive for these transplants outside of the Claims Administrator's transplant network program are considered out-of-network.

- Bone marrow/stem cell

- Combination heart/lung
- Heart
- Liver
- Lung
- Pancreas
- Simultaneous pancreas/kidney

Your care provider must follow the processes described below under Pre-notification and Pre-determination of Expenses to determine if a proposed transplant is covered, and if so, what benefits will be payable.

Benefits are available to both the recipient and donor under the following rules:

- If both donor and recipient have their own medical coverage, each will have their benefits paid by their own coverage.
- If you are a recipient and the donor has no medical coverage from any source, Medical Program benefits will apply to the donor for transplant purposes only.
- If you are the donor and no coverage is available to you from any other source, you will be covered under the Medical Program. No benefits will be provided for the recipient under the program.

Transplant coverage begins at the point of evaluation for a transplant and ends either 180 days from the date of the transplant, or on the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later. Only U.S. or Canadian transportation of a donor organ is covered.

No benefits are provided for transportation of a donor or recipient by an ambulance, or for travel time and related expenses of a medical provider.

BCBS Blue Distinction Centers Transplant Network

In addition to specific transplants, the BCBS Blue Distinction Centers transplant network provides transplant-related services including initial evaluation and follow-up care. Hospitals that have exhibited successful clinical outcomes, met quality of care standards and agreed to acceptable contractual terms have been selected to participate in the network for one or more specific transplants.

Any transplant-related services, including initial evaluation, donor expenses, transplant and follow-up care, will be considered out of network if they are not specifically contracted under the BCBS transplant network program.

Any facility or physician that is not specified as a BCBS Blue Distinction Center is considered out-of-network for transplant-related services, even if the facility or physician is considered in-network for other types of services.

Additional Covered Expenses When You Use the Transplant Network

The transplant network program coordinates solid organ and bone marrow transplants and other specialized care for the types of transplants listed under Special Transplant Network Coverage. When the patient's care is directed to a medical facility more than 100 miles from the patient's home, the transplant program will pay a benefit for travel and lodging expenses, as follows:

Travel Expenses

Covered travel expenses include:

- The patient's transportation between his or her home and the medical facility to receive services related to an approved procedure or treatment, and
- A companion's expenses for transportation when traveling to and from the patient's home and the medical facility for the patient to receive approved services.

Lodging Expenses

- The patient's expenses are covered for lodging away from home while traveling between his or her home and the medical facility to receive services related to an approved procedure or treatment.
- A companion's expenses for lodging away from home are also covered:
  - While traveling with the patient between the patient's home and the medical facility for the patient to receive approved services; or
  - When the companion's presence is required to enable the patient to receive services from the medical facility on an inpatient or outpatient basis.

Limitations

The maximum benefit for lodging expenses is $50 per person per night.

To determine travel and/or lodging expenses, home means the origination point from which a patient travels to begin treatment at the medical facility, or to which he or she travels after discharge. This could be the patient's residence, or a hospital or other temporary residence where the patient was either staying before traveling to the medical facility or will be staying after leaving the medical center.

For any one procedure or treatment type:

- The maximum combined travel and lodging benefit is $10,000 per episode of care.
- Expenses are eligible for reimbursement from the day the patient is approved under the BCBS Blue Distinction Centers or until whichever of the following occurs first:
  - One year after the day the procedure is performed, or
  - The date the patient stops receiving any services from the medical facility in connection with the procedure.

Travel and lodging benefits will not be paid for any charges that are covered by any other part of this Medical Program or any other plan. Expenses may be covered for only one companion who travels with the patient.

Emergency Room Treatment Expenses

Hospital emergency room services are covered if:

- Treatment is received while you are not a full-time inpatient, and
- The treatment is for an emergency service.

Out-of-Network Services

Note that out-of-network providers do not have a contract with the Claims Administrator and may not accept payment of your cost share (your deductible and coinsurance) as payment in full.

1. Emergency Services are covered at the in-network cost-sharing level if services are received from an out-of-network provider.

2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an out-of-network hospital, or by an out-of-network provider in an in-network hospital, is the amount agreed to by the out-of-network provider and Claims Administrator, or as required by applicable state or Federal law.

3. The allowable amount used to determine the Plan's benefit payment when out-of-network Emergency Services result in an inpatient admission is the median amount negotiated with in-network facilities.

You are responsible for applicable in-network cost-sharing amounts (any deductible, copay or coinsurance). You are not responsible for any charges that may be made in excess of the allowable amount. If the out-of-network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact the Claims Administrator at the phone number on your ID card. Make sure your member ID number is on the bill.

Limitation

Expenses for non-emergency treatment in an emergency room are covered as Outpatient Hospital Expenses.

Urgent Care Treatment Expenses

Services of a hospital or urgent care provider to evaluate and treat an urgent condition are covered, including:

- Use of emergency room facilities when in-network urgent care facilities are not in your service area and you cannot reasonably wait to visit your physician.
- Use of urgent care facilities.
- Physicians' services.
- Nursing staff services.
- Radiologists' and pathologists' services.

Please contact your primary care physician (PCP) after receiving treatment of an urgent condition. If you visit an urgent care provider for a non-urgent condition, the program will not cover your expenses.

When traveling to an urgent care provider for treatment of an urgent condition is not feasible, treatment by any licensed provider may be covered as in-network care. If a claim for treatment of an urgent condition is paid at the out-of-network level and you believe that it should have been paid at the in-network level, please call the Claims Administrator at the phone number shown on your medical ID card.

Limitations

Services provided by an urgent care provider for a non-urgent condition are not covered.

Non-urgent care includes, but is not limited to:

- Routine or preventive care (including immunizations).
- Follow-up care.
- Physical therapy.
- Elective surgical procedures.
- Any lab and radiologic exams that are not related to the treatment of the urgent condition.

Walk-in Clinic Expenses

Coverage includes services of walk-in clinics for:

- Unscheduled, non-emergency illnesses and injuries, and
- Administration of certain immunizations.

Telemedicine[25]

Through the telemedicine service, a doctor is available by phone 24 hours a day, 365 days a year. For a flat per-use fee, you can speak with a doctor by phone or two-way video to help diagnose, recommend treatment and prescribe medication for many common medical issues. The service is intended as a convenience when you are traveling, having trouble getting a timely appointment with your doctor or need medical advice when an office visit is impractical. Telemedicine fees count toward your Medical Program annual deductible. You pay separately for any prescribed medications at the pharmacy.

Typical reasons to use telemedicine include:

- Cold and flu symptoms,
- Bronchitis,
- Allergies,
- Poison ivy,
- Pink eye,
- Urinary tract infections,
- Respiratory infections,
- Sinus problems, and
- Ear infections.

Treatment of Alcoholism, Drug Abuse or Mental Disorders

Inpatient Treatment

Coverage includes full-time inpatient care in either a hospital or treatment facility.

Hospital

- Treatment of the medical complications of alcoholism or drug abuse. This means conditions such as cirrhosis of the liver, delirium tremens or hepatitis.
- Effective treatment of alcoholism or drug abuse.
- Treatment of mental disorders.

Treatment Facility

- Room and board at the semi-private room rate and other necessary services and supplies for:
  - Certain expenses for the effective treatment of alcoholism or drug abuse, and
  - Treatment of mental disorders.

[25] *Restrictions may apply depending on where you live. See the Administrative Information – Medical and Vision Care Programs for Pre-Medicare Retirees chapter of this SPD for identification of Claims and Account Administrators and how to contact them.*

Partial Confinement Treatment

Benefits are paid for covered services given through a partial confinement treatment program by either a hospital or residential treatment facility, including those for the effective treatment of alcoholism or drug abuse, or for the treatment of mental disorders.

Outpatient Treatment

Benefits are paid for covered services in settings other than full-time inpatient care in either a hospital or treatment facility, including those for the treatment of alcoholism or drug abuse, or for the treatment of mental disorders.

Residential Treatment Facility

Benefits are paid for covered services in settings other than full-time inpatient care or a partial confinement treatment program in either a hospital or residential treatment facility, including those for residential crisis services.

Mouth, Jaws and Teeth

Coverage includes services and supplies provided by a physician, dentist or hospital for:

- Non-surgical treatment of infections or diseases of the mouth, jaws, jaw joints and supporting tissues including bones, muscles and nerves.
- Surgical treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, including bones, muscles and nerves, needed to:
  - Treat a fracture, dislocation or wound.
  - Cut out cysts, tumors or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is covered only when *not* done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Hospital services and supplies during a stay required because of your covered treatment or condition.
- Dental work, surgery and orthodontic treatment needed *due to accidental injury* to remove, repair, replace, restore or reposition:
  - Natural teeth that have been damaged, lost or removed; or
  - Other body tissues of the mouth that have been fractured or cut.

  These teeth must have been:
  - Free from decay,
  - In good repair, and
  - Firmly attached to the jaw bone at the time of the injury.

  If crowns (caps), dentures (false teeth), bridgework or in-mouth appliances are installed as the result of an accidental injury, the following are covered:
  - The first denture or fixed bridgework to replace lost teeth.
  - The first crown needed to repair each damaged tooth.
  - An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Limitations

Except when needed as the result of a covered injury, Medical Program coverage does not include:

- In-mouth appliances, crowns, bridgework, dentures, tooth restorations, implants or any related fitting or adjustment services, whether or not the purpose of those services or supplies is to relieve pain.
- Root canal therapy.
- Routine tooth removal (not needing the cutting of bone).
- Treatment to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing.
- Treatment to repair, replace or restore fillings, crowns, dentures or bridgework.
- Non-surgical periodontal treatment.
- Dental cleaning, in-mouth scaling, planing or scraping.
- Myofunctional therapy, which is muscle training therapy, or training to correct or control harmful habits.

Medical Pharmaceuticals

Coverage includes certain specialty infused pharmacologic or biologic agents (including some FDA-approved gene therapies[26]) which require administration and billing by a health care provider in either the patient's home, physician's office, outpatient or inpatient medical facility settings when determined to be medically necessary and administered in an appropriate setting. There are specific medical policies in place for many of these drugs/therapies. Coverage criteria for medical pharmaceuticals is managed by the Claims Administrator and may change periodically.

Prescription Drug Benefit

Prescription drugs are covered if they are dispensed by a pharmacy and are medically necessary for the prevention or treatment of an illness or condition. The tables in this chapter show the deductible and copay or coinsurance that apply to covered prescription expenses. No deductible applies to specific preventive medications targeting certain risk factors; for most, you pay only a fixed copay or coinsurance percentage. However, several preventive pharmaceutical products are covered at 100% with no deductible.

If you choose to use a brand-name drug when a generic is available, you will pay the cost difference (unless your doctor requires that the brand name is necessary). The difference will not apply toward your annual deductible, coinsurance maximum or out-of-pocket maximum.

Primary/Preferred Drug List (Formulary)

A Primary/Preferred Drug List (formulary) is part of your prescription drug benefit program. The list contains preferred prescription medications that are proven to be effective but generally are lower in cost than other available drugs. To see which prescription drugs are included in the Primary/Preferred Drug List and which pricing category applies to any drug, you may link to the CVS/caremark site at caremark.com or call CVS/caremark's toll-free number at 800-378-7559. The Specialty Drug List is available at https://archimedesrx.com/resources/or by calling Archimedes at 1-888-601-0967.

[26] *Under Cigna, gene therapy products and their administration are covered only when services are performed at in-network facilities specifically contracted with Cigna for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered with Cigna medical coverage.*

Formulary Exclusions

To maintain a competitive cost structure, CVS/caremark and Archimedes (for specialty drugs) periodically evaluate and exclude certain medications from Medical Program coverage when generic and/or brand-name medications that are judged to be effective and safe are available to treat the same condition. These medications, known as formulary exclusions, are not covered, so you may be required to pay the full cost if you choose to use them. The amount you pay will not count toward your annual deductible, coinsurance maximum or out-of-pocket maximum expense.

Overview of Prescription Drug Coverage Levels

Prescription drugs and certain products and supplies are covered in three ways under the Medical Program, when prescribed by a physician:

❶ ***Most prescription medications and supplies, including Specialty drugs***:
- Subject to deductible.
- You pay a fixed copay or coinsurance percentage once your combined medical and prescription drug expenses reach the deductible.
- You will pay the cost difference if you choose to use a brand-name drug when a generic is available (unless your doctor requires that the brand name is necessary). That cost difference will not count toward your annual deductible, coinsurance maximum or out-of-pocket maximum expense.

❷ ***Specific preventive medications and supplies targeting certain risk factors***:
- Not subject to deductible.
- You pay a fixed copay or coinsurance percentage.

❸ ***Certain preventive products***:
- Covered at 100%.
- No deductible, copays or coinsurance.

❶ Prescription Medications and Supplies

Retail Pharmacy

Except as noted for specific preventive medications and certain products (see ❷ and ❸ on the following pages), your purchases of prescription drugs and supplies are subject to your Medical Program deductible. Once you meet your deductible, the program covers your in-network or out-of-network pharmacy purchases of up to a 34-day supply (or up to a 90-day supply if purchased at CVS pharmacies) of a prescription drug with a fixed copay or coinsurance paid by you. If your share of overall covered expenses reaches the annual out-of-pocket maximum, your eligible prescription drug expenses will be paid at 100% for the rest of the calendar year.

The total covered charge for any prescription drug purchase is determined by the pharmacy and CVS/caremark or Archimedes (if drug being purchased is a specialty drug), the prescription drug Claims Administrator.

If you use an out-of-network retail pharmacy for any prescription purchase, you initially will pay 100% of the prescription price. Then you may submit a paper claim form, along with the original prescription receipt(s), to CVS/caremark for reimbursement of covered expenses. You will pay the difference between the cost charged by the out-of-network pharmacy and the discounted amount that would have been charged by an in-network pharmacy. These additional out-of-network charges do not apply toward the deductible or out-of-pocket maximum.

If you choose to use a brand-name drug when a generic is available, you will pay the cost difference (unless your doctor requires that the brand name is necessary). The difference will not apply toward your annual deductible, coinsurance maximum or out-of-pocket maximum expense.

The time limit to file a paper claim is 365 days from the prescription fill date.

To see which prescription drugs are included in the Primary/Preferred Drug List and which pricing category applies to any drug, you may link to the CVS/caremark website at caremark.com or call CVS/caremark toll-free at 800-378-7559. For specialty drugs, you may reach Archimedes at 888-601-0967.

In-network drug prices include discounts negotiated by CVS/caremark, the prescription drug Claims Administrator, which hold down the expenses you pay.

The Claims Administrator pays the benefit amount to the in-network pharmacy on your behalf.

In-network Retail Pharmacy Purchases[27]	
Prescription Drug Type	**Your Cost (after you meet the deductible):** *(Deductible does not apply to specific preventive medications and products – see ❷ and ❸ on the following pages.)*
Generic	• Up to 34-day supply: $7.50 or actual cost, if less. • Up to 90-day supply if purchased at CVS pharmacies: $15 or actual cost, if less.
Primary/Preferred (Formulary) Brand	• Up to 34-day supply: 25% but not less than $30. Your cost is limited to $120 max.[28] • Up to 90-day supply if purchased at CVS pharmacies: 25% but not less than $60. Your cost is limited to $240 max.[29]
Non-Primary/Preferred (Non-Formulary) Brand	• Up to 34-day supply: 40% but not less than $50. Your cost is limited to $150 max.[29] • Up to 90-day supply if purchased at CVS pharmacies: 40% but not less than $100. Your cost is limited to $300 max.[29]
Specialty Drugs	• Up to 30-day supply: 25%. Your cost is limited to $175 max.

In-network Mail Order[29]

CVS/caremark's mail-order program allows you to order up to a 90-day supply of maintenance or long-term medication for direct delivery to your home. (Quantities for certain preventive products differ as noted at ❸ on page 45.) In addition to the convenience, purchasing a multi-month supply by mail order will likely cost less than purchasing smaller quantities at a retail pharmacy.

[27] *For out-of-network retail purchases (other than specialty drugs), you also pay the difference between the cost charged by the out-of-network pharmacy and the amount that would have been charged by an in-network pharmacy. Out-of-network purchases of specialty drugs are not covered.*

[28] *You will pay the cost difference if you choose to use a brand-name drug when a generic is available (unless your doctor requires that the brand name is necessary). The difference does not apply toward your deductible, coinsurance maximum or out-of-pocket maximum.*

[29] *Out-of-network mail-order pharmacies are not covered.*

Once you meet your Medical Program deductible, your in-network mail-order purchases of prescription drugs are covered at the copay or coinsurance rates in the following table.

In-network Mail-Order Purchases[30]	
Prescription Drug Type	**Your Cost (after you meet the deductible):** *(Deductible does not apply to specific preventive medications and products – see ❷ and ❸ as follows.)*
Generic	$15 or actual cost, if less.
Primary/Preferred (Formulary) Brand	25% but not less than $60. Your cost is limited to $240 max.[31]
Non-Primary/Preferred (Non-Formulary) Brand	40% but not less than $100. Your cost is limited to $300 max.[32]

For questions about mail-order prescriptions, refer to caremark.com or call CVS/caremark at 800-378-7559.

[30] *Out-of-network mail-order pharmacies are not covered.*

[31] *You will pay the cost difference if you choose to use a brand-name drug when a generic is available (unless your doctor requires that the brand name is necessary). The difference does not apply toward your annual deductible, coinsurance maximum or out-of-pocket maximum.*

Specialty Drugs
Benefits are paid *only* for specialty drugs for which you have obtained *pre-authorization* from CVS/caremark, the Claims Administrator. The Specialty Drug List is available at https://archimedesrx.com/resources/ or by calling Archimedes at 1-888-601-0967 and is updated from time-to-time.

If your prescription drug is not covered and you think it should be, you may ask Archimedes to make an exception to the drug coverage rules, by having your physician submit a statement that explains the medical reasons for requesting an exception. This letter and request can be faxed to 866-491-6971.

Up to a 30-day supply of specialty drugs will be covered at a time. Specialty prescriptions must be obtained through CVS Specialty. Not all specialty drugs are covered by the benefit, and some specialty drugs may be covered under the medical benefit. In rare instances you may be required to use a different specialty pharmacy for medications that are available only through limited distribution pharmacies. In those cases, you must use a pharmacy in the Archimedes specialty pharmacy network. You will be responsible for 100% of the drug costs if prescriptions are obtained at out-of-network pharmacies. Please contact Archimedes member services at 1-888-601-0967 for any questions about pharmacy access.

The amount you pay for each prescription order or refill will be determined based on the day supply of the drug. Refills of prescriptions are allowed after 75% of the previous prescription has been used (e.g., 23 days in a 30-day supply).

If the drug has copay assistance available, the amount you pay for select medications may be set to the maximum of the current benefit design, $0 or the amount determined by the manufacturer-funded copay assistance program. Once copay assistance is exhausted, the amount you pay will be no more than your benefit design. Dollars used from copay assistance programs will not be considered member out-of-pocket costs and will not count toward your deductible and/or out-of-pocket maximums. Your monthly contribution includes the cost of access to copay assistance services.

Your cost for up to 30-day supply: 25% up to $175 max.

Prior Authorization, Quantity Limits and Step Therapy for Specialty Drugs

To promote safety and clinically appropriate care while controlling costs, prescription drug coverage may be restricted in quantity or require prior authorization and/or step therapy. Archimedes' Drug Coverage Guidelines can be found in the pharmacy section of Archimdes website. You may also call the Customer Service Department number on the back of your ID card for more information.

Either you or the pharmacy can ask your doctor to call 888-504-5563 to initiate the prior authorization or appeal process. You can also contact Archimedes via mail at:

Archimedes
Prior Authorizations and Appeals
278 Franklin Rd Suite 245

Brentwood, TN 37027

Prior Authorization Forms for specialty drugs can be found at https://archimedesrx.com/resources

❷ Specific Preventive Medications and Supplies Targeting Certain Risk Factors

To encourage you to manage certain controllable health conditions, the Medical Program offers special coverage of specific preventive medications and supplies targeting certain risk factors. ***No deductible applies, and you pay a fixed copay or coinsurance percentage*** as shown in the retail pharmacy and mail-order tables. In addition, ***your share of covered expenses for preventive prescription drugs counts toward your annual out-of-pocket maximum expense***.

List of Specific Preventive Medications Targeting Certain Risk Factors

Prescription medications and supplies eligible for the special no-deductible benefit include medications and certain supplies for:

- Asthma,
- Heart disease,
- Diabetes,
- High cholesterol and high blood pressure control,
- Osteoporosis,
- Stroke prevention, and
- Weight reduction due to obesity.

For the current list of specific preventive medications targeting certain risk factors, go to bnsf.com/retirees/exempt-retirees/plan-details-1/index.page.

In addition, certain preventive products are covered at 100% as noted in ❸ below.

❸ Preventive Products Covered at 100%

When prescribed by a physician, the following products are covered at 100%, with no deductible when purchased from either an in-network or out-of-network retail pharmacy or via mail order. This list is determined in accordance with federal rules applying to preventive care coverage and may change periodically based on recommendations from the federal Agency for Healthcare Research and Quality (AHRQ).

Covered at 100%, No Deductible	
Medication / Product	**When Prescribed For:**
Aspirin (generic)	Participants age 45 or older (limit 100 units per fill).
Contraceptives (generic and single-source brand) • Oral contraceptives • Injectables • Intrauterine devices • Vaginal rings • Subdermal rods • Transdermal patch • Diaphragm and cervical cap	Covered participants.

• Emergency contraception	
Fluoride supplements (generic and brand)	Participants age 1 year or younger (quantity as prescribed).
Folic acid (generic)	Women age 55 or younger (limit 100 units per fill).
Iron supplements (generic and brand)	Participants age 1 year or younger (quantity as prescribed).
Tobacco cessation • Nicotine replacement products including patches, gum, lozenges (generic) • Zyban or Chantix (generic) or Wellbutrin for smoking cessation	Limit 180-day supply per year. Limit 180-day supply per year.

Covered Prescription Drugs

- A prescription legend drug for which a written prescription is required.
- Tobacco cessation aids specified by the Claims Administrator for up to two 12-week regimens per year.
- Oral or injectable insulin dispensed only upon the written prescription of a physician.
- Insulin needles and syringes.
- A compound medication of which at least one ingredient is a prescription legend drug.
- Topical acne products (certain restrictions apply for individuals age 35 and over).
- Any other drug that, under the applicable state law, may be dispensed only upon the written prescription of a physician.
- FDA-approved contraceptive methods.
- Contraceptive devices, including implantable contraceptive devices.
- Prenatal vitamins, upon written prescription.
- An injectable drug, excluding injectable fertility drugs, for which a prescription is required, including needles and syringes.
- Oral fertility drugs up to the $5,000 lifetime maximum for outpatient prescriptions related to fertility treatment.
- Glucose test strips.
- Growth hormones and anabolic steroids (available only through CVS/caremark's Specialty Pharmacy Program).
- A drug prescribed for a particular use for which it has not been approved by the Food and Drug Administration (FDA) only if it meets the following criteria:
  - The drug is recognized for the specific use in any one of the following established references: the United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluation, the American Hospital Formulary Service or any peer-reviewed national professional medical journal;
  - The drug has been otherwise approved by the FDA, granted an NDC number and is available at retail pharmacies; and
  - The drug has not been contraindicated by the FDA for the use prescribed.

Pre-approval May Be Required

As new drugs become available, existing drugs are prescribed for new purposes, protocols change for prescribing a drug and other reasons, coverage of some medications may require pre-approval from CVS/caremark, the prescription drug Claims Administrator or Archimedes, the Specialty drug Claims Administrator. This process involves a review to determine whether the program covers the medication based on medical necessity. To request approval, you, your doctor or your pharmacist may begin the review process by calling CVS/caremark or, for specialty drugs, contact Archimedes.

- Prior Authorization – The Plan requires a review to determine if the drug qualifies for coverage under the benefit. If your physician prescribes a drug that requires a prior authorization, the Claims Administrator will work with your prescriber to complete the prior authorization review. Once your prior authorization is reviewed, a clinician may contact your doctor to discuss your case and potential medication alternatives. Your doctor may change your prescription, when medically appropriate, to a different brand name or generic medication.

- Quantity Restrictions – For certain drugs, the amount of the drug that will be covered by the plan is limited based on national standards and current scientific literature. These limits ensure the quantity of units supplied for each prescription remain consistent with clinical dosing guidelines and benefit plan design.

- Step Therapy – In some cases, you are required to first try certain drugs to treat your medical condition before the Plan will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Plan may not cover Drug B unless you try Drug A first.

Prescription Drug Limitations

No benefits are payable under the Medical Program for the following expenses:

- Drugs not listed on the Plan's Formulary.
- Non-legend drugs, other than those specified as Covered Prescription Drugs.
- To the extent that payment is unlawful where the person resides when expenses are incurred.
- Charges that the person is not legally required to pay.
- Charges that would not have been made if the person was not covered under the Medical Program.
- Experimental drugs or drugs labeled "Caution – limited by federal law to investigational use."
- Drugs that are not considered essential for the necessary care and treatment of an injury or sickness, as determined by the prescription drug benefit Claims Administrator.
- Drugs obtained from an out-of-network mail-order pharmacy.
- Specialty drugs obtained without pre-authorization from the specialty prescription drug Claims Administrator.
- Any compounded Specialty drugs that contain products excluded by the Plan.
- Specialty drugs of unproven clinical efficacy and/or value.

- Specialty drugs that have less expensive, but clinically equivalent alternatives.
- Specialty products recently approved by the FDA may not be covered upon release to the market.
- Prescription drugs not covered by a current prescription order.
- Any prescription filled in excess of the quantity specified by the physician or dispensed more than one year from the date of the physician's order.
- More than a 34-day supply when dispensed in any one prescription order through a retail pharmacy.
- More than a 90-day supply when dispensed in any one prescription order through a participating mail-order pharmacy.
- Indications not approved by the FDA, which may also include off-label use (meaning drugs that may be prescribed, but are not approved for that condition or age group), except as indicated above.
- Any drugs provided through another party's liability insurance coverage. To the extent that the person is covered under the mandatory part of any auto insurance policy written to comply with a no-fault insurance law or an uninsured motorist insurance law (any auto insurance adjustment option chosen under such part will be taken into account).
- Immunization agents, biological sera, blood or blood plasma.
- Therapeutic devices or appliances, including support garments and other non-medicinal substances, excluding insulin syringes.
- Drugs used for cosmetic purposes.
- Administration of any drug.
- Medication that is taken or administered – in whole or in part – at the place where it is dispensed, or while a person is a patient in an institution that operates – or allows to be operated on its premises – a facility for dispensing pharmaceuticals.
- Prescriptions that an eligible person is entitled to receive without charge from any Workers' Compensation or similar law or any public program other than Medicaid.
- Nutritional or dietary supplements or anorexiants unless required for coverage by the Affordable Care Act.
- Vitamins, excluding prescribed prenatal vitamins, upon written prescription.
- Oral fertility drugs in excess of the $5,000 lifetime maximum.
- Injectable fertility drugs.
- Coverage may be changed and/or the amount you pay may vary based on the condition being treated.

PRE-NOTIFICATION AND PRE-DETERMINATION OF EXPENSES

Two Separate Processes for Pre-approval of All Admissions and Certain Services and Treatment

Two steps of approvals need to be completed before you incur expenses for the services listed in this section. Both steps apply whether you use in-network providers or out-of-network providers.

Through the ❶ pre-notification and ❷ pre-determination processes, you and your provider can find out in advance:

❶ **What's Covered** – The pre-notification step determines if services are covered by the Medical Program, but it does not confirm whether certain limitations, requirements and exclusions might limit or deny benefits paid for those services.

Your Responsibility

- Your health care provider may assist you by requesting this advance certification of coverage from BCBS *before* hospital and facility admissions or certain services, tests or treatment begin. However, ***it is always your responsibility to confirm*** that BCBS has approved the pre-notification of your admission, service or treatment.
- The Claims Administrator normally responds within 15 days of receiving the pre-notification request for routine (non-urgent or non-emergency) care.[32]

How to Verify Pre-notification

The Claims Administrator mails a notice to the doctor or hospital and the covered person (you or your dependent) when the pre-notification process has been completed for an admission or service. If you are not certain this process has been completed or know of its outcome, call the Member Services number on your ID card to ask.

❷ **Dollar Amount to Be Paid and Any Limitations that Apply** – The pre-determination step confirms in writing the general dollar amount of benefits payable for your specific admission, test, care and/or treatment. Through this step, you'll find out if benefits for any covered services might be limited or denied due to certain requirements or exclusions that apply to those services.

Your Responsibility

This step is always your responsibility. Ask your provider to request pre-determination by the Claims Administrator. It is your responsibility to confirm the outcome.

Services that require these pre-approval processes include, but are not limited to:

- Hospital admissions,
- Convalescent or skilled nursing facility admissions,
- Skilled nursing care,
- Hospice care,
- Home health care,
- Inpatient tests, procedures and treatment,

[32] *For the claims process, your responsibilities and those of the Claims Administrator, including circumstances when additional time can be taken for making pre-determination decisions, see the Filing a Claim section of the SPD chapter titled Claims Procedures – Medical and Vision Programs for Pre-Medicare Retirees.*

- Certain outpatient tests, procedures and treatment that are not considered routine office visits,
- Hospital and treatment facility admissions and treatment for alcohol and drug abuse and mental disorders,
- Rehabilitation hospitals and subacute facilities,
- Residential treatment,
- Partial hospitalization,
- Advanced radiological imaging,
- Non-emergency ambulance,
- Certain pharmaceuticals, and
- Transplant services.

How to Verify Pre-determination
The Claims Administrator provides your doctor or hospital with an authorization whenever an admission or service has been pre-determined. If you are not certain this process has been completed or know of its outcome, call the Member Services number on your ID card to ask.

Example
If you are scheduled for an outpatient surgery, you might be told that (Step ❶) pre-notification is not necessary. *It is your responsibility to confirm whether pre-notification is necessary and the outcome as determined by the Claims Administrator.*

In addition, by having your doctor's office request (Step ❷) ***pre-determination***, you will learn if your specific surgery procedures will be covered under the Medical Program ***and*** the general level of benefits payable.

It is possible that benefits are not payable because of program limitations, exclusions or requirements. ***Requesting*** (Step ❷) ***pre-determination always is a good idea.***

Pre-notification

Hospital and Facility Admissions

You must obtain pre-notification of an admission whether in-network or out-of-network ***before*** you are admitted to any:

- Hospital,
- Treatment facility for alcoholism or drug abuse,
- Treatment facility for a mental disorder, or
- Convalescent or skilled nursing facility.

Requesting Pre-notification for Hospital and Facility Admissions

- If your admission is a non-urgent admission, it is ***your responsibility*** to make sure your provider obtains pre-notification at least one day before admission.
- If your admission is an emergency admission or an urgent admission, it is ***your responsibility*** to make sure your doctor, or the hospital or facility, obtains confirmation of pre-notification as follows:
  - Before the start of an urgent admission; or

- Not later than 48 hours following an emergency, maternity or mental health/substance abuse admission, or as soon as reasonably possible thereafter. (For an emergency admission on a Friday or Saturday, the 48-hour requirement will be extended to 72 hours.)

If, in the opinion of your doctor, it is necessary for you to be confined for a longer time than already approved by the Claims Administrator, then you, your doctor, or the facility or hospital may request that additional days be approved. This must be done no later than the last day already approved. It is ***your responsibility*** to make sure the request is made and that you have received confirmation that your admission, treatment or service is covered.

The Claims Administrator will promptly send written notice of the number of days approved to the hospital or facility. A copy will be sent to you and your doctor.

If you choose to remain in a hospital, alcoholism or drug abuse facility, mental disorder treatment facility, convalescent facility or skilled nursing facility after the date approved by the Claims Administrator, you are responsible for payment to the hospital or facility for all expenses incurred after the end of the approved days.

Inpatient and Outpatient Services, Skilled Nursing Care, Hospice Care and Home Health Care

You must obtain pre-notification at least one day ***before*** you incur expenses for the following services whether in-network or out-of-network:

- All non-emergency inpatient services that are provided in a hospital or convalescent or skilled nursing facility; and
- All skilled nursing care, hospice care and home health care.

It is your responsibility to make sure that your provider obtains pre-notification and that you have received confirmation that your admission, treatment or service is covered.

GENERAL EXCLUSIONS

Expenses that Are Not Covered

Coverage does not include:

- Services and supplies not necessary, as determined by the Claims Administrator, for the diagnosis, care or treatment of the disease or injury involved. This applies even if the services and supplies are prescribed, recommended or approved by your attending physician or dentist.
- Care, treatment, services or supplies that are not prescribed, recommended or approved by your attending physician or dentist.
- Services or supplies that are, as determined by the Claims Administrator, experimental or investigational. A drug, device, procedure or treatment will be determined to be experimental or investigational if:
  - There is insufficient data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
  - FDA-required approval has not been granted for marketing;
  - In the case of a drug, it has not been granted an NDC number and/or is not available in retail pharmacies;
  - A recognized national medical or dental society or regulatory agency has determined, in writing, that the service or supply is experimental, investigational or for research purposes; or
  - It is stated to be experimental, investigational or for research purposes by:
    - The written protocol or protocols used by the treating facility;
    - The protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment; or
    - The written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment.

  However, this exclusion will not apply to services or supplies (other than drugs) received in connection with a disease if the Claims Administrator determines that the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the Claims Administrator will take into account the results of a review by a panel of independent medical professionals who are selected by the Claims Administrator and who treat the type of disease involved.
- Services, treatment, education testing or training related to learning disabilities or developmental delays, or charges related to those services.
- Care furnished mainly to provide surroundings free from exposure that can worsen your disease or injury.

- Care for any injury or disease resulting from, or in the course of, any employment for wage or profit, except for salaried retirees injured while performing duties for BNSF or a wholly owned subsidiary.
- The following types of treatment: primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training, carbon dioxide therapy or charges related to those services.
- Treatment of those in the mental health care field who receive treatment as a part of their training in that field.
- Services of a resident physician or intern rendered in that capacity.
- Amounts charged only because there is health coverage.
- Amounts you are not legally obligated to pay.
- Custodial care, as determined by the Claims Administrator.
- Services and supplies:
  - Furnished, paid for or for which benefits are provided by a federal armed services medical program.
  - Furnished, paid for or for which benefits are provided or required under any law of a government. (This exclusion will not apply to no-fault auto insurance if it is required by law, is provided on other than a group basis and is included in the definition of Other Plan in the section titled *Coordination with Other Plans Except TRICARE* in the chapter of this SPD titled *Claims Procedures – Medical and Vision Care Programs for Pre-Medicare Retirees*. In addition, this exclusion will not apply to a plan established by a government for its own retirees or their dependents, or Medicaid.)
- Any eye surgery mainly to correct refractive errors or related charges.
- Education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Therapy, supplies or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Drugs or supplies used for the treatment of erectile dysfunction (except up to eight doses annually if purchased at retail or 24 doses by mail order), impotence or sexual dysfunction or inadequacy. This exclusion applies whether or not the drug is delivered in oral, injectable or topical forms.
- Performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent these drugs or supplies are specifically listed as covered.
- Routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations or other preventive services, supplies or products, except to the extent that these exams, immunizations, services, supplies or products are specifically listed under the *Preventive Care Services* section of this Medical Program chapter.
- Marriage, family, child, career, social adjustment, pastoral or financial counseling, or related charges.

- Acupuncture therapy, except acupuncture performed by a physician as a form of anesthesia in connection with surgery that is covered under this Medical Program.
- Speech therapy or related charges. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words and form sentences) as the result of a disease or injury, or therapy related to treatment of Autism Spectrum Disorder.
- Weight control services, including certain surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications, food or food supplements, exercise programs, exercise or other equipment, and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions. *Exceptions:* Certain anti-obesity medications as determined by CVS/caremark, and certain adult nutritional counseling programs and certain bariatric surgical procedures may be covered subject to meeting the Claims Administrator's selection criteria. For more information, call the Member Services number on your ID card.
- Bariatric surgeries performed by an out-of-network provider.
- Dialysis services performed by an out-of-network provider.
- Plastic surgery, reconstructive surgery, cosmetic surgery or other services and supplies that improve, alter or enhance appearance (facings on molar crowns and pontics will always be excluded as cosmetic), whether or not for psychological or emotional reasons, except to the extent needed to:
  - Improve the function of a part of the body that:
    - Is not a tooth or structure that supports the teeth, and
    - Is malformed:
      - As a result of a severe birth defect, including cleft lip, webbed fingers or toes, or
      - As a direct result of disease or surgery performed to treat a disease or injury, including reconstructive surgery following a mastectomy.
  - Repair an injury.
- Amounts to the extent they are not reasonable charges, as determined by the Claims Administrator.
- Reversal of sterilization procedures and certain fertility services not specifically listed as Covered Medical Expenses.

- Services or supplies that, in the opinion of the Claims Administrator, are associated with injuries, illnesses or conditions suffered due to the acts or omissions of a third party and are subject to the Subrogation and Right of Recovery provisions as stated in the *Claims Procedures – Medical and Vision Care Programs for Pre-Medicare Retirees* chapter of this SPD.
- Services or supplies furnished by an in-network provider in excess of the provider's negotiated charge for that service or supply.
- Services or prescription drugs not permitted under applicable state or local laws. Some state or local laws restrict the scope of health care services that a provider may render, or prescription drugs that a provider may prescribe. In such cases, the Plan will not cover such health care services or prescription drugs unless a Participant or Dependent travels to a state or locality without such a restriction to receive such care or prescription drugs.

If any law contradicts a listed exclusion, the exclusion will not apply.

Excluded charges will not be used when determining the amount of any deductible, coinsurance maximum or out-of-pocket maximum expense.

The law of the jurisdiction where a person lives when a claim occurs may prohibit the payment of some benefits. If so, they will not be paid.

SURGERYPLUS BENEFIT

In addition to the regular Medical Program coverage, the supplemental SurgeryPlus benefit helps BCBS participants find board-certified, quality surgeons for *specific planned procedures,* negotiates all costs in advance and coordinates payment for you.[33] Participation is completely voluntary.

Covered Surgeries and Procedures

When SurgeryPlus coordinates your surgery, the Medical Program pays 100% of expenses charged by SurgeryPlus providers, and consult fees are waived after you've met your Medical Program annual deductible. This includes surgeon, anesthesia and facility fees, and inpatient medications and diagnostics. Expenses you pay for SurgeryPlus services count toward your deductible if it has not already been met. The following lists of procedures are not exhaustive and are subject to change.

Orthopedic

- Knee replacement (partial, unilateral, bilateral)
- Knee replacement (total)
- Knee replacement revision
- Hip replacement (partial, unilateral, bilateral)
- Hip replacement (total)
- Hip replacement revision
- Shoulder replacement (partial, unilateral, bilateral)
- Shoulder replacement revision
- Ankle replacement
- Wrist replacement
- Elbow replacement

Spine

- Laminectomy (cervical, lumbar, thoracic)
- Laminotomy (cervical, lumbar, thoracic)
- Disc (cervical, lumbar, thoracic)
- Anterior lumbar interbody fusion (ALIF)
- Posterior lateral fusion (PLIF) (lumbar)
- Anterior/posterior lumbar fusion (360)
- Post fusion and decompression
- Anterior cervical fusion (ACF)
- Posterior cervical fusion (PCF)
- Artificial disc
- Pain management

General Surgery

- Hysterectomy
- Bladder repair (anterior or posterior)
- Thyroidectomy

Bariatrics

- Gastric bypass
- Laparoscopic gastric bypass
- Laparoscopic sleeve gastrectomy

[33] *SurgeryPlus is not administered by or affiliated with Blue Cross Blue Shield (BCBS). See the Administrative Information – Medical and Vision Care Programs for Pre-Medicare Retirees chapter of this SPD for identification of Claims and Account Administrators and how to contact them.*

Cardiac

- Cardiac valve surgery
- Permanent pacemaker implant

Outpatient Procedures

- Ear, nose and throat (ENT)
- Gastroenterology (GI)
- Pain management
- Knee arthroscopy / meniscus
- Shoulder arthroscopy
- Hip arthroscopy
- Ankle arthroscopy
- Medial collateral ligament (MCL) repair
- Anterior cruciate ligament (ACL) repair
- Posterior cruciate ligament (PCL) repair
- Bunionectomy
- Hammer toe repair
- Bicep tendon repair
- Rotator cuff repair
- Carpal tunnel release
- Hernia repair
- Gallbladder removal
- Ankle fusion
- Wrist fusion
- Elbow fusion
- Proximal interphalangeal (PIP) replacement
- Metacarpophalangeal (MCP) replacement
- Finger joint fusion
- Metatarsophalangeal (MTP) fusion

Included Services

Services and expenses commonly included in the covered episode of care are equipment used while in the hospital or facility; in-hospital or in-facility medications or biologics and supplies; implants; labs; in-hospital meals; hospital confinement days; pre- and post- in-hospital or in-facility nursing care; in-hospital physical therapy and follow-up consultations; and any other medically necessary care related to your specific diagnosis that is rendered *prior to discharge*.

Travel Expenses

If participating surgeons are not located in your area, certain travel costs may be covered. It depends on the procedure, provider and distance from your residence.

For procedures requiring inpatient admission or overnight recovery, the travel benefit covers the patient and one companion for a limited time.

Only travel arrangements made through your Care Coordinator are eligible.

How It Works — Finding a Doctor and Planning the Procedure

1. Start by calling a SurgeryPlus Care Coordinator at 855-200-2113 before you begin planning a surgery/procedure. You work with the same Care Coordinator throughout the process to find a doctor, plan for the procedure, schedule appointments and travel, transfer medical records and coordinate bills.
2. With your permission, your Care Coordinator works to provide medical records and other pertinent information for the SurgeryPlus doctor to assess medical necessity and your suitability for the prospective treatment or procedure, including any necessary travel. Based on this initial review / consultation, the SurgeryPlus doctor will decide whether to accept your case.
3. You decide whether or not to proceed by agreeing to the doctor's standard terms of treatment.
4. If you are not satisfied with the doctor or the initial review/consultation, you may ask your Care Coordinator for a second opinion with another SurgeryPlus doctor.

Limitations and Exclusions

SurgeryPlus coverage is limited to services performed by the SurgeryPlus provider within the episode of care and ends when you are discharged from the facility. Exams, tests, treatments or other services, including emergency services, may be required before or after the procedure. If they are not within the episode of care, eligible expenses can be claimed under the BNSF Medical Program's regular coverage.

The SurgeryPlus benefit does not cover:

- Diagnostic studies and imaging,
- Physical therapy,
- Durable medical equipment,
- Prescriptions,
- Lab work,
- Pain injections that are not spine related,
- Pre-operative labs and testing (these are done by your primary care physician office for claiming under the regular Medical Program coverage), and
- Complications after the episode of care.

Also excluded are convenience expenses, procedures or care that are not medically necessary, and Serious Reportable Events (SREs) as defined by the National Quality Forum at qualityforum.org/Home.aspx.

CANCER SUPPORT SERVICES THROUGH ACCESSHOPE

In addition to the regular Medical Program coverage, the supplemental AccessHope benefit connects covered participants to renowned cancer expertise at National Cancer Institute–Designated Comprehensive Cancer Centers. The cancer support services available through AccessHope include:

Cancer Support Services

Cancer Support Line

Covered members can connect to experienced oncology nurses for appointment details, treatment information, or emotional support by calling 833-907-4673. This service helps members:

- Understand their specific type of cancer
- Understand the types of treatments typically provided for the type of cancer
- Prepare for the first appointment with an oncologist
- Learn more about the availability and importance of clinical trials
- Access educational resources on cancer screening, prevention, and treatment

Expert Advisory Review

Members can request that an AccessHope medical expert review their case. This expert will provide treatment plan recommendations to the treating oncologists. A copy of the report and recommendations are also shared with the member. This service is handled remotely so the member does not have to travel. Covered members can initiate a review online at https://bnsf.myaccesshope.org/expert-review/.

Accountable Precision Oncology

In the case of a rare- or complex-cancer diagnosis, AccessHope's algorithms—in collaboration with the medical plan administrators—trigger the case to be securely sent to AccessHope. AccessHope then assigns their multidisciplinary subspecialist to the case. Specializing in your type of cancer, AccessHope's expert agrees or disagrees with the approach, including the latest research findings and any suggested medications, tests, or clinical trials and shares these results with your local treating oncologist. You and your oncologist then decide how this information might impact your treatment plan.

Notwithstanding anything to the contrary in the Summary Plan Description, if a drug, device, medical treatment or other procedure is reviewed and recommended under the Accountable Precision Oncology (APO) program, the treating oncologist and member will work with the Claims Administrator (ex: BlueCross BlueShield, Cigna, CVS/Caremark) to coordinate coverage approval.

How It Works

Contact AccessHope

Visit bnsf.myaccesshope.org or call 833-907-4673 to learn more about AccessHope.

OTHER INFORMATION

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact your medical insurance company at the number on your id card.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans may not under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the birth. In any case, under federal law, the Medical Program may not require that the attending physician or the expectant mother obtain authorization from the Claims Administrator for prescribing a length of stay not in excess of 48 hours (or 96 hours, where applicable). The Claims Administrator must follow these rules.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires that all group health plans that provide medical and surgical benefits for a mastectomy also must provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and coverage for any complications in all stages of mastectomy, including lymphedemas.

The Act requires that coverage be provided in a manner that is consistent with other benefits provided by the Medical Program. The coverage may be subject to annual deductibles and/or to copays.

The Act prohibits any group health plan from:

- Denying a participant or a beneficiary eligibility to enroll or renew coverage in order to avoid the requirements of the Act.
- Penalizing, reducing or limiting reimbursement to the attending provider (e.g., the attending physician, clinic or hospital) to induce the provider to give care that is inconsistent with the Act.
- Providing monetary or other incentives to an attending provider to induce the provider to give care that is inconsistent with the Act.

BNSF's Privacy Practices

Participants in the Burlington Northern Santa Fe Group Benefits Plan (the "Plan") have certain rights under the Health Insurance Portability and Accountability Act (HIPAA). These rights and the Plan's legal duties with respect to protected health information (PHI), including how the Plan may use and disclose PHI, are explained in the Plan's Privacy Practices Notice.

You may view or print a copy of the Privacy Practices Notice at bnsf.com/retirees/exempt-retirees/plan-details-1/index.page. In addition, any participant may request a copy by calling the BNSF Benefits Center at 833-277-8051.

You may also contact the Plan's Privacy Official at 800-234-1283 for more information on the Plan's privacy policies or your rights under HIPAA.

Medical Program Provisions

Expenses Covered Only While Coverage Is in Effect

The BNSF Medical Program for Pre-Medicare Retirees will pay benefits only for eligible expenses incurred while your coverage is in effect. No benefits are payable for expenses incurred before coverage has begun or after coverage has ended. This applies even if the expenses were incurred as a result of an accident, injury or disease which occurred, began or existed while coverage was in effect. An expense for a service or supply is incurred on the date the service or supply is furnished.

Charge for Multiple Services

When a single charge is made for a series of services, each service will bear a proportional share of the total expense. The amount of that share will be determined by the Claims Administrator, and only that amount will be considered incurred on the date of the service.

Limit of Claims Administrator's Responsibility

The Claims Administrator assumes no responsibility for the outcome of any covered services or supplies. The Claims Administrator makes no express or implied warranties concerning the outcome of any covered services or supplies.

WHO TO CALL ABOUT YOUR BENEFITS

- For questions about eligibility for coverage or enrollment in the Medical Program for Pre-Medicare Retirees, 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.
- For questions about the Medical Program options, covered expenses or claims other than services listed below, call the medical Claims Administrator, BCBS, at 888-399-5945. The Specialty Drug administrator, Archimedes may be reached at 1-888-601-0967
- For questions about prescription drug coverage and claims, call CVS/caremark, the prescription drug Claims Administrator, at 800-378-7559.
- For SurgeryPlus information, call 855-200-2113.
- For telemedicine information, call Teladoc at 800-835-2362 (800-TELADOC).

DEFINED TERMS

About These Terms

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

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

Previous view: Return to the 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.

Body mass index (BMI) – A practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Example: A person who is five feet, six inches tall is 1.68 meters tall. The square of 1.68 meters is 2.82 meters squared. If this person weighs 180 pounds (81.7 kilograms), their body mass index is 29. (81.7 kilograms divided by 2.82 meters squared = 29)

Brand-name drug – A prescription drug that is protected by trademark registration.

Charges – The actual billed charges; except when the Claims Administrator has contracted directly or indirectly for a different amount, including where the Claims Administrator has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers of such services and/or supplies.

Claims and Account Administrators – BCBS is the Claims Administrator for Medical Program benefits except prescription drug coverage, which is administered by CVS/caremark and specialty prescription drug coverage, which is administered by Archimedes. See the *Administrative Information – Medical and Vision Care Programs for Pre-Medicare Retirees* chapter of this SPD for identification of Claims and Account Administrators and how to contact them.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. For more information on your COBRA rights, see the chapter of this SPD titled *COBRA – Medical and Vision Care Programs for Pre-Medicare Retirees*.

Coinsurance – Percentage of the eligible expenses that you and the Medical Program each pay after you meet the annual deductible (if any).

Companion – For services provided under the transplant network benefits, this means a person whose presence as a companion or caregiver is necessary to enable a transplant patient to:

- Receive services in connection with a Blue Distinction Center procedure or treatment on an inpatient or outpatient basis, or
- Travel to and from the facility where treatment is given.

For services provided through ***SurgeryPlus***, companion means an individual traveling with the patient who uses the SurgeryPlus travel services.

Convalescent facility (also called a Skilled Nursing Facility) – An institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for recuperating from disease or injury:
  - Professional nursing care by an R.N., or by an L.P.N. directed by a full-time R.N.; and
  - Physical restoration services to help patients meet a goal of self-care in daily living activities.
- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time R.N.

- Is supervised full-time by a physician or R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for substance abuse treatment, for custodial or educational care, for the mentally disabled or for care of other mental disorders.
- Charges for its services.

Copay or Copayment – The fixed dollar amount you pay for purchases of generic prescriptions.

Custodial care – Services and supplies furnished to help you in the activities of daily life, whether or not you are disabled. This includes room and board and other institutional care. Services and supplies are considered to be custodial care, regardless of who recommends, prescribes or performs them.

Deductible – The amount of eligible expenses you must pay each year before the Program begins to pay benefits. See the *Schedule of Benefits* for specific amounts.

Dentist – A legally qualified dentist as well as a physician who is licensed to do the dental work performed.

Designated surgical facility

- Bariatric surgeries must be performed at designated surgical facilities for coverage to be available. Designated are BCBS Blue Distinction Center and Blue Distinction Center+, and SurgeryPlus facilities. If a Blue Distinction Center+ is not available within 50 miles, a Blue Distinction Center must be used. If a Blue Distinction Center is not available, surgery may be performed at a non-designated in-network facility and will be covered at the in-network level.
- The BCBS Solid Organ and Bone Marrow Transplant Program coordinates care and provides access to covered transplant treatment through the national Blue Distinction Centers network. Hospitals that have met extensive criteria for quality and cost-effectiveness have been selected by BCBS to participate as Blue Distinction Centers facilities for solid organ transplants and bone marrow transplants. These facilities have been contracted on a transplant-specific basis and are considered participating only for the transplant type listed in the Blue Distinction Centers network directory.

Detoxification – Treating the after-effects of a specific episode of alcoholism or drug abuse.

Directory – A listing of in-network providers in the service area that is included under the Medical Program. Current lists of BCBS network providers are available through the provider lookup tools on the BNSF Benefits Center website.

Durable medical and surgical equipment – Equipment and the accessories needed to operate the equipment that are:

- Made to withstand prolonged use,
- Made for and mainly used in the treatment of a disease or injury,
- Suited for use in the home,
- Not normally of use to persons who do not have a disease or injury,
- Not for use in altering air quality or temperature, and
- Not for exercise or training.

Excluded is equipment such as: whirlpools, portable whirlpool pumps, sauna baths, massage devices, over-bed tables, elevators, communication aids, vision aids, telephone alert systems and items deemed experimental or investigational.

Effective treatment of alcoholism or drug abuse – A program of alcoholism or drug abuse therapy that is prescribed and supervised by a physician and either:

- Has a follow-up therapy program directed by a physician on at least a monthly basis, or

- Includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

Excluded: Detoxification and maintenance care, meaning providing an environment free of alcohol or drugs.

Emergency

- **Emergency admission** – An event when a physician admits you to a hospital or treatment facility immediately after the sudden and unexpected onset of a change in your physical or mental condition:
  - Which requires confinement immediately as a full-time inpatient; and
  - For which if immediate inpatient care was not given could, as determined by the Claims Administrator, reasonably be expected to result in:
    - Placing your health in serious jeopardy,
    - Serious impairment to bodily function,
    - Serious dysfunction of a body part or organ, or
    - In the case of a pregnant woman, serious jeopardy to the health of the fetus.
- **Emergency medical condition** – A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to place the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, to result in serious impairment to bodily functions, or to result in serious dysfunction of any bodily organ or part.

  Emergency services – With respect to an Emergency medical condition, emergency services include (1) an appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an Emergency medical condition exists; and (2) such further medical examination and treatment as may be required to stabilize the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department. Emergency services includes items and services required for medical screening examinations, stabilization, and additional services, as medically necessary as required under ERISA.

Episode of care – Applies only to the SurgeryPlus benefit. An episode of care is limited to approved services rendered by SurgeryPlus providers 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.

Generic drug – A prescription drug that is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Health Savings Account (HSA) Administrator – HSAs offered in connection with BNSF Medical Program coverage are administered by UMB Bank (if retired prior to 2017) or HealthEquity (if retired in 2017 or later).

Home health care agency – An agency that:

- Mainly provides skilled nursing and other therapeutic services,

- Is associated with a professional group that makes policy (this group must have at least one physician and one R.N.),
- Has full-time supervision by a physician or an R.N.,
- Keeps complete medical records on each person,
- Has a full-time administrator, and
- Meets licensing standards.

Home health care plan – A plan that provides for care and treatment of a disease or injury. The care and treatment must be:

- Prescribed in writing by the attending physician, and
- An alternative to confinement in a hospital or convalescent facility.

Hospice care – Care given to a terminally ill person by or under arrangements with a hospice care agency as part of a hospice care program.

Hospice care agency – An agency or organization that:

- Has hospice care available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it operates.
- Provides:
  - Skilled nursing services,
  - Medical social services, and
  - Psychological and dietary counseling.
- Provides or arranges for other services including:
  - Services of a physician,
  - Physical and occupational therapy,
  - Part-time home health aide services that mainly consist of caring for terminally ill persons, and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel that include at least:
  - One physician,
  - One R.N., and
  - One licensed or certified social worker employed by the agency.
- Establishes policies governing the provision of hospice care.
- Assesses the patient's medical and social needs, and develops a hospice care program to meet those needs.
- Provides an ongoing quality assurance program, including reviews by physicians, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice care program – A written plan of hospice care that:

- Is established and reviewed periodically by:
  - An attending physician, and
  - Appropriate personnel of a hospice care agency.
- Is designed to provide:
  - Palliative and supportive care to terminally ill persons, and
  - Supportive care to their families.
- Includes:
  - An assessment of the patient's medical and social needs, and
  - A description of the care to be given to meet those needs.

Hospice facility – A facility or distinct part of the facility that:

- Mainly provides inpatient hospice care to terminally ill persons,
- Charges for its services,
- Meets any licensing or certification standards set forth by the appropriate jurisdiction,
- Keeps a medical record on each patient,
- Provides an ongoing quality assurance program, including reviews by physicians other than those who own or direct the facility,
- Is run by a staff of physicians, with at least one physician on call at all times,
- Provides 24-hour-a-day nursing services under the direction of an R.N., and
- Has a full-time administrator.

Hospital – A place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment and care of injured and ill persons,
- Is supervised by a staff of physicians,
- Provides 24-hour-a-day R.N. service,
- Is not mainly a place for rest, for the aged, for substance abuse treatment or a nursing home, and
- Charges for its services.

In-network – Services from a health care provider (practitioner, group of practitioners, facility, group of facilities or other entities) that has directly or indirectly contracted to furnish services or supplies for a negotiated charge under the BCBS provider network, or for prescription drugs and supplies under CVS/caremark. Same as participating provider.

Jaw joint disorder –

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint,
- A myofacial pain dysfunction (MPD), or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L.P.N. – A licensed practical nurse.

Mail-order pharmacy – An establishment where prescription drugs are legally dispensed by mail and in larger quantities than are typically dispensed at a retail pharmacy.

Maximum –

- **Annual maximum benefit** – The greatest amount of benefits or services the program will pay for a specific type of expense per covered person in a calendar year. For example, benefits for certain services are limited to a stated number of visits or dollar amount.
- **Coinsurance maximum** – If you have met the deductible, the greatest dollar amount you would have to pay in coinsurance and copayments in a calendar year. See the *Schedule of Benefits* for specific amounts.
- **Out-of-pocket maximum expense** – The greatest amount of deductible and coinsurance/copayment expenses (combined) a person will pay in a calendar year. Also called out-of-pocket expense limit. See the *Schedule of Benefits* for specific amounts.

Mental disorder – A disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes, but is not limited to:

- Alcoholism and drug abuse,
- Schizophrenia,
- Bipolar disorder,
- Pervasive Mental Developmental Disorder,
- Panic disorder,
- Major depressive disorder,
- Psychotic depression, and
- Obsessive compulsive disorder.

Coverage of mental disorders includes alcoholism and drug abuse only if the type of treatment does not apply under other alcoholism and drug abuse provisions of the program.

Morbid obesity – A body mass index that:

- Exceeds 40 kilograms (about 88 pounds) per meter (about 3.28 feet) squared of height, or
- Equals or exceeds 35 kilograms (about 77 pounds) per meter (about 3.28 feet) squared of height with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

Necessary – A service or supply is necessary if the Claims Administrator determines that it is appropriate for the diagnosis, care or treatment of the illness or injury involved. To be appropriate, the service or supply must:

- Be care or treatment that, as it relates both to the illness or injury involved and to your overall health condition, is:
  - As likely to produce a significant positive outcome as any alternative service or supply, and
  - No more likely to produce a negative outcome than any alternative service or supply.

- Or be a diagnostic procedure indicated by your health status that, as it relates both to the illness or injury involved and to your overall health condition, is:
  - As likely to result in information that could affect the course of treatment as any alternative service or supply, and
  - No more likely to produce a negative outcome than any alternative service or supply.
- And be no more costly for diagnosis, care and treatment (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply meeting the above tests.

In determining if a service or supply is appropriate under the circumstances, the Claims Administrator will take into consideration:

- Information provided on your health status,
- Reports in peer-reviewed medical literature,
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data,
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment,
- The opinion of health professionals in the generally recognized health specialty involved, and
- Any other relevant information brought to the Claims Administrator's attention.

In no event will the following services or supplies be considered necessary:

- Those that do not require the technical skills of a medical, mental health or dental professional.
- Those furnished mainly for your personal comfort or convenience or that of any caregiver, family member, health care provider or health care facility.
- Those furnished solely because you are an inpatient on any day on which your illness or injury could safely and adequately be diagnosed or treated while not confined.
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated charge – The maximum amount an in-network provider has agreed to accept for any service or supply for the purpose of determining benefits under this Medical Program coverage.

Non-participating – Same as out-of-network.

Orthodontic treatment – Any medical or dental service or supply furnished to prevent, diagnose or correct a misalignment of teeth or the bite or the jaws or jaw-joint relationship, whether or not for the purpose of relieving pain.

Not considered orthodontic treatment is:

- The installation of a space maintainer, or
- A surgical procedure to correct malocclusion.

Out-of-network care – Services from a health care provider that has not contracted to furnish services or supplies for a negotiated charge under the BCBS provider network, or for prescription drugs and supplies under CVS/caremark. Same as non-participating provider.

Out-of-Network Rate – The payment rate required by ERISA for certain items and services. The Out-of-Network Rate applies to certain Emergency Services received from an out-of-network provider or facility and certain items or services furnished by an out-of-network provider at an in-network facility. The Out-of-Network Rate will be the negotiated rate or the amount determined by the independent dispute resolution process required under ERISA.

Out-of-pocket expense limit – Same as out-of-pocket maximum expense.

Par provider – Out-of-network provider who accepts the BCBS reasonable and customary charge, reimbursed at the out-of-network rate, as payment in full. A par provider does not balance-bill patients for any charges over those amounts. Do not confuse with participating providers defined below.

Participating provider – Same as in-network provider. Do not confuse with BCBS par providers defined above.

Pharmacy – An establishment where prescription drugs are legally dispensed.

Physician – A legally qualified physician.

Pre-determination – See *related section* of this chapter.

Pre-notification – See *related section* of this chapter.

Prescriber – Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a prescription drug.

Prescription – An order of a prescriber for a prescription drug. If it is an oral order, it must promptly be put in writing by the pharmacy.

Prescription drugs (or medications) – Any of the following:

- A drug, biological, compounded prescription or contraceptive device that, by federal law, may be dispensed only by prescription and that is required to be labeled "Caution: Federal law prohibits dispensing without a prescription."
- An injectable contraceptive drug prescribed to be administered by a paid health care professional.
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid health care professional. Covered injectable drugs include insulin.
- Disposable needles and syringes that are purchased to administer a covered injectable prescription drug.
- Disposable diabetic supplies.

Prescription legend drug – A drug that can be dispensed to the public only with an order (prescription) from a properly authorized person (physician, physician assistant or nurse practitioner). The Food and Drug Administration designates if a medication will be considered legend.

Primary care physician (PCP) – An in-network provider listed as a General Practice, Family Practice, Pediatric, Obstetrician/Gynecologist or Internal Medicine physician in the network directory.

Psychiatric physician – A physician who:

- Specializes in psychiatry, or
- Has the training or experience to do the required evaluation and treatment of mental illness.

R.N. – A registered nurse.

Reasonable Charge (also Reasonable and Customary Charge, R&C or Recognized Charge) As Determined by the Claims Administrator — is determined as follows:

If the charge is covered under Medicare, the lowest of:

- The provider's usual charge for furnishing the service or supply,
- The amount agreed to by the out-of-network provider and BCBS; or

- An amount determined by the Claims Administrator to be approximately 100% of the base Medicare reimbursement rate for the service or supply.

If there is no base Medicare reimbursement rate available for a Covered Expense, the lowest of:

- The provider's usual charge for furnishing the service or supply;
- The amount agreed to by the out-of-network provider and BCBS;
- The charge the Claims Administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; or
- The charge the Claims Administrator determines to be the prevailing charge level made for the service or supply in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, the Claims Administrator may take into account factors such as:

- The complexity,
- The degree of skill needed,
- The specialty of the provider,
- The range of services or supplies provided by the facility, and
- The prevailing charge in other areas.

Only that part of a charge which is reasonable is covered.

In some circumstances, the Claims Administrator may have an agreement with a provider (either directly or indirectly through a third party) that sets the charge that the Claims Administrator considers reasonable for a service or supply. In these instances, regardless of the methodology described above, the reasonable charge is established in that agreement.

Room and board charges – Charges made by an institution for room and board and other necessary services and supplies. Charges must be made regularly at a daily or weekly rate.

Semi-private rate – The charge for room and board that an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, the Claims Administrator will determine the semi-private rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Service area – The geographic area, as determined by the Claims Administrator, in which in-network providers for this Medical Program coverage are located.

Specialist – A physician who:

- Practices in any generally accepted medical or surgical sub-specialty, and
- Is providing other than routine medical care.

Specialty drugs – Drugs developed to treat a wide range of complex chronic conditions, such as cancer, growth hormone deficiency, immune deficiency multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia. These medications require special handling, training, monitoring and administration. Benefits are paid only for specialty drugs for which you
have obtained pre-authorization from Archimedes, the Claims Administrator. The Specialty Drug List is available at https://archimedesrx.com/resources/ or by calling Archimedes at 1-888-601-0967 and is updated from time-to-time.

Surgery center – A freestanding ambulatory surgical facility that:

- Meets licensing standards;

- Is set up, equipped and run to provide general surgery;
- Charges for its services;
- Is directed by a staff of physicians, at least one of whom must be on the premises when surgery is performed and during the recovery period;
- Has at least one certified anesthesiologist at the site when surgery that requires general or spinal anesthesia is performed and during the recovery period;
- Extends surgical staff privileges to:
  - Physicians who practice surgery in an area hospital, and
  - Dentists who perform oral surgery.
- Has at least two operating rooms and one recovery room;
- Provides or arranges for diagnostic X-ray and lab services needed in connection with surgery;
- Does not have a place for patients to stay overnight;
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N.;
- Is equipped and has trained staff to handle medical emergencies;
- Has a:
  - Physician trained in cardiopulmonary resuscitation,
  - Defibrillator,
  - Tracheotomy set, and
  - Blood volume expander.
- Has a written agreement with a hospital for immediate emergency transfer of patients. Written procedures for the transfer must be displayed and the staff must be aware of them;
- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility; and
- Keeps a medical record on each patient.

Terminally ill – A medical prognosis of six months or less to live.

Treatment facility (for alcoholism or drug abuse) – An institution that:

- Mainly provides a program for diagnosis, evaluation and effective treatment of alcoholism or drug abuse;
- Charges for its services;
- Meets licensing standards;
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a physician; and
- Provides, on the premises, 24 hours a day:
  - Detoxification services needed with its effective treatment program,
  - Infirmary-level medical services. Also, it provides, or arranges for, any other medical services that may be required,
  - Supervision by a staff of physicians, and
  - Skilled nursing care by licensed nurses who are directed by a full-time R.N.

Treatment facility (for mental disorder) – An institution that:

- Mainly provides a program for the diagnosis, evaluation and effective treatment of mental disorders,
- Is not mainly a school or a custodial, recreational or training institution,
- Provides infirmary-level medical services. Also, it provides, or arranges for, any other medical service that may be required,
- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly,
- Is staffed by psychiatric physicians involved in care and treatment,
- Has a psychiatric physician present during the whole treatment day,
- Provides, at all times, psychiatric social work and nursing services,
- Provides, at all times, skilled nursing care by licensed nurses who are supervised by a full-time R.N.,
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a psychiatric physician,
- Charges for its services, and
- Meets licensing standards.

Urgent admission – An admission to a hospital due to:

- The onset of or change in a disease,
- The diagnosis of a disease, or
- An injury caused by an accident.

This disease or injury, while not requiring an emergency admission, must be severe enough to require confinement as an inpatient in a hospital within two weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider/facility –

- A freestanding medical facility that:
  - Provides unscheduled medical services to treat an urgent condition if your physician is not reasonably available,
  - Routinely provides ongoing, unscheduled medical services for more than eight consecutive hours,
  - Charges for its services,
  - Is licensed and certified as required by any state or federal law or regulation,
  - Keeps a medical record on each patient,
  - Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility,
  - Is run by a staff of physicians. At least one physician must be on call at all times, and
  - Has a full-time administrator who is a licensed physician.
- A physician's office, but only one that has contracted with the Claims Administrator to provide urgent care; and is, with the Claims Administrator's consent, included in the network directory as an in-network Urgent Care Provider.

An Urgent Care Provider is not the emergency room or outpatient department of a hospital.

Urgent condition – A sudden illness, injury or condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health,
- Includes a condition that would subject you to severe pain that could not be adequately managed without urgent care or treatment,
- Does not require the level of care provided in the emergency room of a hospital, and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

Walk-in clinic – A health care facility, typically staffed by nurse practitioners and/or physician assistants with a physician on call during all hours of operation, that provides limited primary care services.