

# **Group Health Insurance Plans**

## **For Former Railroad Employees and their Dependents**

Provided under Group Policy Number GA-23111  
As Amended Effective June 1, 2010

Issued by UnitedHealthcare  
Hartford, Connecticut



# **CERTIFICATE OF COVERAGE**

**for inactive railroad and union Employees and their Dependents who are eligible for Health Benefits Plans offered by:**

## **COOPERATING RAILWAY LABOR ORGANIZATIONS**

**(called the Policyholder)**

**insured by**

**UNITEDHEALTHCARE INSURANCE COMPANY  
Hartford, Connecticut  
(called the Company)**

UnitedHealthcare Insurance Company has issued Group Policy No GA-23111 to the Policyholder, Cooperating Railway Labor Organizations, consisting of the separate organizations shown on page 2 of this Certificate. The Policy covers retired railroad workers as provided through collective bargaining agreements established by the signatories to the Policy as listed on page 2.

This Certificate of Coverage describes the benefits and provisions of the Policy.

This is an Employee's Certificate of Coverage only while that Employee is insured under the Policy. Dependent benefits apply only if the inactive railroad or union Employee is insured under this Plan for Dependent Benefits.

This Certificate describes the Plans in effect as of June 1, 2010. It is void if issued to any other Employee.

This Certificate replaces any and all Certificates previously issued for this Policy.

UNITEDHEALTHCARE INSURANCE COMPANY



Jon Allen Sorbo, President and CEO

105-1085 (5/10)

**THE GROUP HEALTH PLANS DESCRIBED IN THIS CERTIFICATE OF COVERAGE ARE AVAILABLE TO INACTIVE EMPLOYEES OF, OR REPRESENTED BY THE FOLLOWING COOPERATING RAILWAY LABOR ORGANIZATIONS SIGNATORY TO GROUP HEALTH POLICY GA-23111**

**International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers**

**International Brotherhood of Electrical Workers**

**National Conference of Firemen and Oilers**

**International Association of Machinists and Aerospace Workers**

**Sheet Metal Workers' International Association**

**Transportation Communications International Union**

**Brotherhood of Maintenance of Way Employees Department**

**Brotherhood of Railroad Signalmen**

**UNITE HERE**

**Brotherhood of Locomotive Engineers and Trainmen**

**United Transportation Union**

**American Train Dispatchers Association**

**Transportation Workers Union**

**THE PLANS ARE ALSO AVAILABLE TO CERTAIN EMPLOYEES REPRESENTED BY OTHER ORGANIZATIONS.**

## Table of Contents

I	INTRODUCTION .....	5
II	SUMMARY OF THE GROUP POLICY .....	7
	ELIGIBILITY SUMMARY .....	7
	BENEFITS SUMMARY .....	8
III	ENROLLMENT AND PAYMENT PROCEDURES .....	14
	WHO MAY ENROLL .....	14
	WHEN TO ENROLL .....	16
	SPECIAL ENROLLMENT PERIODS .....	17
	IMPORTANT MESSAGE FOR PERSONS ELIGIBLE UNDER MEDICARE .....	18
	EFFECTIVE DATE OF COVERAGE .....	20
	PREMIUM PAYMENT PROCEDURES .....	21
	TERMINATION OF COVERAGE .....	22
IV	PLAN A .....	23
	MAJOR MEDICAL EXPENSE BENEFITS .....	23
	PREFERRED PROVIDERS .....	34
	CARE COORDINATION .....	35
	WELLNESS PROGRAMS .....	39
V	PLAN B .....	41
	MAJOR MEDICAL EXPENSE BENEFITS .....	41
	PREFERRED PROVIDERS .....	52
	CARE COORDINATION .....	53
	WELLNESS PROGRAMS .....	57
V	PLAN C .....	59
	MAJOR MEDICAL EXPENSE BENEFITS .....	59
	PREFERRED PROVIDERS .....	70
	CARE COORDINATION .....	71
	WELLNESS PROGRAMS .....	75
VI	PLAN E .....	77
	MAJOR MEDICAL EXPENSE BENEFITS .....	79
VII	PLAN F .....	89
	HOSPITAL EXPENSE BENEFITS .....	91
	SKILLED NURSING FACILITY EXPENSE BENEFITS .....	92
	HOSPICE CARE BENEFITS .....	93
	MEDICAL EXPENSE BENEFITS .....	94
	FOREIGN EMERGENCY CARE BENEFITS .....	95
	AT-HOME RECOVERY CARE EXPENSE .....	96
	PREVENTIVE MEDICAL CARE EXPENSE BENEFITS .....	98
	TREATMENT CENTER EXPENSE BENEFITS .....	99

VIII	PLAN M .....	100
	MAJOR MEDICAL EXPENSE BENEFITS .....	100
	PREFERRED PROVIDERS .....	111
	CARE COORDINATION .....	112
IX	GENERAL EXCLUSIONS .....	114
X	BENEFITS AFTER COVERAGE ENDS .....	120
XI	DEFINITIONS .....	121
XII	CLAIM INFORMATION .....	133
XIII	IMPORTANT MESSAGE FOR AMTRAK RETIREES AND CERTAIN OTHER RETIREES COVERED UNDER PLAN E.....	135
	IMPORTANT MESSAGE FOR RETIREES OF MASSACHUSETTS BAY COMMUTER RAIL COVERED UNDER PLAN M .....	136

# INTRODUCTION

The Plans included in this Certificate have been made available by the Railway Labor Organizations to provide benefits under Group Policy GA-23111 for Employees and Dependents formerly covered under the Health & Welfare Plan, the NRC/UTU Plan, GA-46000, or GA-107300 and for parents of Employees currently covered under one of these plans.

Some of the terms used in this Certificate need explanation because they have specialized or important meanings for the purposes of the Group Policy. When any of these terms is used in this Certificate, it will have the meaning shown for that term in the Definitions section of this Certificate of Coverage. Refer to this section whenever you have a question about any of the terms listed below.

Alternate Care Plan

Ambulatory Surgical Center

Chemotherapy

Covered Health Services

Custodial Care

Dependent

Durable Medical Equipment

Employee

Experimental or Investigational or Unproven Service(s)

Full Medicare Coverage

Furloughed Employee

GA-107300

GA-46000

Health & Welfare Plan

Home Health Care Agency

Hospice

Hospital

Inactive Employee

Level of Care

MBCR

Medically Appropriate

Medicare

NRC/UTU Plan

Person Eligible Under Medicare

Physician

Policy

Policyholder

Preferred Providers

Psychologist

Reasonable Charge  
Skilled Nursing Facility  
Student  
Transplant Facility  
Treatment Center  
Urgent Care Center

Whenever the pronouns "he", "his", or "him" appear in this text, they refer equally to the female as well as the male gender.



## II SUMMARY OF THE GROUP POLICY

The benefits described in this Certificate are for U.S. residents only. Here is a brief summary of the eligibility and benefit provisions of Group Policy GA-23111. The detailed description of these provisions is contained later in this Certificate of Coverage.

### ELIGIBILITY SUMMARY

When your coverage under the Health & Welfare Plan, the NRC/UTU Plan, GA-46000 or GA-107300 terminates you may enroll in Plan A, B, C, E, F or M for yourself and/or your Dependents in accordance with the following:

Plans A, B and C for all persons eligible for coverage under GA-23111 except Persons Eligible Under Medicare, and persons eligible under GA-46000.

Plan E for persons eligible under GA-46000.

Plan F for Persons Eligible Under Medicare. Each person must be enrolled separately and a separate premium paid under Plan F.

Plan M for persons eligible under Massachusetts Bay Commuter Rail (MCBR) Early Retirement Plan.

## BENEFITS SUMMARY – PLANS A, B AND C

Benefit	Policy GA-23111		
	Plan A	Plan B	Plan C
<b>Annual Deductible (applies to OOP deductible)</b>	\$1,000	\$750	\$500
<b>Annual Out of Pocket Maximum</b>	\$15,000	\$10,000	\$7,500
<b>Policy Lifetime Maximum Benefit</b>	\$500,000	\$500,000	\$500,000
<b>Inpatient Hospital and Related Services (includes maternity)</b>  <b>Inpatient Mental Health and Substance Abuse Services</b>  <b>Surgical Procedures (Surgeon, Anesthesiology and Facility, including Ambulatory Surgical Center and Outpatient Surgical Center)</b>	50% of eligible expenses after satisfying deductible.	60% of eligible expenses after satisfying deductible.	70% of eligible expenses after satisfying deductible.
<b>Medical Services/ Physician's Office Visit</b>	50% of eligible expenses after satisfying deductible. 100% of eligible expenses without deductible for the following: Mammography and Pap Smear.	60% of eligible expenses after satisfying deductible. 100% of eligible expenses without deductible for the following: Mammography and Pap Smear.	70% of eligible expenses after satisfying deductible. 100% of eligible expenses without deductible for the following: Mammography and Pap Smear.
<b>Outpatient Mental Health and Substance Abuse services</b>	75% of eligible expenses after satisfying deductible for the first 40 visits, 60% for any visits thereafter.	75% of eligible expenses after satisfying deductible for the first 40 visits, 60% for any visits thereafter.	75% of eligible expenses after satisfying deductible for the first 40 visits, 60% for any visits thereafter.
<b>Outpatient Rehabilitation (physical, occupational, speech therapy and Chiro)</b>	50% of eligible expenses after satisfying deductible. *Limited to 30 visits per calendar year. Exception: Calendar year visit limit does not apply to services for a child under age 21 with a congenital or birth defect.	60% of eligible expenses after satisfying deductible. *Limited to 30 visits per calendar year. Exception: Calendar year visit limit does not apply to services for a child under age 21 with a congenital or birth defect.	70% of eligible expenses after satisfying deductible. *Limited to 30 visits per calendar year. Exception: Calendar year visit limit does not apply to services for a child under age 21 with a congenital or birth defect.
<b>Allergy/Acupuncture Services</b>	50% of eligible expenses after satisfying deductible.	60% of eligible expenses after satisfying deductible.	70% of eligible expenses after satisfying deductible.

Benefit	Policy GA-23111		
	Plan A	Plan B	Plan C
<b>Emergency Room Services</b>	50% of eligible expenses after satisfying deductible.	60% of eligible expenses after satisfying deductible.	70% of eligible expenses after satisfying deductible.
<b>Durable Medical Equipment</b> Prior notification is required for items over \$1,000.*	50% of eligible expenses after satisfying deductible.	60% of eligible expenses after satisfying deductible.	70% of eligible expenses after satisfying deductible.
<b>Prescription Drugs</b>	Not Covered	Not Covered	Not Covered
<b>Home Health Care Services*</b>	50% of eligible expenses after satisfying deductible up to 30 visits per calendar year.	60% of eligible expenses after satisfying deductible up to 30 visits per calendar year.	70% of eligible expenses after satisfying deductible up to 30 visits per calendar year.
<b>Hospice Facility*</b>	50% of eligible expenses after satisfying deductible for up to a period of six (6) months.	60% of eligible expenses after satisfying deductible for up to a period of six (6) months.	70% of eligible expenses after satisfying deductible for up to a period of six (6) months.
<b>Skilled Nursing Facility</b>	50% of eligible expenses after satisfying deductible for up to 31 days per confinement; confinement applies to skilled nursing facility only.	60% of eligible expenses after satisfying deductible for up to 31 days per confinement; confinement applies to skilled nursing facility only.	70% of eligible expenses after satisfying deductible for up to 31 days per confinement; confinement applies to skilled nursing facility only.
<b>Emergency Transportation Services</b>	50% of eligible expenses after satisfying deductible for ambulance service to a hospital in the event of an emergency.	60% of eligible expenses after satisfying deductible for ambulance service to a hospital in the event of an emergency.	70% of eligible expenses after satisfying deductible for ambulance service to a hospital in the event of an emergency.
<b>Exclusions (partial list):</b>	Hearing Wisdom Teeth Orthodontics Massage Therapy	Hearing Wisdom Teeth Orthodontics Massage Therapy	Hearing Wisdom Teeth Orthodontics Massage Therapy

*\* Requires prior notification – Care Coordination must be contacted to determine whether the purchase, rental of equipment or services provided are Medically Appropriate.*

## **PLAN A**

### **Major Medical Expense Benefits**

Maximum Amount per lifetime – \$500,000

Cash Deductible per calendar year – \$1,000

Out-of-Pocket Maximum per calendar year – \$15,000

Percentage of Covered Expenses payable – 50% (40% if Care Coordination is not called when required).

Percentage of Covered Expenses payable after Out-of-Pocket Maximum is reached - 100% (80% if Care Coordination is not called when required)

## **PLAN B**

### **Major Medical Expense Benefits**

Maximum Amount per lifetime - \$500,000

Cash Deductible per calendar year – \$750

Out-of-Pocket Maximum per calendar year – \$10,000

Percentage of Covered Expenses payable – 60% (48% if Care Coordination is not called when required).

Percentage of Covered Expenses payable after Out-of-Pocket Maximum is reached - 100% (80% if Care Coordination is not called when required)

## **PLAN C**

### **Major Medical Expense Benefits**

Maximum Amount per lifetime – \$500,000

Cash Deductible per calendar year – \$500

Out-of-Pocket Maximum per calendar year – \$7,500

Percentage of Covered Expenses payable – 70% (56% if Care Coordination is not called when required).

Percentage of Covered Expenses payable after Out-of-Pocket Maximum is reached - 100% (80% if Care Coordination is not called when required)

## **PLAN F**

### **Hospital Expense Benefits**

For confinements up to 90 days:

- the Medicare Part A Deductible for the first 60 days;
- the Medicare Part A daily coinsurance amount for the 61st to the 90th day.

For confinements over 90 days:

- any Medicare Part A coinsurance amount when lifetime reserve days are used;
- up to 365 days of Hospital charges in a person's lifetime after all lifetime reserve days are used.

### **Skilled Nursing Facility Expense Benefits**

The Medicare Part A daily coinsurance amount for the 21st to the 100th day of a Medicare approved confinement.

### **Hospice Care Benefits**

The amount of the Medicare five percent (5%) coinsurance charge for hospice respite care provided on an inpatient basis.

The Medicare copayment amount, up to a maximum of \$5, for each outpatient prescription drug that is prescribed for symptom control or pain relief.

### **Medical Expense Benefits**

The amount of the Medicare Part B deductible.

The amount of the Medicare Part B coinsurance.

The amount of the Medicare Part B limiting charge when a physician or provider does not accept a Medicare assignment.

The Medicare blood deductible.

### **Foreign Emergency Care Benefits**

80% of charges for necessary emergency care in a foreign country, up to a lifetime maximum of \$50,000.

### **At-Home Recovery Care Expense Benefits**

Up to \$1,600 per year for short-term at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

### **Preventive Medical Care Expense Benefits**

Up to \$500 per year for preventive screening tests or preventive services.

### **Treatment Center Expense Benefits**

Confinements in a Treatment Center:

- 60 days per Calendar Year.
- 12 days per Calendar Year for detoxification services.

## **PLAN E & PLAN M**

### **Major Medical Expense Benefits**

Maximum Amount per lifetime – \$500,000

Cash Deductible per calendar year – \$100

Out-of-Pocket Maximum per calendar year – \$5,000

Percentage of Covered Expenses payable:

- All expenses except Outpatient Alcoholism, Chemical Dependency and/or Mental Illness Services  
70%
- Expenses for Outpatient Alcoholism, Chemical Dependency and/or Mental Illness Services - 75% for the first 40 visits, 60% for any visits thereafter

Percentage of Covered Expenses payable after the Out-of-Pocket Maximum is reached - 100%

### **Treatment Center Expense Benefits**

Confinements in a Treatment Center:

- 60 days per Calendar Year.
- 12 days per Calendar Year for detoxification services.

## **ALL PLANS**

Under federal law, benefits may not be restricted 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 delivery by cesarean section. However, benefits may be paid for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

If the mother agrees, the attending provider may discharge the mother and/or newborn child earlier than these minimum time frames.

In all cases of early discharge, coverage shall be provided for post-delivery care within the minimum time periods shown above in the Employee's home, or, in a provider's office, as determined by the Physician in consultation with the mother.

The at-home post-delivery care shall be provided by a registered professional nurse, Physician, nurse-practitioner, nurse-midwife, or physician assistant experienced in maternal and child health, and shall include:

- parental education;
- assistance and training in breast or bottle feeding; and
- performance of any necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

Additional Benefits may be available to you or your Dependents depending on your state of residence. For more information contact UnitedHealthcare, Railroad Administration, P. O. Box 150453, Hartford, CT 06115-0453.

In addition, any provision of this Certificate which, on its effective date, is in conflict with the statutes of the jurisdiction in which you reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

# III ENROLLMENT AND PAYMENT PROCEDURES

## WHO MAY ENROLL

### EMPLOYEES AND DEPENDENTS

GA-23111 enrollment is available to certain Employees and their Dependents, when their employer group health coverage ends. This employer group health coverage must have been provided under one of the following plans:

- Health & Welfare Plan (including AmPlan);
- GA-46000 (including AmPlan Early Retirement Benefits and MBCR Early Retirement Benefits);
- GA-107300;
- NRC/UTU Plan;
- Any other health and welfare plan established pursuant to an agreement between one or more railroads and one or more labor organizations.

GA-23111 is also available to former Railway Industry Employees, and their Dependents, who were not covered under one of the above listed plans, but who are members in accordance with the constitution or by-laws of one of the participating railway labor organizations, when coverage under the employer group health plan which applies to them ends.

If you live outside of the United States of America, you are not eligible for the coverage provided in this Certificate.

#### **Important Message for Hospital Association Employees**

If your Employee health benefits were provided by a hospital association while you were actively working, you may enroll for Employee benefits under GA-23111 only:

- If you are retired and do not qualify for benefits similar to GA-46000 through the hospital association, or
- If you are not retired, but are not actively at work, your membership in the hospital association is discontinued.

If you do qualify for benefits similar to GA-46000 through the hospital association, you can enroll for Employee benefits under GA-23111 when you become eligible for Medicare.



In the event Dependent benefits end under GA-107300 because a widow or a widower remarries, the surviving spouse, and any surviving dependent children, may enroll for Dependent benefits under GA-23111.

If you have questions about when your active group health coverage ends, please refer to the booklet titled The Health and Welfare Plan of the Nation's Railroads, the Railway Labor Organizations or the National Railway Carriers & United Transportation Union Health & Welfare Plan.

In order to determine when coverage ends under GA-46000 or GA-107300, refer to your benefits booklet for these plans, or call UnitedHealthcare at 1-800-842-5252.

In order to determine when your coverage under any other employer group health plan ends, refer to your benefits booklet, or call a representative of that plan.

If you are a Suspended or a Dismissed Employee enrolled under GA-23111, and if you are awarded full back pay for all time lost as a result of your suspension or dismissal, you may be entitled to a refund of the premiums you paid under GA-23111. If this occurs, you should contact UnitedHealthcare for additional information.

#### **STUDENTS AND INCAPACITATED CHILDREN**

Dependent benefits under Plans A, B, C, E and M cover children age 19 or over who are Students or who are incapacitated. Therefore if you are enrolling for Dependent benefits under Plans A, B, C, E or M, you are not required to enroll these children separately unless the child is eligible under Medicare. However, proof of Student or incapacitated status may be required. When incapacitated children are no longer eligible for Dependent benefits under Plans A, B, C, E or M, they must be enrolled separately, and an additional payment is required.

#### **PARENTS OF EMPLOYEES COVERED UNDER THE HEALTH & WELFARE PLAN, THE NRC/UTU PLAN, GA-23111 AND GA-107300**

Employees covered under the Health & Welfare Plan, the NRC/UTU Plan, GA-23111 or GA-107300 may enroll under Plan F to provide benefits for parents and parents-in-law who are eligible under Medicare.

## WHEN TO ENROLL

There is an initial four month period during which you or your Dependents may enroll under GA-23111. This initial four month period begins in the month in which your employer group health coverage ends, and extends for the next three months. For example, if your employer group health coverage ends on May 15, you may enroll under GA-23111 at anytime from May 1 through August 31. If you have questions about when your active group health coverage ends, please refer to the booklet titled The Health and Welfare Plan of the Nation's Railroads, the Railway Labor Organizations or the National Railway Carriers & United Transportation Union Health & Welfare Plan.

If you did not enroll during your initial four month period, a second four month period is available when you or any individual Dependent first becomes eligible for Medicare. This second four month period begins in the month immediately prior to your Medicare eligibility date, and extends for the next three months.

Two examples may help explain these two enrollment periods:

1. If you are covered under the Health & Welfare Plan or the NRC/UTU Plan and you leave compensated service on September 30, 2010 to retire, your Employee and Dependents health benefits under that plan would end October 31, 2010. Your initial four month period begins October 1, 2010 and ends January 31, 2011.
2. If you did not enroll under GA-23111 during your initial four month period, you have a second four month period beginning in the month prior to the month you become eligible for Medicare. If your Medicare eligibility date is October 1, 2010, your second four month period begins September 1, 2010 and ends December 31, 2010. If your spouse's Medicare eligibility date is March 1, 2011, your spouse's second four month period begins February 1, 2011 and ends May 31, 2011.

If you or your Dependents are continuing your employer group health coverage under COBRA, your initial four month enrollment period begins in the month in which your COBRA continuation coverage ends.

If you are enrolling your parents or parents-in-law under GA-23111, there is only an initial four month enrollment period. It begins as follows:

- If your parent or parent-in-law is already eligible for Medicare when you first become covered under the Health & Welfare Plan, the NRC/UTU Plan, GA-23111 or GA-107300, your four month period begins in your first month of coverage.
- If your parent or parent-in-law becomes eligible for Medicare after you become covered under any of these plans, your four month period begins in the month prior to the month of your parent's or parent-in-law's Medicare eligibility date.

**If you do not enroll during your initial or second four month enrollment period, you may enroll in an Open Enrollment Period.**

## SPECIAL ENROLLMENT PERIODS

You and/or your Dependents may be able to enroll during a special enrollment period, which is the first thirty (30) days immediately following a special enrollment event. A special enrollment period is not available to you or your Dependent if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

A special enrollment period applies to you or your Dependent when one of the following events occurs:

- Birth.
- Legal adoption of an eligible child or the placement of a child with you for adoption.
- Marriage.

A special enrollment period also applies for you or your Dependent who did not enroll under the Policy if the following are true:

- You or your Dependent had existing health coverage under another plan at the time you/they had an opportunity to enroll under the Policy; and
- Coverage under the prior plan ended because of any of the following?
  - Loss of eligibility (including, but not limited to, legal separation, divorce or death).
  - The employer stopped paying the contributions. This is true even if you or your Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - You or your Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  - The plan no longer offers benefits to a class of individuals that include you and/or your Dependent.
  - You or your Dependent incurs claims that would exceed a lifetime limit on all benefits.

When an event takes place (for example, a birth or marriage), coverage begins on the date of the event. For you or your Dependent who did not enroll under the Policy because you/they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends.

You must notify UnitedHealthcare within thirty (30) days of the occurrence of any of the special enrollment events. If you do not notify UnitedHealthcare within that timeframe, you will not be able to enroll yourself or your Dependent under the Policy until the next open enrollment period.

You will be responsible for any increase in your monthly premium due to the addition of a new Dependent to the Policy (i.e., going from employee only, to employee plus spouse, etc.)

## **IMPORTANT MESSAGE FOR PERSONS ELIGIBLE UNDER MEDICARE**

No person may enroll under Plan F if that person is covered under any one of the programs called Medicare Advantage Plans (formerly called Medicare+Choice). These programs are described in the Medicare Handbook *Medicare & You*.

Any individual covered under Plan F who subsequently enrolls under any of the programs called Medicare Advantage cannot continue coverage under Plan F beyond the effective date of the individual's coverage under the Medicare Advantage plan. You must notify UnitedHealthcare if you become covered under a Medicare Advantage plan.

If you cancel coverage under any of the Medicare Advantage plans with a cancellation effective date of December 31, you may enroll under Plan F, with an effective date of January 1 of the following year. You may enroll in December or January for a January 1 effective date under these circumstances, provided you notify UnitedHealthcare within 30 days of your Medicare Advantage plan cancellation, you provide documentation that your coverage under that plan was cancelled, and you make the January payment for coverage under Plan F.

If you cancel your Medicare Advantage plan at any other point during a calendar year, you will only be able to enroll in Plan F during an Open Enrollment Period.

If you lose your Medicare Advantage coverage because the plan closes and you return to Medicare, you can enroll in Plan F provided you notify UnitedHealthcare within 30 days of the termination. You must provide documentation showing the plan closed to all individuals, such as a letter from the Plan or a public notice of the closure in a newspaper.

### **OPEN ENROLLMENT PERIOD**

An Open Enrollment Period is held in November and December of each even calendar year (2010, 2012, etc.), and there may be additional special enrollment periods. Enrollments during the Open Enrollment Period (or any special enrollment period) are for coverage beginning on the 1<sup>st</sup> day of the month following the Open or special enrollment period.

### **HOW TO ENROLL**

1. Fill out and sign the enrollment form. If you do not have an enrollment form, you can obtain one by calling UnitedHealthcare at 1-800-842-5252. Please be sure all employment information on the form is completed. In selecting the person(s) to be covered and the plan on the reverse side of the form, remember the following:
  - Plans A, B and C are only available to Employees and Dependents who are not eligible under Medicare or GA-46000.
  - Each Person Eligible Under Medicare may enroll in Plan F. This includes children who are eligible under Medicare. If your spouse is enrolled under Plan F, your Dependent children must be separately enrolled under Plans A, B or C in order to be covered under GA-23111.
  - You must be covered under GA-46000 in order to be eligible under Plan E. Eligibility requirements for GA-46000 are described in the GA-46000 booklet. If you meet the eligibility requirements for GA-46000, but you or one of your Dependents is eligible for Medicare, you or that Dependent must enroll under Plan F in order to be covered under GA-23111.

- You must be covered under the MBCR Early Retirement Plan in order to be eligible under Plan M. If you meet the eligibility requirements for the MBCR Early Retirement Plan, but you or one of your Dependents is eligible for Medicare, you or that Dependent must enroll under Plan F in order to be covered under GA-23111.
3. Mail the completed enrollment form with check or money order in the amount required, as specified on the form, to UnitedHealthcare in accordance with the instructions on the enrollment form.
  4. After you have enrolled for coverage **you must notify** UnitedHealthcare whenever:
    - One of your children reaches age 19 and qualifies as either a Student or incapacitated child.
    - You or one of your Dependents become eligible for Medicare due to disability or end stage renal disease.

Coverage for each Person Eligible Under Medicare will not be continued under Plans A, B, C, E or M as of the date of Medicare eligibility. Coverage for such Employee or Dependent will be automatically transferred to Plan F at age 65.

**IMPORTANT:** If you or your Dependent becomes eligible under Medicare before age 65, you **must** notify UnitedHealthcare and send a copy of your Medicare card so that continued coverage, if desired, can be transferred to Plan F.

5. If you return to compensated service, and you again become covered under an employer group health plan, you should:
  - Make no further premium payments under GA-23111.
  - Advise us of your return to work date, and the date your employer group health plan coverage becomes effective, by writing to UnitedHealthcare, Railroad Administration, P. O. Box 150453, Hartford, CT 06115-0453.

## **EFFECTIVE DATE OF COVERAGE**

If you enroll in the first or second month of your initial four month period, your GA-23111 coverage will be effective beginning on the day after your coverage under the employer group health plan ends. You will have no gap in coverage between plans.

If you enroll in the third or fourth month of your initial four month period, your GA-23111 coverage will be effective on the first day of the month following your enrollment. You will have a gap between the date your coverage under the employer group health plan ends, and the date your GA-23111 coverage begins.

If you enroll in the first or second month of your second four month period, your GA-23111 coverage will be effective on your Medicare effective date.

If you enroll in the third or fourth month of your second four month period, your GA-23111 coverage will be effective on the first day of the month following your enrollment.

If you are enrolling your parents or parents-in-law who are already eligible for Medicare when you first become covered under the Health & Welfare Plan, NRC/UTU Plan, GA-23111 or GA-107300, your GA-23111 coverage will always be effective on the first day of the month following your enrollment.

If you are enrolling your parents or parents-in-law who become eligible for Medicare after you become covered under the Health & Welfare Plan, NRC/UTU Plan, GA-23000, GA-23111 or GA-107300, the rules stated above applicable to the second four month period will apply.

If you enroll during an Open Enrollment Period, your coverage will be effective on the first of the following month.

For the purposes of determining the effective date of GA-23111 coverage, your enrollment occurs when your completed Enrollment Form and payment is mailed (postmarked) to UnitedHealthcare.

For newborn coverage, benefits are payable for a newborn child for 31 days after the child's birth, even if the Employee has not enrolled the child. In order to cover the child beyond the 31 days, the Employee must enroll the child within those 31 days from the date of the birth.

## PREMIUM PAYMENT PROCEDURES

Premiums under GA-23111 may be paid on either a monthly or a quarterly basis. You may select the type of billing you prefer by checking the appropriate box on the enrollment form.

### Monthly Billing

If you select monthly billing, you will be paying for coverage one month in advance. You will receive a "Notice of Payment Due" no later than the first week of each month. The payment is due by the 20th of that month, and will provide coverage for the following month.

With each "Notice of Payment Due" you will also receive a "Certification of Coverage-Payment Receipt." This form will acknowledge your previous payment and certify your coverage during the current month. It can be used as an identification card for hospitals and other providers of medical services.

If any monthly payment is not received by UnitedHealthcare by the due date shown on the "Notice of Payment Due," your next "Notice of Payment Due" will request payment for both the current month (which is past due) and the following month. If the past due amount is not paid, coverage will terminate as described in Termination of Coverage section.

### Quarterly Billing

If you select quarterly billing, you will be paying for coverage one quarter in advance. You will receive a "Notice of Payment Due" no later than the first week of the month in which payment is due. The payments are due as follows:

Payments due by:	Provides coverage for the months of:
May 20	June, July and August
August 20	September, October and November
November 20	December, January and February
February 20	March, April and May

If you request quarterly billing, your initial payment should include the remaining months in the current quarter. For example, if you enroll for coverage effective October 1, your initial payment should include the amount due for October and November. You would then be billed during the first week of November for coverage in the next quarter (December, January and February).

If a quarterly payment is not received by UnitedHealthcare by the due date shown on the "Notice of Payment Due," you will receive a "Late Payment Offer" in the next month. If this payment is not made, coverage will terminate as described in Termination of Coverage that follows.

## TERMINATION OF COVERAGE

If you are billed monthly and do not pay any amount shown as past due, or if you are billed quarterly and do not pay the amount requested on the "Late Payment Offer", your coverage will terminate. You will **not** receive an additional notice. The termination will be effective as of the end of the last month or quarter for which payment has been received by UnitedHealthcare.

You may voluntarily terminate your coverage at any time by giving advanced notice in writing to UnitedHealthcare, P.O. Box 150453, Hartford, CT 06115-0453. Your termination will be effective on the first day of the month following the month in which your notice is received by UnitedHealthcare, unless your request clearly states a preferred advanced termination date.



## **IV PLAN A**

### **APPLICABLE TO PERSONS NOT ELIGIBLE UNDER MEDICARE OR GA-46000 MAJOR MEDICAL EXPENSE BENEFITS**

The Plan pays a percentage of Covered Expenses incurred in a calendar year which exceed the Deductible.

#### **DEDUCTIBLE**

The Deductible amount is \$1,000. It applies separately to each covered individual each calendar year.

#### **PERCENTAGE OF COVERED EXPENSES PAYABLE**

The Plan pays 50% (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and 60% for any visits thereafter) of the Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays 40% of the Covered Expenses in a calendar year after the Deductible is satisfied when Care Coordination is not called when required. See the Care Coordination description contained in this Section IV.

The Plan pays 100% of Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met. (80% if Care Coordination is not called when required.)

#### **OUT-OF-POCKET MAXIMUM**

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum is \$15,000 each calendar year. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limits or exclusions.
- Charges you pay for expenses not covered by the Plan.
- Charges you pay as a result of the reduction in benefits payable when Care Coordination is not notified or if the service or supply, although a Covered Health Service, is not Medically Appropriate.

#### **MAXIMUM AMOUNT**

The Maximum Amount payable with respect to you or any of your Dependents is \$500,000. The Maximum Amount applies to a person's entire lifetime and is a combined lifetime maximum under Plans A, B and C.

The Maximum Amount for anyone who has received benefits will be restored each January 1 by \$1,000, or lesser amount, until the maximum is again \$500,000.

## **COVERED EXPENSES**

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for Covered Health Services (see Definitions) and supplies listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are considered Covered Health Services.

### **Accupuncture Services**

Accupuncture services for the following conditions:

- Pain therapy, when another method of pain management has failed.
- Nausea that is related to surgery, pregnancy or chemotherapy.

Accupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Accupuncturist.
- Chiropractor.
- Physician's Assistant.

### **Allergy Immunotherapy Received in a Physician's Office**

Benefits are available for allergy immunotherapy received in a Physician's office.

### **Ambulatory Surgical Center**

Charges for services and supplies furnished in an Ambulatory Surgical Center in connection with a surgical procedure within 24 hours from and in connection with the surgical procedure.

### **Anesthetics**

### **Assistant Surgeon**

Coverage for assistant surgeon services are limited to 1/5 of the amount of the Reasonable Charge for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are covered at the same or lesser rate.

### **Chemotherapy**

## Clinical Trials

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare's medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.

- A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
- An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

### **Diabetes Treatment**

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

### **Durable Medical Equipment**

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed. Non-hospital beds, comfort beds, and motorized beds/mattresses are generally excluded from coverage.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.

- Insulin pumps and all related necessary supplies.
- Wigs, but only for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury, and up to a maximum of \$500.
- Speech aid prosthetics and traceo-esophageal voice prosthetics. All other devices and computers to assist in communication and speech are not considered Durable Medical Equipment.
- External prosthetic devices that replace a limb or body part.

Benefits under this section do not include:

- Durable Medical Equipment provided to you by a Physician.
- Generally, any device, appliance, pump, machine stimulator, or monitor that is fully implanted into the body.

If you have any questions regarding whether a particular item is considered to be Durable Medical Equipment, please contact Care Coordination.

Care Coordination must be contacted for any purchase or rental of Durable Medical Equipment that exceeds \$1,000. UnitedHealthcare will decide if the equipment should be purchased or rented.

Benefits that are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.
- Replacement of Durable Medical Equipment is limited to every three years, unless there are catastrophic circumstances, in which case you should notify UnitedHealthcare and an individual case evaluation will be performed.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece that UnitedHealthcare has determined is the most cost-effective.

### **Emergency Transportation Services**

Transportation charges are covered for transportation to a Hospital in connection with an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

### **Habilitative Services**

Habilitative Services for children 0-21 years old are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitative Services, a congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congenital or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

## **Home Health Care Agency Services**

Charges for services of a Home Health Care Agency prescribed in writing by a Physician to be in lieu of Hospital confinement, up to a maximum of 30 visits during any one calendar year. Each visit by a member of a home health care team will be considered as one home health care visit. Four hours of home health care services will be considered as one home health care visit. If a visit exceeds four hours, each additional four hours, or part thereof, will count as one additional visit. Each visit by any other member of the home health care team will count as an additional visit.

The following services and supplies of a Home Health Care Agency are covered:

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Temporary or part-time care by a home health aide.
- Physical therapy, occupational therapy or speech therapy.
- Medical supplies.
- Drugs and medications ordered by a Physician.
- X-ray and laboratory tests.

## **Hospice**

Hospice care that is recommended by a Physician, for a period of up to six (6) months. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the patient is receiving hospice care.

You must notify and receive approval from Care Coordination prior to receiving any inpatient or outpatient hospice care in order to be eligible for this benefit.

Benefits are available when hospice care is received from a licensed hospice agency.

A Physician must certify that the patient is terminally ill and that the patient's life expectancy is six (6) months or less.

## **Hospital Services**

Services and supplies provided by a Hospital on an inpatient basis, except that if charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the national Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital on an outpatient basis including:

- Emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:
  - Placing the patient's health in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- Voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening test is necessary for the treatment of the condition for which the emergency care is sought.

### **Medical Supplies**

- Medical and surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood derivatives only if not donated or replaced.

### **Multiple Surgical Procedures**

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

- Covered Expenses for the second procedure will be limited to 50% of the Reasonable Charge for that procedure had it been performed alone.
- Covered Expenses for any subsequent procedure are limited to 50% of the Reasonable Charge for the subsequent procedures.

### **Organ/Tissue Transplants**

- Donor Charges

In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

If a qualified procedure, listed below, is Medically Appropriate and performed at a Transplant Facility, the "Medical Care and Treatment" and "Transportation and Lodging" provisions set forth below apply:

- Heart transplants
- Lung transplants
- Heart/lung transplants
- Liver transplants
- Kidney transplants
- Pancreas transplants

- Kidney/pancreas transplants
- Bone marrow/stem cell transplants
- Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

If a transplant, even if determined to be Medcially Appropriate, is not performed at a Transplant Facility, there will be no benefit payable for the “Medical Care and Treatment” or the “Transportation and Lodging” provisions set forth below.

- Medical Care and Treatment
  - The following services provided in connection with the transplant are Covered Health Services:
    - Pre-transplant evaluation for one of the procedures listed above
    - Organ acquisition and procurement
    - Hospital and Physician fees
    - Transplant procedures
    - Follow-up care for a period up to one year after the transplant
    - Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of \$25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people.

Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the \$100 per diem rate.

There is a combined overall lifetime maximum of \$10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under Plans A, B and C, combined, in connection with all transplant procedures.

If you or your Dependent(s) receive reimbursement for meals associated with this Transportation and Lodging benefit that is not part of inpatient care, federal tax rules require that such reimbursements be reported to the Employee. You will receive appropriate notification of any such taxable amounts paid to you.



## **Outpatient Alcoholism, Chemical Dependency and Mental Illness Services**

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and then 60% of any additional visits.

## **Outpatient Rehabilitation**

Short-term outpatient rehabilitation services, limited to:

- Physical therapy
- Occupational therapy
- Chiropractic treatment
- Speech therapy
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

Rehabilitation services are limited to thirty (30) visits per calendar year for any combination of services.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital.

We will pay benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders.

## **Physician Services**

Physician charges for professional services incurred:

- in a Physician's office;
- during a Hospital confinement;
- for the performance of a surgical operation; or
- in a Skilled Nursing Facility.

When determined to be a Covered Health Service, charges by an assistant surgeon are also covered under the plan.

### **Preventive Adult Health Services**

- One routine physical examination per calendar year, subject to the calendar year Deductible.
- Necessary laboratory tests and/or immunizations, subject to the calendar year Deductible.
- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
  - a baseline mammogram; and
  - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above for mammography testing and pap smears are not subject to the calendar year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Prostate cancer screenings are covered in accordance with the latest screening guidelines used by the American Cancer Society.

### **Preventive Child Health Services**

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and
- Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

### **Radiation Therapy**

#### **Skilled Nursing Facility**

Services and supplies up to 31 days of confinement following each Hospital confinement per calendar year.

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

Skilled nursing facility stays must be approved in advance by Care Coordination in order to be eligible for benefits.

**Treatment Center Services**

Charges for services at a Treatment Center when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

**Urgent Care Center Services**

Charges for Covered Health Services received at an Urgent Care Center.

**X-ray and Laboratory Tests**

**IMPORTANT: It should be noted that the Covered Expenses listed above do not include charges for drugs, private duty nursing, Physician's home visits, and some other services and supplies which are covered under the Health & Welfare Plan, NRC/UTU Plan, GA-46000 or GA-107300.**

## **PREFERRED PROVIDERS**

UnitedHealthcare has arranged with certain health care providers to become Preferred Providers. These Preferred Providers have agreed to discount their charges for Covered Expenses.

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

You will receive an Identification Card showing that you and/or your Dependents Covered under Plans A, B or C, are entitled to these discounts. This Identification Card must be shown every time health care services are given. This is how the provider knows that you and/or your Dependent is covered under a Preferred Provider plan. Otherwise, you could be billed for the provider's normal charge.

Call UnitedHealthcare at 1-800-842-5252 to inquire about or locate Preferred Providers in your area. You may also access Preferred Provider information online at [myuhc.com](http://myuhc.com).

Preferred Providers are responsible for filing your claims directly to UnitedHealthcare. You do not need to submit claims for Preferred Providers services or supplies.

You must submit claims for services and supplies rendered by other providers as described in the section entitled Claim Information.

If a Preferred Provider bills you for any part of the discount amount, call UnitedHealthcare at 1-800-842-5252 for assistance.

## CARE COORDINATION

Care Coordination is designed to encourage an efficient system of care for you and your Dependent(s) by identifying possible unmet covered health needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. Care Coordination activities are not a substitute for the medical judgment of your Physician, however, and the ultimate decision as to what medical care you actually receive must be made by you and your Physician.

Care Coordination is triggered when UnitedHealthcare receives notification of an upcoming treatment or service. The notification process serves as a gateway to care coordination activities.

### When to Notify Care Coordination

Care Coordination must be notified as soon as possible after you know that you require any of the services or supplies shown below:

- Inpatient admissions to a Hospital or Skilled Nursing Facility.
- Home health care.
- Hospice care.
- Durable medical equipment (over \$1,000).
- Reconstructive procedures.
- Dental services rendered as a result of an accident.

With regard to organ/tissue transplants, Care Coordination must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation of a transplant.
- The donor search.
- The organ procurement/tissue harvest.
- The transplant procedure.

For an in-patient confinement which is the result of an emergency, you (or your representative or Physician) must call Care Coordination within one day (excluding weekends and holidays) from the date the confinement begins.

You should notify Care Coordination promptly after you become aware that you are pregnant. You are required to give this notice, however, only if and when inpatient care for the mother or child is expected to continue beyond:

- 48 hours following a normal delivery; or
- 96 hours following a Caesarean section.

The notice you give must be given in sufficient time to allow UnitedHealthcare to complete a review of the matter before the services are rendered. In the absence of advance notice, UnitedHealthcare may not be able to complete its review and determine, before you incur expenses, if the service is a Covered Health Service, and if so, whether it is medically appropriate.

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

The notification does not apply to injuries incurred by an Employee while on duty for an employing railroad, but UnitedHealthcare customer service representatives are available to answer questions about your proposed medical treatment.

#### **How to Give the Required Notice**

Notice should be given by telephone at 1-800-842-5252. You can call at any time, day or night. However, if you call outside of the normal hours of operation, you may leave a message with your telephone number on an answering machine, and your call will be returned within one working day.

#### **What Happens After You Give the Required Notice?**

UnitedHealthcare will review the services for which you have given notice and will determine whether they are Covered Health Services, and, if so, whether they are Medically Appropriate.

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

## **Effects on Benefits**

- Benefits are reduced if you do not give the required notice or if UnitedHealthcare determines that the service or supply, although a Covered Health Service, is not Medically Appropriate. In either case, the benefit will be reduced from 50% to 40% of the benefits payable under the Plan. If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to 80%.
- No benefits are payable if UnitedHealthcare determines that the service or supply is not a Covered Health Service.

If UnitedHealthcare determines that a service is not a Covered Health Service or is not Medically Appropriate, you or your Physician can appeal that determination. Please see the Claim Information section for a description of the appeal process.

## **Case Management Services**

UnitedHealthcare also provides case management services. These services focus on severe illnesses and injuries which could result in long-term hospital confinements. UnitedHealthcare will determine whether case management services are appropriate in your case.

Through case management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

## **Disease Management Services**

UnitedHealthcare also provides disease management services. These programs focus on providing information about certain chronic medical conditions, such as heart failure, coronary artery disease, diabetes, or asthma, and the ways these conditions can be treated or managed. If you have been diagnosed with a chronic medical condition, UnitedHealthcare may contact you to discuss this program. Or you may call UnitedHealthcare at 1-800-842-5252 to learn whether you are eligible to participate in a program. Participation is voluntary, and there is no charge for these services.

Through disease management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

## **Telephonic Access to Nurses and Counselors**

UnitedHealthcare provides a toll-free telephone number that puts you in immediate contact with a registered nurse any time, 24 hours a day, seven days a week. These nurses can provide health information for routine or urgent health concerns, such as a recent diagnosis, a minor sickness or injury, or other health-related topics. You can also listen to pre-recorded messages on a variety of medical topics.

This service is available to you and your Dependents at no charge. To use it, you can call UnitedHealthcare at 1-866-735-5685.



## WELLNESS PROGRAMS

### Healthy Weight Program

UnitedHealthcare provides a non-surgical approach to addressing weight and obesity through nutritional and activity guidance. You may receive free educational information on the web or through the mail and may even be called by a health coach who is a specialist in weight management. This health coach will be a resource to advise and help you manage your weight.

This program offers:

- on-line self help tools: health assessment, exercise tracker, meal planner, calorie counter and educational content;
- education on weight management and self-care strategies;
- nutritional guidance and counseling by a health coach and registered dietician (if needed); and
- activity recommendations and encouragement by a health coach and exercise physiologist (if needed).

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

### Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help smokers withdraw from nicotine dependence. By participating in this program, you will receive educational material through the mail and one on one telephone sessions with trained cessation specialists.

This program offers:

- a quit kit that includes a cessation manual and quit aids designed to provide support through this program;
- toll free telephone access to cessation specialists (you will receive five (5) coaching sessions and may place unlimited calls to the cessation specialists when you have a question); and
- medication recommendations, and/or free over-the-counter nicotine replacement therapies if you or your Dependent is over the age of 18.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID Card.

### Health Assessment

You and your spouse are invited to learn more about your health and wellness at **myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

**Next Steps**

Individuals that complete a health assessment and are identified with three or more high risks will be provided with telephonic outbound coaching. Coaching will be provided for any/all of the following topics, as appropriate; participation is completely voluntary and without extra charge:

- exercise,
- blood pressure management;
- smoking cessation;
- nutrition;
- stress management;
- cholesterol management; and
- back care/ergonomics.

## **V PLAN B**

### **APPLICABLE TO PERSONS NOT ELIGIBLE UNDER MEDICARE OR GA-46000 MAJOR MEDICAL EXPENSE BENEFITS**

The Plan pays a percentage of Covered Expenses incurred in a calendar year which exceed the Deductible.

#### **DEDUCTIBLE**

The Deductible amount is \$750. It applies separately to each covered individual each calendar year.

#### **PERCENTAGE OF COVERED EXPENSES PAYABLE**

The Plan pays 60% (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and 60% for any visits thereafter) of the Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays 48% of the Covered Expenses in a calendar year after the Deductible is satisfied when Care Coordination is not called when required. See the Care Coordination description contained in this Section V.

The Plan pays 100% of Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met. 80% if Care Coordination is not called when required.)

#### **OUT-OF-POCKET MAXIMUM**

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum is \$10,000 each calendar year. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limits or exclusions.
- Charges you pay for expenses not covered by the Plan.
- Charges you pay as a result of the reduction in benefits payable when Care Coordination is not notified or if the service or supply, although a Covered Health Service, is not Medically Appropriate.

#### **MAXIMUM AMOUNT**

The Maximum Amount payable with respect to you or any of your Dependents is \$500,000. The Maximum Amount applies to a person's entire lifetime and is a combined lifetime maximum under Plans A, B and C.

The Maximum Amount for anyone who has received benefits will be restored each January 1 by \$1,000, or lesser amount, until the maximum is again \$500,000.

## **COVERED EXPENSES**

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for Covered Health Services (see Definitions) and supplies listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are considered Covered Health Services.

### **Accupuncture Services**

Accupuncture services for the following conditions:

- Pain therapy, when another method of pain management has failed.
- Nausea that is related to surgery, pregnancy or chemotherapy.

Accupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Accupuncturist.
- Chiropractor.
- Physician's Assistant.

### **Allergy Immunotherapy Received in a Physician's Office**

Benefits are available for allergy immunotherapy received in a Physician's office.

### **Ambulatory Surgical Center**

Charges for services and supplies furnished in an Ambulatory Surgical Center in connection with a surgical procedure within 24 hours from and in connection with the surgical procedure.

### **Anesthetics**

### **Assistant Surgeon**

Coverage for assistant surgeon services are limited to 1/5 of the amount of the Reasonable Charge for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are covered at the same or lesser rate.

### **Chemotherapy**

## Clinical Trials

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.

- A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
- An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

### **Diabetes Treatment**

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

### **Durable Medical Equipment**

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed. Non-hospital beds, comfort beds, and motorized beds/mattresses are generally excluded from coverage.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.

- Insulin pumps and all related necessary supplies.
- Wigs, but only for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury, and up to a maximum of \$500.
- Speech aid prosthetics and traceo-esophageal voice prosthetics. All other devices and computers to assist in communication and speech are not considered Durable Medical Equipment.
- External prosthetic devices that replace a limb or body part.

Benefits under this section do not include:

- Durable Medical Equipment provided to you by a Physician.
- Generally, any device, appliance, pump, machine stimulator, or monitor that is fully implanted into the body.

If you have any questions regarding whether a particular item is considered to be Durable Medical Equipment, please contact Care Coordination.

Care Coordination must be contacted for any purchase or rental of Durable Medical Equipment that exceeds \$1,000. UnitedHealthcare will decide if the equipment should be purchased or rented.

Benefits that are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.
- Replacement of Durable Medical Equipment is limited to every three years, unless there are catastrophic circumstances, in which case you should notify UnitedHealthcare and an individual case evaluation will be performed.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece that UnitedHealthcare has determined is the most cost-effective.

### **Emergency Transportation Services**

Transportation charges are covered for transportation to a Hospital in connection with an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

### **Habilitative Services**

Habilitative Services for children 0-21 years old are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitative Services, a congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congenital or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

## **Home Health Care Agency Services**

Charges for services of a Home Health Care Agency prescribed in writing by a Physician to be in lieu of Hospital confinement, up to a maximum of 30 visits during any one calendar year. Each visit by a member of a home health care team will be considered as one home health care visit. Four hours of home health care services will be considered as one home health care visit. If a visit exceeds four hours, each additional four hours, or part thereof, will count as one additional visit. Each visit by any other member of the home health care team will count as an additional visit.

The following services and supplies of a Home Health Care Agency are covered:

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Temporary or part-time care by a home health aide.
- Physical therapy, occupational therapy or speech therapy.
- Medical supplies.
- Drugs and medications ordered by a Physician.
- X-ray and laboratory tests.

## **Hospice**

Hospice care that is recommended by a Physician, for a period of up to six (6) months. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the patient is receiving hospice care.

You must notify and receive approval from Care Coordination prior to receiving any inpatient or outpatient hospice care in order to be eligible for this benefit.

Benefits are available when hospice care is received from a licensed hospice agency.

A Physician must certify that the patient is terminally ill and that the patient's life expectancy is six (6) months or less.

## **Hospital Services**

Services and supplies provided by a Hospital on an inpatient basis, except that if charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the national Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.



Services and supplies provided by a Hospital on an outpatient basis including:

- Emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:
  - Placing the patient's health in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- Voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening is necessary for the treatment of the condition for which the emergency care is sought.

### **Medical Supplies**

- Medical and surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood derivatives only if not donated or replaced.

### **Multiple Surgical Procedures**

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

- Covered Expenses for the second procedure will be limited to 50% of the Reasonable Charge for that procedure had it been performed alone.
- Covered Expenses for any subsequent procedure are limited to 50% of the Reasonable Charge for the subsequent procedures.

### **Organ/Tissue Transplants**

- Donor Charges

In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

If a qualified procedure, listed below, is Medically Appropriate and performed at a Transplant Facility, the "Medical Care and Treatment" and "Transportation and Lodging" provisions set forth below apply:

- Heart transplants
- Lung transplants
- Heart/lung transplants
- Liver transplants
- Kidney transplants
- Pancreas transplants

- Kidney/pancreas transplants
- Bone marrow/stem cell transplants
- Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

If a transplant, even if determined to be Medcially Appropriate, is not performed at a Transplant Facility, there will be no benefit payable for the “Medical Care and Treatment” or the “Transportation and Lodging” provisions set forth below.

- Medical Care and Treatment

The following services provided in connection with the transplant are Covered Health Services:

- Pre-transplant evaluation for one of the procedures listed above
- Organ acquisition and procurement
- Hospital and Physician fees
- Transplant procedures
- Follow-up care for a period up to one year after the transplant
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of \$25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people.

Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the \$100 per diem rate.

There is a combined overall lifetime maximum of \$10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under Plans A, B and C, combined, in connection with all transplant procedures.

If you or your Dependent(s) receive reimbursement for meals associated with this Transportation and Lodging benefit that is not part of inpatient care, federal tax rules require that such reimbursements be reported to the Employee. You will receive appropriate notification of any such taxable amounts paid to you.

## **Outpatient Alcoholism, Chemical Dependency and Mental Illness Services**

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and then 60% of any additional visits.

## **Outpatient Rehabilitation**

Short-term outpatient rehabilitation services, limited to:

- Physical therapy
- Occupational therapy
- Chiropractic treatment
- Speech therapy
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

Rehabilitation services are limited to thirty (30) visits per calendar year for any combination of services.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital.

We will pay benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders.

## **Physician Services**

Physician charges for professional services incurred:

- in a Physician's office;
- during a Hospital confinement;
- for the performance of a surgical operation; or
- in a Skilled Nursing Facility.

When determined to be a Covered Health Service, charges by an assistant surgeon are also covered under the plan.

### **Preventive Adult Health Services**

- One routine physical examination per calendar year, subject to the calendar year Deductible.
- Necessary laboratory tests and/or immunizations, subject to the calendar year Deductible.
- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
  - a baseline mammogram; and
  - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above for mammography testing and pap smears are not subject to the calendar year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Prostate cancer screenings are covered in accordance with the latest screening guidelines used by the American Cancer Society.

### **Preventive Child Health Services**

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and
- Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

### **Radiation Therapy**

#### **Skilled Nursing Facility**

Services and supplies up to 31 days of confinement following each Hospital confinement per calendar year.

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

Skilled nursing facility stays must be approved in advance by Care Coordination in order to be eligible for benefits.

**Treatment Center Services**

Charges for services at a Treatment Center when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

**Urgent Care Center Services**

Charges for Covered Health Services received at an Urgent Care Center.

**X-ray and Laboratory Tests**

**IMPORTANT: It should be noted that the Covered Expenses listed above do not include charges for drugs, private duty nursing, Physician's home visits, and some other services and supplies which are covered under the Health & Welfare Plan, NRC/UTU Plan, GA-46000 or GA-107300.**

## **PREFERRED PROVIDERS**

UnitedHealthcare has arranged with certain health care providers to become Preferred Providers. These Preferred Providers have agreed to discount their charges for Covered Expenses.

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

You will receive an Identification Card showing that you and/or your Dependents Covered under Plans A, B or C, are entitled to these discounts. This Identification Card must be shown every time health care services are given. This is how the provider knows that you and/or your Dependent is covered under a Preferred Provider plan. Otherwise, you could be billed for the provider's normal charge.

Call UnitedHealthcare at 1-800-842-5252 to inquire about or locate Preferred Providers in your area. You may also access Preferred Provider information online at [myuhc.com](http://myuhc.com).

Preferred Providers are responsible for filing your claims directly to UnitedHealthcare. You do not need to submit claims for Preferred Providers services or supplies.

You must submit claims for services and supplies rendered by other providers as described in the section entitled Claim Information.

If a Preferred Provider bills you for any part of the discount amount, call UnitedHealthcare at 1-800-842-5252 for assistance.

## CARE COORDINATION

Care Coordination is designed to encourage an efficient system of care for you and your Dependent(s) by identifying possible unmet covered health needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. Care Coordination activities are not a substitute for the medical judgment of your Physician, however, and the ultimate decision as to what medical care you actually receive must be made by you and your Physician.

Care Coordination is triggered when UnitedHealthcare receives notification of an upcoming treatment or service. The notification process serves as a gateway to care coordination activities.

### When to Notify Care Coordination

Care Coordination must be notified as soon as possible after you know that you require any of the services or supplies shown below:

- Inpatient admissions to a Hospital or Skilled Nursing Facility.
- Home health care.
- Hospice care.
- Durable medical equipment (over \$1,000).
- Reconstructive procedures.
- Dental services rendered as a result of an accident.

With regard to organ/tissue transplants, Care Coordination must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation of a transplant.
- The donor search.
- The organ procurement/tissue harvest.
- The transplant procedure.

For an in-patient confinement which is the result of an emergency, you (or your representative or Physician) must call Care Coordination within one day (excluding weekends and holidays) from the date the confinement begins.

You should notify Care Coordination promptly after you become aware that you are pregnant. You are required to give this notice, however, only if and when inpatient care for the mother or child is expected to continue beyond:

- 48 hours following a normal delivery; or
- 96 hours following a Caesarean section.

The notice you give must be given in sufficient time to allow UnitedHealthcare to complete a review of the matter before the services are rendered. In the absence of advance notice, UnitedHealthcare may not be able to complete its review and determine, before you incur expenses, if the service is a Covered Health Service, and if so, whether it is medically appropriate.

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

The notification does not apply to injuries incurred by an Employee while on duty for an employing railroad, but UnitedHealthcare customer service representatives are available to answer questions about your proposed medical treatment.

### **How to Give the Required Notice**

Notice should be given by telephone at 1-800-842-5252. You can call at any time, day or night. However, if you call outside of the normal hours of operation, you may leave a message with your telephone number on an answering machine, and your call will be returned within one working day.

### **What Happens After You Give the Required Notice?**

UnitedHealthcare will review the services for which you have given notice and will determine whether they are Covered Health Services, and, if so, whether they are Medically Appropriate.

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



## **Effects on Benefits**

- Benefits are reduced if you do not give the required notice or if UnitedHealthcare determines that the service or supply, although a Covered Health Service, is not Medically Appropriate. In either case, the benefit will be reduced from 60% to 48% of the benefits payable under the Plan. If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to 80%.
- No benefits are payable if UnitedHealthcare determines that the service or supply is not a Covered Health Service.

If UnitedHealthcare determines that a service is not a Covered Health Service or is not Medically Appropriate, you or your Physician can appeal that determination. Please see the Claims Information section for a description of the appeal process.

## **Case Management Services**

UnitedHealthcare also provides case management services. These services focus on severe illnesses and injuries which could result in long-term hospital confinements. UnitedHealthcare will determine whether case management services are appropriate in your case.

Through case management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

## **Disease Management Services**

UnitedHealthcare also provides disease management services. These programs focus on providing information about certain chronic medical conditions, such as heart failure, coronary artery disease, diabetes, or asthma, and the ways these conditions can be treated or managed. If you have been diagnosed with a chronic medical condition, UnitedHealthcare may contact you to discuss this program. Or you may call UnitedHealthcare at 1-800-842-5252 to learn whether you are eligible to participate in a program. Participation is voluntary, and there is no charge for these services.

Through disease management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

## **Telephonic Access to Nurses and Counselors**

UnitedHealthcare provides a toll-free telephone number that puts you in immediate contact with a registered nurse any time, 24 hours a day, seven days a week. These nurses can provide health information for routine or urgent health concerns, such as a recent diagnosis, a minor sickness or injury, or other health-related topics. You can also listen to pre-recorded messages on a variety of medical topics.

This service is available to you and your Dependents at no charge. To use it, you can call UnitedHealthcare at 1-866-735-5685.

## WELLNESS PROGRAMS

### Healthy Weight Program

UnitedHealthcare provides a non-surgical approach to addressing weight and obesity through nutritional and activity guidance. You may receive free educational information on the web or through the mail and may even be called by a health coach who is a specialist in weight management. This health coach will be a resource to advise and help you manage your weight.

This program offers:

- on-line self help tools: health assessment, exercise tracker, meal planner, calorie counter and educational content;
- education on weight management and self-care strategies;
- nutritional guidance and counseling by a health coach and registered dietician (if needed); and
- activity recommendations and encouragement by a health coach and exercise physiologist (if needed).

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

### Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help smokers withdraw from nicotine dependence. By participating in this program, you will receive educational material through the mail and one on one telephone sessions with trained cessation specialists.

This program offers:

- a quit kit that includes a cessation manual and quit aids designed to provide support through this program;
- toll free telephone access to cessation specialists (you will receive five (5) coaching sessions and may place unlimited calls to the cessation specialists when you have a question); and
- medication recommendations, and/or free over-the-counter nicotine replacement therapies if you or your Dependent is over the age of 18.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID Card.

### Health Assessment

You and your spouse are invited to learn more about your health and wellness at **myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

**Next Steps**

Individuals that complete a health assessment and are identified with three or more high risks will be provided with telephonic outbound coaching. Coaching will be provided for any/all of the following topics, as appropriate; participation is completely voluntary and without extra charge:

- exercise,
- blood pressure management;
- smoking cessation;
- nutrition;
- stress management;
- cholesterol management; and
- back care/ergonomics.

## **VI PLAN C**

### **APPLICABLE TO PERSONS NOT ELIGIBLE UNDER MEDICARE OR GA-46000**

#### **MAJOR MEDICAL EXPENSE BENEFITS**

The Plan pays a percentage of Covered Expenses incurred in a calendar year which exceed the Deductible.

#### **DEDUCTIBLE**

The Deductible amount is \$500. It applies separately to each covered individual each calendar year.

#### **PERCENTAGE OF COVERED EXPENSES PAYABLE**

The Plan pays 70% (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and 60% for any visits thereafter) of the Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays 56% of the Covered Expenses in a calendar year after the Deductible is satisfied when Care Coordination is not called when required. See the Care Coordination description contained in this Section VI.

The Plan pays 100% of Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met. (80% if Care Coordination is not called when required.)

#### **OUT-OF-POCKET MAXIMUM**

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum is \$7,500 each calendar year. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limits or exclusions.
- Charges you pay for expenses not covered by the Plan.
- Charges you pay as a result of the reduction in benefits payable when Care Coordination is not notified or if the service or supply, although a Covered Health Service, is not Medically Appropriate.

#### **MAXIMUM AMOUNT**

The Maximum Amount payable with respect to you or any of your Dependents is \$500,000. The Maximum Amount applies to a person's entire lifetime and is a combined lifetime maximum under Plans A, B and C.

The Maximum Amount for anyone who has received benefits will be restored each January 1 by \$1,000, or lesser amount, until the maximum is again \$500,000.

## **COVERED EXPENSES**

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for Covered Health Services (see Definitions) and supplies listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are considered Covered Health Services.

### **Accupuncture Services**

Accupuncture services for the following conditions:

- Pain therapy, when another method of pain management has failed.
- Nausea that is related to surgery, pregnancy or chemotherapy.

Accupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Accupuncturist.
- Chiropractor.
- Physician's Assistant.

### **Allergy Immunotherapy Received in a Physician's Office**

Benefits are available for allergy immunotherapy received in a Physician's office.

### **Ambulatory Surgical Center**

Charges for services and supplies furnished in an Ambulatory Surgical Center in connection with a surgical procedure within 24 hours from and in connection with the surgical procedure.

### **Anesthetics**

### **Assistant Surgeon**

Coverage for assistant surgeon services are limited to 1/5 of the amount of the Reasonable Charge for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are covered at the same or lesser rate.

### **Chemotherapy**

## **Clinical Trials**

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.

- A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
- An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

### **Diabetes Treatment**

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

### **Durable Medical Equipment**

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed. Non-hospital beds, comfort beds, and motorized beds/mattresses are generally excluded from coverage.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.



- Insulin pumps and all related necessary supplies.
- Wigs, but only for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury, and up to a maximum of \$500.
- Speech aid prosthetics and traceo-esophageal voice prosthetics. All other devices and computers to assist in communication and speech are not considered Durable Medical Equipment.
- External prosthetic devices that replace a limb or body part.

Benefits under this section do not include:

- Durable Medical Equipment provided to you by a Physician.
- Generally, any device, appliance, pump, machine stimulator, or monitor that is fully implanted into the body.

If you have any questions regarding whether a particular item is considered to be Durable Medical Equipment, please contact Care Coordination.

Care Coordination must be contacted for any purchase or rental of Durable Medical Equipment that exceeds \$1,000. UnitedHealthcare will decide if the equipment should be purchased or rented.

Benefits that are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.
- Replacement of Durable Medical Equipment is limited to every three years, unless there are catastrophic circumstances, in which case you should notify UnitedHealthcare and an individual case evaluation will be performed.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece that UnitedHealthcare has determined is the most cost-effective.

### **Emergency Transportation Services**

Transportation charges are covered for transportation to a Hospital in connection with an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

### **Habilitative Services**

Habilitative Services for children 0-21 years old are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitative Services, a congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congenital or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

## **Home Health Care Agency Services**

Charges for services of a Home Health Care Agency prescribed in writing by a Physician to be in lieu of Hospital confinement, up to a maximum of 30 visits during any one calendar year. Each visit by a member of a home health care team will be considered as one home health care visit. Four hours of home health care services will be considered as one home health care visit. If a visit exceeds four hours, each additional four hours, or part thereof, will count as one additional visit. Each visit by any other member of the home health care team will count as an additional visit.

The following services and supplies of a Home Health Care Agency are covered:

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Temporary or part-time care by a home health aide.
- Physical therapy, occupational therapy or speech therapy.
- Medical supplies.
- Drugs and medications ordered by a Physician.
- X-ray and laboratory tests.

## **Hospice**

Hospice care that is recommended by a Physician, for a period of up to six (6) months. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the patient is receiving hospice care.

You must notify and receive approval from Care Coordination prior to receiving any inpatient or outpatient hospice care in order to be eligible for this benefit.

Benefits are available when hospice care is received from a licensed hospice agency.

A Physician must certify that the patient is terminally ill and that the patient's life expectancy is six (6) months or less.

## **Hospital Services**

Services and supplies provided by a Hospital on an inpatient basis, except that if charges are made for a private room, Covered Expenses will be limited to the hospital's average daily charge for a semi-private room.

Coverage is provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the national Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital on an outpatient basis including:

- Emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:
  - Placing the patient's health in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- Voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening is necessary for the treatment of the condition for which the emergency care is sought.

### **Medical Supplies**

- Medical and surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood derivatives only if not donated or replaced.

### **Multiple Surgical Procedures**

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

- Covered Expenses for the second procedure will be limited to 50% of the Reasonable Charge for that procedure had it been performed alone.
- Covered Expenses for any subsequent procedure are limited to 50% of the Reasonable Charge for the subsequent procedures.

### **Organ/Tissue Transplants**

- Donor Charges

In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

If a qualified procedure, listed below, is Medically Appropriate and performed at a Transplant Facility, the "Medical Care and Treatment" and "Transportation and Lodging" provisions set forth below apply:

- Heart transplants
- Lung transplants
- Heart/lung transplants
- Liver transplants
- Kidney transplants
- Pancreas transplants

- Kidney/pancreas transplants
- Bone marrow/stem cell transplants
- Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.

If a transplant, even if determined to be Medcially Appropriate, is not performed at a Transplant Facility, there will be no benefit payable for the “Medical Care and Treatment” or the “Transportation and Lodging” provisions set forth below.

- Medical Care and Treatment

The following services provided in connection with the transplant are Covered Health Services:

- Pre-transplant evaluation for one of the procedures listed above
- Organ acquisition and procurement
- Hospital and Physician fees
- Transplant procedures
- Follow-up care for a period up to one year after the transplant
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of \$25,000 is payable for all charges made in connection with the search.

- Transportation and Lodging

Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people.

Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the \$100 per diem rate.

There is a combined overall lifetime maximum of \$10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under Plans A, B and C, combined, in connection with all transplant procedures.

If you or your Dependent(s) receive reimbursement for meals associated with this Transportation and Lodging benefit that is not part of inpatient care, federal tax rules require that such reimbursements be reported to the Employee. You will receive appropriate notification of any such taxable amounts paid to you.

## **Outpatient Alcoholism, Chemical Dependency and Mental Illness Services**

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and then 60% of any additional visits.

## **Outpatient Rehabilitation**

Short-term outpatient rehabilitation services, limited to:

- Physical therapy
- Occupational therapy
- Chiropractic treatment
- Speech therapy
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

Rehabilitation services are limited to thirty (30) visits per calendar year for any combination of services.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital.

We will pay benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders.

## **Physician Services**

Physician charges for professional services incurred:

- in a Physician's office;
- during a Hospital confinement;
- for the performance of a surgical operation; or
- in a Skilled Nursing Facility.

When determined to be a Covered Health Service, charges by an assistant surgeon are also covered under the plan.

### **Preventive Adult Health Services**

- One routine physical examination per calendar year, subject to the calendar year Deductible.
- Necessary laboratory tests and/or immunizations, subject to the calendar year Deductible.
- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
  - a baseline mammogram; and
  - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above for mammography testing and pap smears are not subject to the calendar year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Prostate cancer screenings are covered in accordance with the latest screening guidelines used by the American Cancer Society.

### **Preventive Child Health Services**

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and
- Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

### **Radiation Therapy**

#### **Skilled Nursing Facility**

Services and supplies up to 31 days of confinement following each Hospital confinement per calendar year.

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

Skilled nursing facility stays must be approved in advance by Care Coordination in order to be eligible for benefits.

**Treatment Center Services**

Charges for services at a Treatment Center, when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

**Urgent Care Center Services**

Charges for Covered Health Services received at an Urgent Care Center.

**X-ray and Laboratory Tests**

**IMPORTANT: It should be noted that the Covered Expenses listed above do not include charges for drugs, private duty nursing, Physician's home visits, and some other services and supplies which are covered under the Health & Welfare Plan, NRC/UTU Plan, GA-46000 or GA-107300.**

## **PREFERRED PROVIDERS**

UnitedHealthcare has arranged with certain health care providers to become Preferred Providers. These Preferred Providers have agreed to discount their charges for Covered Expenses.

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

You will receive an Identification Card showing that you and/or your Dependents Covered under Plans A, B or C, are entitled to these discounts. This Identification Card must be shown every time health care services are given. This is how the provider knows that you and/or your Dependent is covered under a Preferred Provider plan. Otherwise, you could be billed for the provider's normal charge.

Call UnitedHealthcare at 1-800-842-5252 to inquire about or locate Preferred Providers in your area. You may also access Preferred Provider information online at [myuhc.com](http://myuhc.com).

Preferred Providers are responsible for filing your claims directly to UnitedHealthcare. You do not need to submit claims for Preferred Providers services or supplies.

You must submit claims for services and supplies rendered by other providers as described in the section entitled Claim Information.

If a Preferred Provider bills you for any part of the discount amount, call UnitedHealthcare at 1-800-842-5252 for assistance.



## CARE COORDINATION

Care Coordination is designed to encourage an efficient system of care for you and your Dependents by identifying possible unmet covered health needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. Care Coordination activities are not a substitute for the medical judgment of your Physician, however, and the ultimate decision as to what medical care you actually receive must be made by you and your Physician.

Care Coordination is triggered when UnitedHealthcare receives notification of an upcoming treatment or service. The notification process serves as a gateway to care coordination activities.

### When to Notify Care Coordination

Care Coordination must be notified as soon as possible after you know that you require any of the services or supplies shown below:

- Inpatient admissions to a Hospital or Skilled Nursing Facility.
- Home health care.
- Hospice care.
- Durable medical equipment (over \$1,000).
- Reconstructive procedures.
- Dental services rendered as a result of an accident.

With regard to organ/tissue transplants, Care Coordination must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation of a transplant.
- The donor search.
- The organ procurement/tissue harvest.
- The transplant procedure.

For an in-patient confinement which is the result of an emergency, you (or your representative or Physician) must call Care Coordination within one day (excluding weekends and holidays) from the date the confinement begins.

You should notify Care Coordination promptly after you become aware that you are pregnant. You are required to give this notice, however, only if and when inpatient care for the mother or child is expected to continue beyond:

- 48 hours following a normal delivery; or
- 96 hours following a Caesarean section.

The notice you give must be given in sufficient time to allow UnitedHealthcare to complete a review of the matter before the services are rendered. In the absence of advance notice, UnitedHealthcare may not be able to complete its review and determine, before you incur expenses, if the service is a Covered Health Service, and if so, whether it is medically appropriate.

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

The notification does not apply to injuries incurred by an Employee while on duty for an employing railroad, but UnitedHealthcare customer service representatives are available to answer questions about your proposed medical treatment.

### **How to Give the Required Notice**

Notice should be given by telephone at 1-800-842-5252. You can call at any time, day or night. However, if you call outside of the normal hours of operation, you may leave a message with your telephone number on an answering machine, and your call will be returned within one working day.

### **What Happens After You Give the Required Notice?**

UnitedHealthcare will review the services for which you have given notice and will determine whether they are Covered Health Services, and, if so, whether they are Medically Appropriate.

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

## **Effects on Benefits**

- Benefits are reduced if you do not give the required notice or if UnitedHealthcare determines that the service or supply, although a Covered Health Service, is not Medically Appropriate. In either case, the benefit will be reduced from 70% to 56% of the benefits payable under the Plan. If you have satisfied your Out-of-Pocket Maximum, benefits will be reduced from 100% to 80%.
- No benefits are payable if UnitedHealthcare determines that the service or supply is not a Covered Health Service.

If UnitedHealthcare determines that a service is not a Covered Health Service or is not Medically Appropriate, you or your Physician can appeal that determination. Please see the Claim Information section for a description of the appeal process.

## **Case Management Services**

UnitedHealthcare also provides case management services. These services focus on severe illnesses and injuries which could result in long-term hospital confinements. UnitedHealthcare will determine whether case management services are appropriate in your case.

Through case management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

## **Disease Management Services**

UnitedHealthcare also provides disease management services. These programs focus on providing information about certain chronic medical conditions, such as heart failure, coronary artery disease, diabetes, or asthma, and the ways these conditions can be treated or managed. If you have been diagnosed with a chronic medical condition, UnitedHealthcare may contact you to discuss this program. Or you may call UnitedHealthcare at 1-800-842-5252 to learn whether you are eligible to participate in a program. Participation is voluntary, and there is no charge for these services.

Through disease management services, benefits for alternative treatment, which are otherwise not Covered Health Services, may be offered to you or your Dependent when it is appropriate and cost effective. The decision to accept alternative treatment rests with the patient and Physician.

## **Telephonic Access to Nurses and Counselors**

UnitedHealthcare provides a toll-free telephone number that puts you in immediate contact with a registered nurse any time, 24 hours a day, seven days a week. These nurses can provide health information for routine or urgent health concerns, such as a recent diagnosis, a minor sickness or injury, or other health-related topics. You can also listen to pre-recorded messages on a variety of medical topics.

This service is available to you and your Dependents at no charge. To use it, you can call UnitedHealthcare at 1-866-735-5685.

## WELLNESS PROGRAMS

### Healthy Weight Program

UnitedHealthcare provides a non-surgical approach to addressing weight and obesity through nutritional and activity guidance. You may receive free educational information on the web or through the mail and may even be called by a health coach who is a specialist in weight management. This health coach will be a resource to advise and help you manage your weight.

This program offers:

- on-line self help tools: health assessment, exercise tracker, meal planner, calorie counter and educational content;
- education on weight management and self-care strategies;
- nutritional guidance and counseling by a health coach and registered dietician (if needed); and
- activity recommendations and encouragement by a health coach and exercise physiologist (if needed).

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

### Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help smokers withdraw from nicotine dependence. By participating in this program, you will receive educational material through the mail and one on one telephone sessions with trained cessation specialists.

This program offers:

- a quit kit that includes a cessation manual and quit aids designed to provide support through this program;
- toll free telephone access to cessation specialists (you will receive five (5) coaching sessions and may place unlimited calls to the cessation specialists when you have a question); and
- medication recommendations, and/or free over-the-counter nicotine replacement therapies if you or your Dependent is over the age of 18.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID Card.

### Health Assessment

You and your spouse are invited to learn more about your health and wellness at **myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

**Next Steps**

Individuals that complete a health assessment and are identified with three or more high risks will be provided with telephonic outbound coaching. Coaching will be provided for any/all of the following topics, as appropriate; participation is completely voluntary and without extra charge:

- exercise,
- blood pressure management;
- smoking cessation;
- nutrition;
- stress management;
- cholesterol management; and
- back care/ergonomics.

## VI PLAN E

### **APPLICABLE TO PERSONS ELIGIBLE UNDER THE RAILROAD EMPLOYEES NATIONAL EARLY RETIREMENT MAJOR MEDICAL BENEFIT PLAN (GA-46000)**

This Plan has been developed to supplement the benefits for retired and disabled railroad Employees and their Dependents who qualify for coverage under GA-46000. Coverage under GA-46000 is provided by the participating railroads at no cost to eligible Employees.

In general, eligibility for coverage on the basis of age under GA-46000 is limited to Employees who apply to a "60/30" annuity under the Railroad Retirement Act of 1974 subject to the following requirements:

- Application for the "60/30" annuity is made on or after the date the Employee attains age 60.
- The Employee was covered under the Health & Welfare Plan and the NRC/UTU Plan on the day before the application for the "60/30" annuity is made.

However, Employees may apply for an annuity during the three months before their 60th birthday if they continue working or receive vacation pay into the month prior to the month in which their 60th birthday occurs. Employees will not be disqualified from participation in this Plan, provided they satisfy the other eligibility requirements.

In addition, GA-46000 covers certain disabled Employees who were still covered under the Health & Welfare Plan and the NRC/UTU Plan when they reached age 60. The disability qualification requirements are quite specific and any questions in this regard should be directed to your Employer, your Labor Organization or UnitedHealthcare, Railroad Administration, P.O. Box 150453, Hartford, CT 06115-0453. A booklet containing a complete description of the rules governing eligibility for GA-46000 benefits is available through employing railroads.

If you qualify for coverage under GA-46000 you may enroll for Employee and/or Dependent benefits under Plan E provided your enrollment and payment are mailed (postmarked) to UnitedHealthcare on or before the last day of the month in which coverage under the Health & Welfare plan or NRC/UTU Plan terminates or in the next three calendar months. If your benefits under the Railroad Employees National Early Retirement Major Medical Benefit Plan are paid by a hospital association, you may enroll for Dependent benefits only.

Your Employee coverage under GA-46000 ceases when you become eligible for Medicare due to age or disability. If you become eligible for Medicare due to end stage renal disease, your coverage under GA-46000 ends, after you have been eligible for Medicare for 30 months. If you qualify for Medicare due to age (65), your coverage under Plan E will be automatically transferred to Plan F. If you qualify for Medicare for reasons other than age, you must notify UnitedHealthcare so that coverage can be transferred from Plan E to Plan F.

Keep in mind that your Dependent coverage under GA-46000 terminates when you qualify for Medicare due to age (65). In the event of your death, your Dependent(s) will be covered until you would have qualified for Medicare due to age (65). When your Dependent(s) are no longer covered under GA-46000, coverage for Dependent(s) will automatically be transferred from Plan E to Plan C. If you would prefer to enroll your Dependent(s) in either Plan A or Plan B, or if you want to decline coverage for your Dependent(s), you will have to call UnitedHealthcare at 1-800-842-5252.

Your Dependents may be entitled to continue coverage under GA-46000 after it would otherwise terminate as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Full

information concerning COBRA has been made available to persons covered under GA-46000. If your Dependents are continuing GA-46000 coverage under COBRA, your Dependents benefits will remain under Plan E. When their COBRA continuation coverage terminates, their GA-23111 coverage will automatically be transferred to Plan F if they are entitled to Medicare, or Plan C if they are not entitled to Medicare. If your Dependents are not entitled to Medicare, and you would prefer them to be enrolled in either Plan A or Plan B, or if you want to decline coverage for your Dependents, you will have to call UnitedHealthcare at 1-800-842-5252.

Coverage under GA-46000 for an individual Dependent will cease when that Dependent becomes eligible for Medicare. When this occurs, you must notify UnitedHealthcare so that coverage can be transferred from Plan E to Plan F.



## **MAJOR MEDICAL EXPENSE BENEFITS**

The Plan pays 70% (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness and 60% for any visits thereafter) of the Covered Expenses incurred in a calendar year which exceed the Deductible.

### **DEDUCTIBLE**

The Deductible is separate for you and each of your Dependents each calendar year. It has two parts - a Basic Benefits Deductible and a Cash Deductible.

#### **Basic Benefits Deductible**

The Basic Benefits Deductible is the total payments made during the calendar year under GA-46000 or, if the benefits under GA-46000 are reduced in accordance with its Coordination of Benefits provisions, the payments which would have been made had such reduction not occurred.

#### **Cash Deductible**

The Cash Deductible is \$100.

### **PERCENTAGE OF COVERED EXPENSES PAYABLE**

The Plan pays 70% (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness and 60% for any visits thereafter) of Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays 100% of the Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met.

### **OUT-OF-POCKET MAXIMUM**

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum each calendar year is \$5,000. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limitations or exclusions.
- Charges you pay for expenses not covered by the Plan.
- Charges you pay as a result of a reduction in benefits under GA-46000 if the required Care Coordination notification is not made, or if Care Coordination determines that the service or supply is not a Covered Health Service as that term is defined under GA-46000.
- Co-payments you make and any other charges you pay under the GA-46000 Managed Pharmacy Services Benefit.

### **MAXIMUM AMOUNT**

The Maximum Amount payable with respect to you or any one of your Dependents is \$500,000. This Maximum Amount applies to a person's entire lifetime.

## COVERED EXPENSES

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for the Covered Health Services (see Definitions) listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are covered under the Plan.

The services and supplies for which Covered Expenses may be incurred are as follows:

### **Ambulatory Surgical Center Services**

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

### **Anesthetics**

### **Birth Center Services**

### **Chemotherapy**

### **Clinical Trials**

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
  - A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
  - An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

### **Diabetes Treatment**

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

## **Durable Medical Equipment**

Durable Medical Equipment means equipment that meets all of the following criteria:

- It is for repeated use and is not consumable or disposable
- It is used primarily for a medical purpose.
- It is appropriate for use in the home.

Some examples of durable medical equipment are:

- Appliances that replace a lost body organ or part or help an impaired one to work.
- Orthotic devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.
- Monitoring devices.

Care Coordination must be contacted for any purchase or rental costs which exceed \$1,000. Care Coordination will determine whether the purchase or rental of the equipment is Medically Appropriate.

## **Habilitative Services**

Habilitative Services for children 0-21 years old are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitative Services, a congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congenital or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

## **Home Health Care Agency Services**

- Part-time or intermittent nursing care rendered by or supervised by a registered nurse.
- Part-time or intermittent care by a home health aide.
- Physical therapy or occupational therapy.
- Speech therapy to restore speech lost or impaired due to removal of vocal cords, cerebral thrombosis, or brain damage due to injury or organic brain lesion.
- Prescription Drugs.
- Medical Supplies.
- X-rays and laboratory tests.

## **Hospice Care Services**

Up to a maximum payment of \$3,000 for each Course of Care for room, board, care and treatment charged by a Hospice.

Up to a maximum payment of \$1,000 for each Course of Care for:

- Counseling for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor.
- Bereavement counseling up to 15 visits for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor and given within six months after the patient's death.

The Physician must certify that the patient is terminally ill with 6 months or less to live.

"Immediate Family" means you or any member of your family who is covered under this Plan.

"Course of Care" means all services given to the patient and the patient's Immediate Family in connection with the terminal illness of the patient.

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

## **Hospital Services**

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

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

Coverage is also provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the National Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital for emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Coverage is also provided for the cost of a voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening is necessary for the treatment of the condition for which the emergency care is sought.

## **Infertility Treatment**

Diagnosis and treatment of infertility, including surgery and drug therapy. This does not include procedures or services to facilitate a pregnancy, such as, but not limited to, in vitro fertilization, embryo transfer, artificial insemination and immunotherapy for infertility.

## **Medical Supplies**

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood plasma only if not donated or replaced.

## **Nursing Services**

Services of a trained nurse or a Nurse-Midwife..

## **Occupational Therapy**

Services of a licensed occupational therapist provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement within 2 months of the start of treatment.

## **Organ/Tissue Transplants**

- Donor Charges

In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

If a qualified procedure, listed below, is Medically Appropriate, the "Medical Care and Treatment" provisions set forth below apply:

- Heart transplants
- Lung transplants
- Heart/lung transplants
- Liver transplants
- Kidney transplants
- Pancreas transplants
- Kidney/pancreas transplants
- Bone marrow/stem cell transplants

- Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.
- Medical Care and Treatment

The following services provided in connection with the transplant are Covered Health Services:

- Pre-transplant evaluation for one of the procedures listed above
- Organ acquisition and procurement
- Hospital and Physician fees
- Transplant procedures
- Follow-up care for a period up to one year after the transplant
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of \$25,000 is payable for all charges made in connection with the search.
- Transportation and Lodging

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

Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people.

Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the \$100 per diem rate.

There is a combined overall lifetime maximum of \$10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan E, in connection with all transplant procedures.

If you or your Dependent(s) receive reimbursement for meals associated with this Transportation and Lodging benefit that is not part of inpatient care, federal tax rules require that such reimbursements be reported to the Employee. You will receive appropriate notification of any such taxable amounts paid to you.

## **Outpatient Alcoholism, Chemical Dependency and Mental Illness Services**

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and then 60% of any additional visits

## **Physical Therapy**

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician.
- The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

## **Physicians Services**

### **Prescription Drugs**

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

### **Prescription Contraceptive Devices**

Devices approved by the U.S. Food and Drug Administration for the prevention of a pregnancy are covered for female employees and the wives of male employees.

## **Preventive Adult Health Services**

- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
  - a baseline mammogram; and
  - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above are not subject to the calendar year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Screenings in accordance with the latest screening guidelines issued by the American Cancer Society.



## **Preventive Child Health Services**

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and
- Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

## **Psychologist Services**

### **Radiation Therapy**

### **Rehabilitative Services**

Benefits for occupational therapy, speech therapy and physical therapy for Dependent children, under the age of 21, with congenital or birth defects (including autism and cerebral palsy).

### **Skilled Nursing Facility Care After Hospital Confinement**

Services and supplies up to 31 days of confinement following each Hospital confinement.

Separate confinements for the same cause are considered to be one confinement, unless separated by 14 or more days.

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

### **Speech Therapy**

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

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

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

### **Spinal Manipulations**

Services of a physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

No benefits are available for any type of therapy, service or supply, including, but not limited to, spinal manipulation by a chiropractor or other physician once the therapy, service or supply ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

### **Transportation Services**

Transportation charges are covered for transportation to a Hospital in an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

### **Treatment Center Services**

Charges for services at a Treatment Center when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

### **X-ray and Laboratory Tests**

## **EXCLUSIONS**

Major Medical Expenses Benefits are not payable for expenses for:

- Expenses for any confinement, treatment, services or supplies which would have been payable under GA-46000, but which were not payable due to you or your Dependent's non-compliance with Care Coordination described under GA-46000.
- Prescription Drugs purchased from a pharmacy or by mail order.
- Expenses for treatment of on-duty injuries if the railroad has paid those expenses.

Other exclusions that apply to this Benefit are in the General Exclusions section.

# VII

## PLAN F

### APPLICABLE TO PERSONS ELIGIBLE FOR FULL MEDICARE COVERAGE

This plan is available to Persons Eligible Under Medicare.

#### INFORMATION ABOUT MEDICARE

An individual becomes eligible under Medicare:

- On the basis of **age**, on the first day of the month in which he or she attains age 65 (if an individual's birthday is on the first day of the month, he is considered to reach 65 in the previous month).
- On the basis of **disability**, on the first day of the month following receipt of disability benefits for 24 consecutive months under Railroad Retirement or Social Security. There is a waiting period of 5 full calendar months of disability before disability benefits begin. To be eligible for Medicare, a Railroad Retirement beneficiary must meet the disability qualifications of the Social Security Act which require that an individual be totally disabled (unable to perform the duties of any occupation).
- On the basis of **end stage renal disease**, on the first day of the third month after the month in which a course of renal dialysis is initiated, or when a kidney transplant is received. However, for individuals covered under GA-46000 or the MBCR Early Retirement Plan, Medicare benefits are paid secondary to GA-46000 or the MBCR Early Retirement Plan benefits for the first 30 months of Medicare eligibility. Coverage for individuals previously enrolled under Plan E or M will transfer to Plan F at the end of this 30 month period. Individuals not enrolled under Plan E or M who wish to enroll under Plan F when they become eligible for Medicare cannot do so until the end of this 30 month period. They may enroll under Plan F in the month immediately preceding the end of this 30 month period, or in the next three calendar months.

Individuals who are receiving age or disability benefits under Social Security or Railroad Retirement will be automatically enrolled under Medicare. No payment is required under Part A of Medicare. The required payment under Part B of Medicare will be deducted automatically from the individual's monthly benefit. An individual may file a waiver form with Social Security or Railroad Retirement declining Part B coverage. If the individual does so, no deduction will be made from the monthly benefit but the individual will not have the maximum available coverage.

Individuals age 65 or over who are not otherwise eligible for coverage under Part A of Medicare may voluntarily enroll for such coverage. These individuals must pay the full cost of such coverage and must also enroll for coverage under Part B of Medicare.

An individual with end stage renal disease will have to enroll under Medicare in order to have coverage for Medicare benefits. Information about such enrollment should be obtained from a Railroad Retirement Board or Social Security Administration office.

#### INFORMATION ABOUT PLAN F

Plan F is not a replacement for Medicare. Any individual eligible for Medicare who declines Medicare benefits, or who fails to enroll, will lose whatever benefits Medicare could have paid. Plan F benefits will be paid as if the individual had enrolled in Medicare.

When you or your spouse attain age 65 while covered under Plan A, B, C, E or M, the coverage will automatically be changed to Plan F as of the first day of the month in which you or your spouse attain age 65. You will then be billed and should make payment in the amount applicable to Plan F.

When UnitedHealthcare is notified that a disabled individual or an individual with end stage renal disease becomes eligible under Medicare while covered under Plan A, B, C, E or M, that individual will be moved to Plan F. The required payment rate will be adjusted accordingly. For individuals covered under Plan E or M, coverage will not be changed until the individual's coverage under GA-46000 or the MBCR Early Retirement Plan ends.

**To avoid undue delay in making the necessary change, immediately notify UnitedHealthcare's Railroad Administration when the individual first becomes eligible under Medicare.**

If coverage for one of your Dependents is changed to Plan F because that Dependent is eligible under Medicare, and you have additional Dependents who are not eligible under Medicare, you may continue coverage for those additional Dependents under Plans A, B, C, E or M.

**Benefits under Plan A, B, C, E or M will cease on the date an individual is eligible to be covered under Medicare. However, such individual can become covered under Plan F.**

**It is important that you notify UnitedHealthcare when you or one of your Dependents becomes eligible under Medicare.**

See the section entitled **When To Enroll** for important information about Medicare Advantage.

**Medicare benefits are sometimes awarded on a retroactive basis. When a retroactive award is made, Medicare usually offers the individual a choice to have Medicare Part B effective currently, or retroactive to the original effective date. Part A is always made effective as of the original effective date. If a retroactive effective date for Medicare Part B is selected, the individual must pay the Medicare Part B premium for each month of retroactive coverage.**

**An individual who receives a retroactive award may have paid for coverage under Plans A, B, C, E or M between the original Medicare effective date and the date of the award. Benefits under one of those plans may have been paid. In all such cases, the individual must reimburse UnitedHealthcare for all benefits paid under Plans A, B, C, E or M for services rendered on or after the original Medicare effective date. The individual may choose between the following options:**

- 1. Elect coverage under Plan F retroactive to the original Medicare effective date. Premiums paid under any other GA- 23111 plan will be applied for Plan F coverage, and all expenses incurred will be reconsidered under Plan F.**
- 2. Cancel GA-23111 coverage retroactive to the original Medicare effective date. Premiums paid under any other GA-23111 plan will be used to offset any benefits paid under the other plan. Premiums paid in excess of benefits paid will be reimbursed.**

**An individual electing the second option may enroll under Plan F effective the first of the month following the month the individual notifies UnitedHealthcare of the retroactive Medicare award.**

## **HOSPITAL EXPENSE BENEFITS**

Plan F covers confinement in a Hospital provided that benefits are also payable by Part A Medicare for the confinement.

The following benefits will be paid in full during each benefit period:

- The amount of the Medicare Part A deductible for the first 60 days.
- The amount of the Medicare Part A coinsurance for each day from the 61st through the 90th day.
- The amount of the Medicare Part A coinsurance for each day that Medicare lifetime reserve days are used.

If you exhaust all Medicare Part A benefits in a benefit period, Plan F will pay 100% of the Reasonable Charge (see Definitions) for the Covered Health Services (see Definitions) provided by the Hospital for up to 365 days of Hospital confinement during your lifetime.

A benefit period is defined by Medicare. It begins on the day you are admitted to a Hospital. It ends when you have been out of a Hospital or Skilled Nursing Facility for 60 straight days. It also ends if you are in a Skilled Nursing Facility but have not received skilled care there for 60 straight days.

### **EXCLUSIONS**

Hospital Expense Benefits are not payable for any day of confinement during which lifetime reserve days are available, but you do not use them.

Hospital Expense Benefits are not payable for any day of confinement in a Hospital which does not participate in Medicare, except when required by applicable federal or state law. In such cases, Hospital Expense Benefits will be paid as if the Hospital did participate in Medicare. For the first 90 days of the confinement, and for any days during which Medicare lifetime reserve days would otherwise be payable. Hospital Expense Benefits will be limited to the Medicare Part A deductible and coinsurance amounts described above.

Hospital Expense Benefits are not payable for any day of confinement in a psychiatric Hospital which participates in Medicare after the maximum Medicare lifetime benefit has been reached.

If charges are made for a private room, payment will be limited to the Hospital's average charge for a semi-private room.

Other exclusions that apply to this Benefit are in the General Exclusions section.

## **SKILLED NURSING FACILITY EXPENSE BENEFITS**

Plan F covers confinement in a Skilled Nursing Facility provided that benefits are also payable by Medicare Part A for the confinement.

Payment will be made for Skilled Nursing Facility charges during a benefit period for an amount up to the Medicare Part A coinsurance for the 21st to the 100th day of confinement.

A benefit period is defined by Medicare. It begins on the day you are admitted to a Hospital. It ends when you have been out of a Hospital or Skilled Nursing Facility for 60 straight days. It also ends if you are in a Skilled Nursing Facility but have not received skilled care there for 60 straight days.

### **EXCLUSIONS**

Skilled Nursing Facility Expenses Benefits are not payable for any day of confinement unless Medicare Part A benefits are also payable for that day, except when required by applicable federal or state law. In such cases, Skilled Nursing Facility Expense Benefits will be paid as if the Skilled Nursing Facility did participate in Medicare. For the first 20 days of the confinement, no benefits will be payable. For the next 80 days of the confinement, Skilled Nursing Facility Expense Benefits will be limited to the Medicare Part A coinsurance amounts described above.

Other exclusions that apply to this Benefit are in the General Exclusions section.

## **HOSPICE CARE BENEFITS**

Plan F covers hospice care provided that benefits are also payable by Part A Medicare.

The following benefits will be paid:

- The amount of the Medicare five percent (5%) coinsurance charge for hospice respite care provided on an inpatient basis; and
- The Medicare copayment amount, up to a maximum of \$5, for each outpatient prescription drug that is prescribed for symptom control or pain relief.

## **EXCLUSIONS**

No benefits are payable unless a Physician has certified that the patient is terminally ill with a life expectancy of six (6) months or less.

Other Exclusions that apply to this benefit are in the General Exclusions section.

## MEDICAL EXPENSE BENEFITS

Plan F covers medical care treatment which is eligible for payment under Medicare Part B.

The following amounts **will be paid in full**:

- The amount of the Medicare Part B deductible.
- The amount of the Medicare Part B coinsurance (generally 50% of the Medicare approved charges for outpatient mental health services, and 20% of the Medicare approved charges for all other services).
- In the event a provider does not accept a Medicare assignment, the amount over and above the amount of the Medicare approved charge, up to the amount of charge limitations set by either Medicare or state law. This amount is often referred to as "Medicare Part B excess charges".
- The amount you pay for up to three pints of blood per calendar year. This includes blood provided on an inpatient basis (covered under Medicare Part A) or an outpatient basis (covered under Medicare Part B). Charges for blood you have replaced yourself, or which was replaced by another person donating on your behalf, are not covered under this provision.

Plan F also covers medical care and treatment for certain expenses that are not eligible for payment under Medicare Part B. These Covered Expenses are listed below. They are the actual cost to you of the Reasonable Charge (see Definitions) for Covered Health Services (see Definitions) and supplies not payable by Medicare Part B listed below. The service or supply must be needed because of injury, sickness or pregnancy. Plan benefits are paid at the rate of 100% of Covered Expenses unless otherwise indicated.

Covered Expenses are:

- Government Expenses: Charges for outpatient services, and for Physician services, provided by a United States Government Hospital, when required by federal law. Benefits are paid as if the services were provided by a non-government facility and covered under Medicare.
- Medical Supplies: Charges for any supply not covered under Medicare Part B because of a specific Medicare limitation, provided the supplier is permitted to charge for that supply.
- Nursing Services: Charges of a nurse (other than one who normally resides in your home or who is a member of your immediate family) for professional services. A member of your immediate family includes you, your spouse, and the children, brothers, sisters or parents of you or your spouse. Benefits are **at the rate of 80%** of Covered Expenses, and cannot exceed \$5,000 per any one person in a calendar year. These services must meet the definition of a Covered Health Service (see Definitions). They cannot be for Custodial Care (see Definitions).
- Outpatient Physical and Occupational Therapy and Speech Pathology Services: Charges which would be payable under Medicare Part B except for the Medicare annual maximum benefit for these services.
- Physician's Services: Charges for any service or supply not covered by Medicare Part B because of a specific Medicare limitation, provided the Physician is permitted to charge for that service or supply.
- Transportation Services: Transportation services to or from a Hospital in your local area. If there are no local Hospitals that can provide the care needed, transportation service to the nearest Hospital outside your local area qualified to give the required treatment will be covered.

Medical Expense Benefit will be determined at all times as if the Person Eligible Under Medicare has Full Medicare Coverage (see Definitions).

## EXCLUSIONS

Other exclusions that apply to this Benefit are in the General Exclusions section.



## **FOREIGN EMERGENCY CARE BENEFITS**

The Plan covers a percentage of Emergency Medical Care Expenses incurred while on a trip outside the United States. The Expense is the actual cost to you for the Reasonable Charges (see Definitions) for the Covered Health Services (see Definitions) described below.

Foreign Emergency Medical Care Expenses are charges you incur for any care you receive while on a trip outside the United States. The care must be needed immediately for an injury or sickness which develops in a sudden and unexpected way during your trip. The care must be for services and supplies which would have been covered under the Hospital Expense Benefits or the Medical Expense Benefits if it had been provided in the United States. It must be received during the first 60 days of your trip.

### **PERCENTAGE OF FOREIGN EMERGENCY MEDICAL CARE EXPENSES PAYABLE**

The Plan pays 80% of Foreign Emergency Medical Care Expenses in a calendar year. Payment will be made in United States currency in an amount based on the bank transfer exchange rate in effect on the day the claim is processed by UnitedHealthcare.

### **MAXIMUM AMOUNT**

The Maximum Amount payable for you or any of your Dependents is \$50,000. This Maximum Amount applies to a person's entire lifetime.

### **EXCLUSIONS**

Foreign Emergency Medical Care Expense Benefits are not payable for any expenses that are eligible for payment under Medicare.

Foreign Emergency Medical Care Expense Benefits are not payable for any expense incurred after the first 60 days of any one trip outside the United States. One trip begins on the day you leave the United States and ends on the day you return to the United States.

Other Exclusions that apply to this Benefit are in the General Exclusions section.

## AT- HOME RECOVERY CARE EXPENSE

The Plan covers At-Home Recovery Care Expenses incurred for at-home assistance on a short term basis for visits for Activities of Daily Living while you are recovering from an injury or sickness.

Activities of Daily Living are bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

Payment will be made for up to \$40 per visit, for up to 7 visits in any one week, and for up to \$1,600 for you or any of your covered Dependents in any one calendar year. Each visit by a member of an at-home recovery team will be considered as one visit. Four hours of At-Home Recovery Care services will be considered as one visit. If a visit exceeds four hours, each additional four hours, or part thereof, in any one 24 hour period will count as one additional visit. Each visit by any other member of an at-home recovery team will count as an additional visit.

The following conditions must be met for each visit:

- Your Physician must certify that you need At-Home Recovery Care.
- You must have been approved for Home Health Services under Medicare for the same injury or sickness.
- The visit must occur during a Medicare approved period of Home Health Care, or within 8 weeks from your last Medicare approved Home Health Care visit.
- The visit is not paid for by Medicare or any other government program.
- The visit is not covered under the Medical Expense Benefits under the description of Nursing Services.
- The visit is provided by a Care Provider (see definition below).
- The visit is not provided by a member of your immediate family - comprising the Employee, the Employee's wife or husband, and the children, brothers, sisters and parents of either the Employee or the Employee's wife or husband.
- The visit is not provided by an unpaid volunteer.
- The visit occurs in your home. Your home is any place used by you as a place of residence, provided that such place would qualify as a residence for Home Health Care Services covered by Medicare. A Hospital or Skilled Nursing Facility would not be considered your home.

A Care Provider is a duly qualified or licensed Home Health Aide, Homemaker, Personal Care Aide or Nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

A Home Health Aide, Homemaker or Personal Care Aide is a person who provides personal care services. If state or local licensing is required, the person must be licensed as a home health aide, homemaker or personal care aide where service is performed. If licensing is not required, any person who meets the minimum training qualifications recognized by the National Home Caring Council, National League of Nursing or Health Care Financing Administration will be considered a Home Health Aide, Homemaker or Personal Care Aide.

A Nurse is a professional nurse legally designated "RN" (Registered Nurse) or "LPN" (Licensed Practical Nurse) who, where licensing is required, holds a valid license from the state in which the nursing service is performed. "LPN" shall include a licensed vocational nurse ("LVN") and any other similarly designated nurse in those jurisdictions in which a professional nurse is designated as other than a "LPN", and for whom licensing is required.

#### **EXCLUSIONS**

Other Exclusions that apply to this Benefit are in the General Exclusions section.

## **PREVENTIVE MEDICAL CARE EXPENSE BENEFITS**

The Plan covers Preventive Medical Care Expenses.

Preventive Medical Care Expenses are the following:

- An annual clinical preventive medical history and physical examination and patient education to address preventive health care measures.
- Any of the following preventive screening tests or preventive services approved by your Physician:
  - fecal occult blood test and/or digital rectal examination;
  - mammogram;
  - dipstick urinalysis for hematuria, bacteriuria and proteinuria;
  - pure tone (air only) hearing screening test;
  - serum cholesterol screening, but only once in every five year period;
  - thyroid function test;
  - diabetes screening;
  - prostate cancer screening;
  - colorectal cancer screening.
- Influenza vaccine administered at any appropriate time during the year.
- Tetanus and diphtheria booster once in every ten year period.
- Any other test or preventive measures determined appropriate by your Physician.

Benefits will be paid for the actual cost to you for the Reasonable Charges (see Definitions), up to \$500 in a calendar year for you or any of your Dependents.

The Plan will pay the Reasonable Charges for pap smears, mammograms, colorectal cancer screenings and prostate cancer screenings and such charges will not be counted towards the \$500 calendar year limit.

### **EXCLUSIONS**

Other exclusions that apply to this Benefit are in the General Exclusions section.

**TREATMENT CENTER EXPENSE BENEFITS  
FOR ALCOHOLISM AND CHEMICAL DEPENDENCY**

The Plan covers confinement of you or your covered Dependent in a Treatment Center because of alcoholism and/or chemical dependency when such dependency has been certified by a Physician or Psychologist and the confinement has been prescribed.

Payment will be made for the Reasonable Charges made by the Treatment Center for room, board, care and treatment for any one person, up to a calendar year maximum of 60 days.

Detoxification services will be covered for up to 12 days annually.

## **VIII PLAN M**

### **APPLICABLE TO PERSONS ELIGIBLE UNDER THE MASSACHUSETTS BAY COMMUTER RAIL EARLY RETIREMENT PLAN (MBCR Plan)**

#### **ELIGIBILITY**

**This Plan has been developed to supplement the benefits for retired and disabled railroad Employees and their Dependents who qualify for coverage under the MBCR Plan.**

If you qualify for coverage under the MBCR Plan you may enroll for Employee and/or Dependents benefits under Plan M provided your enrollment and payment are mailed (postmarked) to UnitedHealthcare on or before the last day of the month in which coverage under the MBCR health plan for active employees terminates or in the next three calendar months.

When coverage for you or any family member terminates under the MBCR plan, you are no longer eligible for Plan M. You must notify UnitedHealthcare immediately when this occurs.

If you or a family member qualifies for Medicare due to age (65), your coverage under Plan M will be automatically transferred to Plan F.

If you or a family member becomes eligible for Medicare for any other reason you must notify UnitedHealthcare immediately.

#### **MAJOR MEDICAL EXPENSE BENEFITS**

**The following benefits are payable only for services which are considered out-of-network under the MBCR Plan or when the lifetime maximum under the MBCR Plan has been exhausted. No benefits are payable under Plan M for In-network services**

#### **PLAN M CLAIM DETERMINATIONS**

Both the Cooperating Railway Labor Organizations, who are the policyholder under GA-23111, and UnitedHealthcare, desire a consistency in coverage under the MBCR Plan and Plan M. However, there are some services covered under the MBCR plan which are not covered under Plan M. See the section entitled "Covered Services".

The sections below entitled "Preferred Providers" and "Care Coordination" apply only when the lifetime maximum has been exhausted under the MBCR Plan.

## **DEDUCTIBLE**

The Deductible is separate for you and each of your Dependents each calendar year. It has two parts - a Basic Benefits Deductible and a Cash Deductible.

### **Basic Benefits Deductible**

The Basic Benefits Deductible is the total payments made during the calendar year under the MBCR Plan or, if the benefits under the MBCR Plan are reduced in accordance with its Coordination of Benefits provisions, the payments which would have been made had such reduction not occurred.

### **Cash Deductible**

The Cash Deductible is \$100.

## **PERCENTAGE OF COVERED EXPENSES PAYABLE**

The Plan pays 70% (75% for the first 40 outpatient visits for alcoholism, chemical dependency and/or mental illness, and 60% for any visits thereafter) of the Covered Expenses in a calendar year after the Deductible is satisfied.

The Plan pays 100% of the Covered Expenses in a calendar year after the Out-of-Pocket Maximum is met.

## **OUT-OF-POCKET MAXIMUM**

The Out-of-Pocket Maximum limits the amount of Covered Expenses you will have to pay for any one covered individual in a calendar year. The Out-of-Pocket Maximum each calendar year is \$5,000. Covered Expenses used to satisfy your Deductible are also used to help satisfy your Out-of-Pocket Maximum.

The following expenses do not count in determining if any Out-of-Pocket Maximum has been met:

- Charges you pay that are in excess of the Reasonable Charge.
- Charges you pay that are in excess of specific Plan limitations or exclusions.
- Charges you pay for expenses not covered by the Plan.
- The \$500 (or any part thereof) reduction in benefits under the MBCR Plan if the required HPHC notification is not made.
- Co-payments you make and any other charges you pay under the MBCR Plan Managed Pharmacy Services Benefit.

## **MAXIMUM AMOUNT**

The Maximum Amount payable with respect to you or any one of your Dependents is \$500,000. This Maximum Amount applies to a person's entire lifetime.

## COVERED EXPENSES

Covered Expenses are the actual cost to you of the Reasonable Charges (see Definitions) for the Covered Health Services (see Definitions) listed below. The service or supply must be needed because of injury, sickness or pregnancy.

A service or supply is not a Covered Health Service just because it is furnished by, or ordered by, your provider. The services and supplies will be reviewed by UnitedHealthcare to determine if they are covered under the Plan.

The services and supplies for which Covered Expenses may be incurred are as follows:

### **Ambulatory Surgical Center Services**

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

### **Anesthetics**

### **Birth Center Services**

### **Chemotherapy**

### **Clinical Trials**

Routine patient care costs incurred during participation in an approved clinical trial meeting the approved clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in an approved clinical trial.

Benefits are available only when the Covered Family Member is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.



- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be an approved clinical trial, a clinical trial must meet all of the following criteria:

- Be approved and funded in full or in part by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS.
  - The Department of Defense (DOD), the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
  - A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA.
  - An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with federal regulations.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

### **Durable Medical Equipment**

Durable Medical Equipment means equipment that meets all of the following criteria:

- It is for repeated use and is not consumable or disposable
- It is used primarily for a medical purpose.
- It is appropriate for use in the home.

Some examples of durable medical equipment are:

- Appliances that replace a lost body organ or part or help an impaired one to work.
- Orthotic devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.

- Respirators or other equipment for the use of oxygen.
- Monitoring devices.

Care Coordination must be contacted for any purchase or rental costs which exceed \$1,000. Care Coordination will determine whether the purchase or rental of the equipment is Medically Appropriate.

### **Diabetes Treatment**

Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by certified, registered or licensed health care professional.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and a periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

### **Habilitative Services**

Habilitative Services for children 0-21 years old are covered, except for Habilitative Services provided in early intervention and school services.

Habilitative Services includes services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitative Services, a congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congenital or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.

### **Home Health Care Agency Services**

- Part-time or intermittent nursing care rendered by or supervised by a registered nurse.
- Part-time or intermittent care by a home health aide.
- Physical therapy or occupational therapy.
- Speech therapy to restore speech lost or impaired due to removal of vocal cords, cerebral thrombosis, or brain damage due to injury or organic brain lesion.
- Prescription drugs
- Medical Supplies.
- X-rays and laboratory tests.

## **Hospice Care Services**

Up to a maximum payment of \$3,000 for each Course of Care for room, board, care and treatment charged by a Hospice.

Up to a maximum payment of \$1,000 for each Course of Care for:

- Counseling for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor.
- Bereavement counseling up to 15 visits for the patient's Immediate Family. Services must be given by a licensed social worker or a licensed pastoral counselor and given within six months after the patient's death.

The Physician must certify that the patient is terminally ill with 6 months or less to live.

"Immediate Family" means you or any member of your family who is covered under this Plan.

"Course of Care" means all services given to the patient and the patient's Immediate Family in connection with the terminal illness of the patient.

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

## **Hospital Services**

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

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

Coverage is also provided for up to 60 inpatient days per calendar year for alcoholism, chemical dependency and/or mental illness services. In addition, coverage is provided for up to 12 days per calendar year for inpatient detoxification services.

Coverage is also provided for newborn infant hearing screenings and all necessary audiological examinations provided as recommended by the National Joint Committee on Infant Hearing. For purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries.

Services and supplies provided by a Hospital for emergency care and treatment for a medical emergency, including the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Coverage is also provided for a voluntary HIV screening test performed while receiving emergency care in a Hospital, once per calendar year, regardless of whether or not the HIV screening is necessary for the treatment of the condition for which the emergency care is sought.

## **Infertility Treatment**

Diagnosis and treatment of infertility, including surgery and drug therapy. This does not include procedures or services to facilitate a pregnancy, such as, but not limited to, in vitro fertilization, embryo transfer, artificial insemination and immunotherapy for infertility.

## **Medical Supplies**

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood plasma only if not donated or replaced.

## **Nursing Services**

Services of a trained nurse or a Nurse-Midwife.

## **Occupational Therapy**

Services of a licensed occupational therapist provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement within two (2) months of the start of treatment.

## **Organ/Tissue Transplants**

- Donor Charges

In the case of an organ or tissue transplant, no services or supplies for the donor are considered Covered Health Services unless the recipient is the Employee or his/her Dependent. If the recipient is not the Employee or his/her Dependent, no benefits are payable for donor charges.

The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Transplant Facility.

- Qualified Procedures

If a qualified procedure, listed below, is Medically Appropriate, the "Medical Care and Treatment" provisions set forth below apply:

- Heart transplants
- Lung transplants
- Heart/lung transplants
- Liver transplants
- Kidney transplants
- Pancreas transplants
- Kidney/pancreas transplants
- Bone marrow/stem cell transplants

- Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Treatment Facility.
- Medical Care and Treatment

The following services provided in connection with the transplant are Covered Health Services:

- Pre-transplant evaluation for one of the procedures listed above
- Organ acquisition and procurement
- Hospital and Physician fees
- Transplant procedures
- Follow-up care for a period up to one year after the transplant
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of \$25,000 is payable for all charges made in connection with the search.
- Transportation and Lodging

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

Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Reasonable and necessary expenses for transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people.

Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Transplant Facility.

If the Dependent who is the patient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the \$100 per diem rate.

There is a combined overall lifetime maximum of \$10,000 per Employee or Dependent for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan M, in connection with all transplant procedures.

If you or your Dependent(s) receive reimbursement for meals associated with this Transportation and Lodging benefit that is not part of inpatient care, federal tax rules require that such reimbursements be reported to the Employee. You will receive appropriate notification of any such taxable amounts paid to you.

## **Outpatient Alcoholism, Chemical Dependency and Mental Illness Services**

Benefits for outpatient services to treat alcoholism, chemical dependency and/or mental illness. The Plan pays 75% of the Covered Expenses in a calendar year after the Deductible is satisfied, for the first 40 outpatient visits, and then 60% of any additional visits.

## **Physical Therapy**

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician.
- The therapist must submit progress reports to the Physician at the intervals stated in the treatment plan.

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

In addition, benefits for physical therapy for Dependent children, under the age of 21, with congenital or birth defects (including autism and cerebral palsy) will be covered.

## **Physicians Services**

### **Prescription Contraceptive Devices**

Devices approved by the U.S. Food and Drug Administration for the prevention of a pregnancy are covered for female employees and the wives of male employees.

### **Prescription Drugs**

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

### **Preventive Adult Health Services**

- Benefits are available for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:
  - a baseline mammogram; and
  - follow-up mammograms on an annual basis.
- Pap smears are covered annually, or when it is determined by the attending physician that the test is necessary.

The preventive services listed above are not subject to the Calendar Year Deductible.

- Colorectal cancer screenings are covered in compliance with the American Cancer Society colorectal cancer screenings guidelines.
- Screenings in accordance with the latest screening guidelines issued by the American Cancer Society.

## **Preventive Child Health Services**

Benefits are available from birth to age 21 including:

- Coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and
- Coverage for preventive and primary care services, including physician examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to age 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

## **Psychologist Services**

### **Radiation Therapy**

### **Skilled Nursing Facility Care After Hospital Confinement**

Services and supplies up to 31 days of confinement following each Hospital confinement.

Separate confinements for the same cause are considered to be one confinement, unless separated by 14 or more days.

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

### **Speech Therapy**

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

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

The therapy must be expected to result in significant, objective, measurable physical improvement within two months of the start of the treatment.

In addition, benefits for speech therapy for Dependent children, under the age of 21, with congenital or birth defects (including autism and cerebral palsy) will be covered.

### **Spinal Manipulations**

Services of a physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

No benefits are available for any type of therapy, service or supply, including, but not limited to, spinal manipulation by a chiropractor or other physician once the therapy, service or supply ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

### **Treatment Center Services**

Charges for services at a Treatment Center when a Physician or Psychologist has certified an alcoholism or chemical dependency and has prescribed such services, up to a calendar year maximum of 60 days. In addition, detoxification services will be covered for up to 12 days annually.

### **Transportation Services**

Transportation charges are covered for transportation to a Hospital in an emergency.

The transportation services must be to a Hospital in your local area. If there are no local Hospitals that can provide the care needed, charges for transportation to the nearest Hospital outside your local area qualified to give the required treatment, will be covered.

### **X-ray and Laboratory Tests**

## **EXCLUSIONS**

Major Medical Expenses Benefits are not payable for expenses for:

- Expenses for any confinement, treatment, services or supplies which would have been payable under the MBCR Plan, but which were not payable due to you or your Dependent's non-compliance with Care Coordination described under the MBCR Plan.
- Prescription Drugs purchased from a pharmacy or by mail order.
- Expenses for treatment of on-duty injuries if the railroad has paid those expenses.

Other exclusions that apply to this Benefit are in the General Exclusions section.



## **PREFERRED PROVIDERS**

UnitedHealthcare has arranged with certain health care providers to become Preferred Providers. These Preferred Providers have agreed to discount their charges for Covered Expenses.

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

You will receive an Identification Card showing that you and/or your Dependents covered under Plan M are entitled to these discounts. This Identification Card must be shown every time health care services are given. This is how the provider knows that you and/or your Dependent is covered under a Preferred Provider plan. Otherwise, you could be billed for the provider's normal charge.

Call UnitedHealthcare at 1-800-842-5252 to inquire about or locate Preferred Providers in your area. You may also access Preferred Provider information online at [myuch.com](http://myuch.com).

Preferred Providers are responsible for filing your claims directly to UnitedHealthcare. You do not need to submit claims for Preferred Providers services or supplies.

You must submit claims for services and supplies rendered by other providers as described in the Claim Information section.

If a Preferred Provider bills you for any part of the discount amount, call UnitedHealthcare at 1-800-842-5252 for assistance.

## **CARE COORDINATION**

### **Notification**

UnitedHealthcare's Care Coordination must be contacted for the following services:

- Inpatient facility admissions.
- Reconstructive procedures.
- Maternity Services (if stay exceeds the 48/96 guidelines).
- Transplant services.

### **How to Notify Care Coordination**

Care Coordination is notified by calling toll-free 1-800-842-4555. Their working days are Monday through Friday, except for State and Federal holidays. The hours of operation are 8:00 a.m. to 7:00 p.m. However, you can call Care Coordination at any time, day, or night. If you call outside the hours of operation, you may leave a message with your telephone number on an answering machine, and a Care Coordination representative will return your call within one working day.

### **When to Notify Care Coordination**

Care Coordination should be notified as promptly as possible before any of the services listed above are rendered. The notification allows Care Coordination sufficient time to complete a review before the services are rendered. Otherwise, if Care Coordination does not receive sufficient advance notice, they may not be able to complete the review before you incur expenses.

For an emergency which results in a confinement, you (or a representative or your Physician) must call Care Coordination within two days (excluding weekends and holidays) of the date the confinement begins.

You should notify Care Coordination promptly after you become aware that you are pregnant. You must notify Care Coordination only if the inpatient care for the mother or child is expected to continue beyond:

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

### **What Care Coordination Does**

Care Coordination reviews the services you are to receive with your Physician, and agrees on a treatment plan. If there is disagreement between Care Coordination and your Physician, a Care Coordination Physician Advisor may be involved.

If there is still not agreement on a treatment plan, you and your Physician always make the final decision.

**Effect on Benefits**

If Care Coordination is not notified when required, benefits otherwise payable at 70% will be paid at 60%. If your Out-of-Pocket Maximum has been met, the Plan will pay 100% of Covered Expenses even if Care Coordination is not notified. If your benefits are reduced from 70% to 60% because Care Coordination is not notified when required, the full 40% you pay will be applied to your Out-of-Pocket Maximum.

The Plan pays a percentage of Covered Expenses incurred in calendar year which exceed the Deductible.

*Remember: This notice obligation is your responsibility. It is not the responsibility of your Physician, your Hospital, or any other provider to make the required notification to Care Coordination. However, your Physician, Hospital, or other provider may make this notice for you.*

Other exclusions that apply to this Benefit are in the General Exclusions section.

# IX

## GENERAL EXCLUSIONS

This Plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with the following, even if recommended or prescribed by a Physician or is the only treatment available for your condition:

- Dependent who is covered as an Employee for the same services under this Plan.
- A Dependent who is covered as an Employee under any Hospital Association Plan.
- Dependent child's pregnancy or the resulting childbirth, adoption or miscarriage.
- Dependents' Work Related Injury or Sickness - services or supplies for which your Eligible Dependent is entitled to indemnity under any workers' compensation or similar law.
- Service or supplies received before an Employee or his or her Dependent becomes covered under the Plan.
- Abdominoplastys (unless covered under GA-46000).
- Alternative Treatments, such as acupressure, aromatherapy, hypnotism, massage therapy, rolfing, and art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*.
- Breast reduction surgery (unless covered under GA-46000).
- Chelation therapy, except to treat heavy metal poisoning.
- Completion of claim forms, or missed appointments.
- Cosmetic/Reconstructive Surgery - Cosmetic or reconstructive surgery or treatment, whether or not it is for psychological or emotional reasons, except for reconstructive surgery to improve the function of a body part when the malfunction is a direct result of one of the following:
  - Birth defect.
  - Sickness.
  - Injury which occurs while the individual is covered under this policy.
  - Surgery.

The following reconstructive surgery is also covered:

- Reconstructive breast surgery following a mastectomy, including surgery on the non-affected breast to achieve symmetry. Additional services include breast prosthesis and treatment of physical complications during all stages of the mastectomy including lymphedemas.
- Reconstructive surgery to remove scar tissue on the neck, face or head if the scar tissue is due to injury which occurs or a sickness which commences while the individual is covered under this policy.
- Court Ordered Treatment - Examinations or treatment ordered by a court in connection with legal proceedings except as specifically provided under this policy.

- Coverage Under Other Railroad Health Plans - any confinement, treatment, services or supplies if benefits are payable for these expenses under any other employer group health plan as an Employee. Any premium payments made under this policy for any month that coverage is provided under any other employer group health plan will be refunded upon your request. Contact UnitedHealthcare for assistance.
- Custodial Care (see Definitions), except as specifically covered under Plan F.
- Drugs, including the following:
  - Prescription drug products for outpatient use that are filled by a prescription order or refill.
  - Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
  - Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
  - Over-the-counter drugs and treatments.
  - Growth hormone therapy (unless covered under GA-46000).
- Durable Medical Equipment does not include any of the following items:
  - Non-hospital beds, comfort beds, motorized beds/mattresses.
  - Devices and computers to assist in communication and speech except for speech aid prosthetics and traceo-esophageal voice prosthetics.
  - Wigs in excess of \$500 and/or for reasons other than loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury.
  - Dental braces.
  - Braces that straighten or change the shape of a body part, except those braces that stabilize an injured body part and braces to treat curvature of the spine.
  - Air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items.
  - Durable Medical Equipment provided to you by a Physician.
  - Generally, any device, appliance, pump, machine stimulator, or monitor that is fully implanted into the body.
- Ecological or environmental medicine, diagnosis and/or treatment.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Eye examinations, glasses or contact lenses for diagnosis or treatment of refractive errors except to the extent needed for repair of damages caused by bodily injury sustained while covered (unless covered under GA-46000).
- Ear examinations, hearing aids or cochlear implants for diagnosis or treatment of hearing loss except due to the extent needed for repair of damages caused by bodily injury sustained while covered (unless covered under GA-46000).
- Experimental or Investigation or Unproven Services and all services related to Experimental or Investigations and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

- Herbal medicine, holistic or homeopathic care, including drugs.
- Services, supplies medical care or treatment given by one of the following members of the Employee's immediate family:
  - The Employee's spouse.
  - The child, brother, sister, parent or grandparent of either the Employee or the Employee's spouse.
- Charges for procedures which facilitate a pregnancy but do not treat the cause of infertility, such as in vitro fertilization, artificial insemination, embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer and tubal ovum transfer.
- Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time UnitedHealthcare Insurance Company makes a determination regarding coverage in a particular case are determined to be:
  - not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
  - subject to review and approval by any institutional review board for the proposed use; or
  - the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
  - a service that does not meet the definition of a Covered Health Service.

If a Covered Person has a "life-threatening" Sickness or condition (one which is likely to cause death within one year of the request for treatment), UnitedHealthcare may determine that an Experimental, Investigational or Unproven Service meets the definition of a Covered Health Service for the Sickness or condition. For this to take place, UnitedHealthcare must determine that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

- Services and supplies which the Covered Person is not legally required to pay.
- Liposuction.
- Surgical correction or other treatment of a malocclusion.
- Services and supplies which are not Covered Health Services, including any confinement or treatment given in connection with a service or supply which is not covered under the Plan.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Nutritional counseling except if provided for diabetes self-management training.
- Services given by a pastoral counselor.
- Personal convenience items, including but not limited to such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.
- Private duty nursing services.

- Routine foot care, including but not limited to, nail cutting and trimming and removal of corns and calluses, except when required for the prevention of complications due to diabetes or severe systemic disease.
- Services for a surgical procedure to correct refractive errors of the eye, including any confinement, treatment, services or supplies given in connection with or related to the surgery.
- Sterilization procedures, except to avoid a life-threatening condition.
- Reversal of sterilization.
- Rhytidectomy.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- Charges made by a Hospital for a confinement in a special area of the Hospital which provides non-acute care, by whatever name called, including but not limited to the type of care given by the facilities listed below. If that type of facility is otherwise covered under this Plan, then benefits for that covered facility which is part of a Hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a Hospital.
  - Adult or child day care center.
  - Ambulatory Surgical Center.
  - Birth Center.
  - Half-way house.
  - Hospice.
  - Skilled Nursing Facility.
  - Treatment Center.
  - Vocational rehabilitation center.
  - Any other area of a Hospital which renders services on an inpatient basis for other than acute care of sick, injured or pregnant persons.
- Stand-by services required by a Physician.
- Dental Services - care of and treatment to the teeth and gums except for the following:
  - Hospital, radiology and pathology services while confined as an in-patient in a Hospital for dental surgery or within 72 hours of dental surgery, and
  - Full or partial dentures, fixed bridgework, or repair to natural teeth if needed because of accidental injury to natural teeth which happens while covered.
- Treatment or consultations provided via telephone.
- Transplant services that are not performed at a Transplant Facility. This exclusion applies to Plans A, B and C only.
- Tobacco dependency.
- Services or supplies received as a result of war declared or undeclared, or international armed conflict.

- Weight reduction or control (unless there is a diagnosis of morbid obesity).
- Special foods, food supplements, liquid diets, diet plans or any related products.
- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury), hair transplants, hair weaving or any drug if such drug is used in connection with baldness.
- Services given by volunteers or person who do not normally charge for their services.
- Donor Expenses - expenses incurred by an organ donor, except as specifically provided under this Policy.
- Government Hospital –
  - for any confinement in a United States government or agency hospital. However, the reasonable cost incurred by the United States or one of its agencies for in-patient or out-patient medical care and treatment given by a military hospital may be covered under the Plan. This coverage applies only to care and treatment provided to:
    - A person retired from the uniformed services,
    - a family member of a person who is retired from the uniformed services,
    - a family member of a person who is active in the uniformed services, or
    - a family member of a deceased member of the uniformed services.
- Educational rehabilitation, or treatment of learning disabilities, regardless of the setting in which such services are provided.
- Treatment for personal or professional growth, development, or training or professional certification.
- Evaluation, consultation, or therapy for educational or professional training or for investigational purposes relating to employment.
- Examinations, testing, evaluations or treatment which may be required solely for purposes of obtaining or maintaining employment or insurance, pursuant to judicial order or administrative proceedings, or as may be required to participate in sports or attend school, to travel, or for the purposes of marriage or adoption.
- Academic education during residential treatment.
- Therapies such as Erhard/The Forum, primal therapy, aversion therapy, bioenergetic therapy, crystal healing therapy.
- Counseling services and/or treatment related to such problems as financial, marital or occupational difficulties, adult anti-social behavior or parent-child relationships.
- Non-abstinence based or nutritionally based chemical dependency treatment.

If a person is covered under this policy as a dependent of two Employees, benefits payable under this policy will be limited to the benefits for which only one of the Employees is entitled to on account of the expenses incurred in connection with the Dependent.

In no event will benefits under Plans A, B, C, E or M be payable for any expenses incurred by any person on or after the date he or she becomes a Person Eligible Under Medicare.



Expenses incurred for services and supplies that the policy would not normally cover will be considered for payment of benefits if they are part of an "Alternate Care Plan (ACP)" that has been developed by UnitedHealthcare and agreed to by you or your dependent as a substitute for services and supplies that you or your Dependent are eligible for under the policy. Benefits for services and supplies provided under the Alternate Care Plan are subject to and count towards the policy's provisions regarding benefit amounts, maximum benefits, copayments and deductibles that apply to the services and supplies for which they are in substitution.

# X

## BENEFITS AFTER COVERAGE ENDS

### Plans A, B and C

If you or your Dependent is disabled on the date your coverage ends, Major Medical Expense Benefits apply to expenses incurred in the calendar year in which your coverage ends and the next succeeding calendar year, but only for the bodily injury or sickness causing continuous disability of you or your Dependent from the date your coverage ends, except that benefits are not payable on or after the date the disabled person becomes a Person Eligible Under Medicare.

Maternity Benefits apply to expenses incurred after coverage ends in connection with a pregnancy which commenced while you or your Dependent wife was covered. The disability requirements stated above do not apply.

The Treatment Center Services benefits apply to confinements that began while you were covered.

### Plan F

Treatment Center Expense Benefits apply to confinements that began while you were covered.

All other benefits are not provided under Plan F for expenses incurred after coverage ends.

### Plans E and M

If you or your Dependent is disabled on the date your coverage ends Major Medical Expense Benefits will continue to apply subject to the following conditions:

Benefits are payable only for expenses incurred with respect to your or your Dependent's bodily injury or sickness causing the disability.

The disability must be continuous from the date coverage ends to the date each expense is incurred.

Benefits are payable for the calendar year in which coverage ends and during the next calendar year.

Benefits are not payable on account of expenses incurred by any person on or after the date he or she becomes a Person Eligible Under Medicare.

Treatment Center Expense Benefits apply to confinements that began while you were covered.

# XI

## DEFINITIONS

### **Alternate Care Plan**

A plan of alternate utilization of medical services which includes cost- effective appropriate care alternatives to services which are otherwise covered by the policy. The alternate medical services may not be otherwise covered by the policy.

### **Ambulatory Surgical Center**

A specialized facility which fully meets all the tests set forth in (1) or (2) below:

- (1) Has been licensed as an ambulatory surgical center in accordance with the applicable laws in the jurisdiction in which it is located by the state's regulatory authority, as being established, equipped, operated and staffed primarily for the purpose of performing surgical procedures; or
- (2) Where state licensing is not required, meets all of the following requirements:
  - It is established, equipped and staffed primarily for the purpose of performing surgical procedures.
  - It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full time to such supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one hospital in the area.
  - It requires in all cases other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
  - It provides at least one operating room and at least one post- anesthesia recovery room.
  - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain such, as necessary.
  - It has trained personnel and necessary equipment to handle emergency situations.
  - It has immediate access to a blood bank or blood supplies, if necessary.
  - It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating room and in the post-anesthesia recovery room.
  - It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

### **Assistant Surgeon Services**

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

### **Birth Center**

A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which the facility is located.
- Where licensing is not required, it meets all of the following requirements:
  - It is operated and equipped in accordance with any applicable state law.
  - It is equipped to perform routine diagnostic and laboratory examinations.
  - It has trained personnel and necessary equipment available to handle foreseeable Emergencies.
  - It is operated under the full-time supervision of a doctor of medicine (M.D.) or registered nurse (R.N.)
  - It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
  - It is expected to discharge or transfer patients within 24 hours following delivery.

### **Chemotherapy**

The treatment of malignant conditions using antineoplastic agents which are administered

- at a controlled rate through a catheter placed surgically in an artery,
- intramuscularly,
- subcutaneously, or
- orally.

Antineoplastic agents are those chemotherapy drugs which have been accepted for inclusion in the U.S. Pharmacopoeia, National Formulary, or have been accepted by the Federal Drug Administration and/or have received official approval by the American Medical Association Council on Drugs.

## **Covered Health Service(s)**

Covered Health Services are those health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or symptoms. Covered Health Services must be provided:

- When the Plan is in effect;
- Prior to the date that any of the individual termination conditions set forth in this Summary Plan Description; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

A Covered Health Service must meet each of the following criteria:

- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes and are based on trials that meet the following designs:
  - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
  - Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- It is the most cost-effective method and yields a similar outcome to other available alternatives.
- It is a health service or supply that is described in this Certificate, and which is not excluded under General Exclusions.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

## **Custodial Care**

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

- Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
- Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.
- Care that meets one of the conditions above is custodial care regardless of any of the following:
  - Who recommends, provides or directs the care.
  - Where the care is provided.
  - Whether or not the patient can be or is being trained to care for himself or herself.

## **Dependent**

*With respect to Plans A, B, C, E and M*

- The Employee's wife or husband,
- The Employee's unmarried children from birth through age 18,
- The Employee's unmarried children 19 years of age but under 25 years of age, who have their legal residence with the Employee, and who are wholly dependent upon the Employee for maintenance and support and who are registered Students in regular, full-time attendance at an accredited secondary school, college or university or institution for the training of nurses, and
- The Employee's unmarried children 19 years of age or over who have their legal residence with the Employee and who are wholly dependent upon the Employee for maintenance and support and who have a permanent physical or mental condition which is such that they are unable to engage in any regular employment, provided that such disability began prior to the child attaining 19 years of age.

Please note, in order to continue Dependent coverage past age 19, you must contact UnitedHealthcare and notify us of your Dependent's Student status or disability. In addition, proof of Student status or disability may be required.

**Durable Medical Equipment** – medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a sickness, injury or their symptoms.
- Is generally not useful to a person in the absence of a sickness, injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Generally, is not implantable within the body.

## **Employee**

A U.S. resident who is classified as one of the following:

- a currently inactive railway employee who was covered as an active employee under one of the following plans:
  - Health & Welfare Plan (including AmPlan)
  - NRC/UTU Plan.
  - Any other health and welfare plan established pursuant to an agreement between one or more railroads and one or more labor organizations.
- A currently retired or disabled railway industry employee who is covered under The Railroad Employees National Early Retirement Major Medical Benefit Plan (GA-46000) or any other group health plan deemed by UnitedHealthcare to provide benefits identical to those provided under GA-46000.
- A currently inactive Cooperating Railway Labor Organization employee who was covered as an active employee under the Railway Labor Organizations Group Life and Hospital, Surgical and Medical Benefit Plan for Their Officers and Employees (GA-107300).
- With respect to coverage for parents and parents-in-law under Plan F, an active or Inactive Employee covered under GA-23111, Health & Welfare Plan, NRC/UTU Plan, of GA-107300.

### **Experimental or Investigational or Unproven Service(s)**

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by an institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical test set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Life-Threatening Sickness or Condition. If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment) UnitedHealthcare may, in its discretion, consider an otherwise Experimental or Investigational or Unproven Service to be a Covered Health Services for that sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

### **Full Medicare Coverage**

Coverage for all the benefits provided under both Medicare Part A and Medicare Part B. For the purpose of coverage under this policy, each Person Eligible Under Medicare shall be deemed to have Full Medicare Coverage.

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

- The person is not enrolled in Medicare.
- The person is enrolled in a Medicare Advantage Plan.
- The person receives services from a provider who has elected to opt- out of Medicare.
- The person is enrolled under a plan with a Medicare Savings Account.
- Medicare benefits are reduced because of any benefits paid in accordance with:
  - any plan of insurance regulated by or through action of any automobile reparations act of any government,
  - any policy or plan which includes automobile medical payments benefits,
  - the provisions of any liability insurance policy or plan, or
  - the availability of health coverage under a group health plan which must pay benefits primary to Medicare.

## **Furloughed Employee**

The term "Furloughed Employee" as used herein means an Employee furloughed or placed on leave of absence while covered for Employee or Dependents Benefits under the Health & Welfare or NRC/UTU Plans or GA-107300. The term Furloughed Employee shall also include:

- any individual whose coverage under the Health & Welfare or NRC/ UTU Plan is terminated but whose status is being considered in proceedings under the Railway Labor Act, as certified by the Policyholder; and
- any Employee on furlough or leave of absence who was covered as a Furloughed Employee under the Former Policy; and
- any individual whose insurance under the Health & Welfare or NRC/ UTU Plan is terminated following the termination of his or her employment relationship by a reason of his or her change in the Employer's practices or method of operation, such as a merger, consolidation or abolition of the individual's position, but in no event beyond date such individual becomes covered under a health and welfare plan.

Wherever reference is made herein to employment, furlough or being placed on a leave of absence, it shall mean employment, furlough or being placed on leave of absence by the Employer included under the Health & Welfare or NRC/UTU Plan or GA-107300 by whom the Employee was last employed prior to the termination of his or her coverage under such plans.

In no event shall the term Furloughed Employee include any individual beyond the termination of any such furlough or leave.

## **GA-107300**

Railway Labor Organizations Group Life Insurance and Hospital, Surgical and Medical Benefit Plan for Their Officers and Employees. Any reference to any other employer group health plan is a reference to GA-107300.

## **GA-46000**

The Railroad Employees National Early Retirement Major Medical Benefit Plan, AmPlan Early Retirement Benefits and any other group health plan which is determined by UnitedHealthcare to provide benefits identical to the Railroad Employees National Early Retirement Benefit Plan.

## **Health & Welfare Plan**

The Railroad Employees National Health and Welfare Plan and AmPlan.



## **Home Health Care Agency**

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

- It is approved under Medicare.
- It is established and operated in accordance with the applicable licensing and other laws.
- It meets all of the following tests:
  - It has the primary purpose of providing a home health care delivery system bringing supportive services to the home.
  - It has a full-time administrator.
  - It maintains written records of services provided to the patient.
  - Its staff includes at least one registered graduate nurse (R.N.) or it has nursing care by a registered graduate nurse (R.N.) available.
  - Its employees are bonded and it provides malpractice and malplacement insurance.

## **Hospice**

An agency that provides counseling and incidental medical services for a terminally ill individual. The agency must meet all of the following tests:

- It is approved under any required state or governmental Certificate of Need.
- It provides 24 hour-a-day, 7 day-a-week service.
- It is under the direct supervision of a physician.
- It has a social-service coordinator who is licensed in the area in which it is located.
- The main purpose of the agency is to provide Hospice services.
- It has a full-time administrator.
- It is established and operated in accordance with any applicable state laws.

A part of a Hospital that meets the criteria set forth above will be considered as a Hospice for the purpose of this Policy.

## **Hospital**

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient basis at the patient's expense and which fully meets all the tests set forth in (a) or (b) or (c) below:

- (a) It is a hospital accredited by the Joint Commission on Accreditation of Health Care Organizations.
- (b) It is a hospital, a psychiatric hospital or a tuberculosis hospital, as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare.
- (c) It is an institution which fully meets all of the following tests:
  - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians; and

- It continuously provides on the premises Twenty-four hour a day nursing service by or under the supervision of registered graduate nurses; and
- It is operated continuously with organized facilities for operative surgery on the premises.

### **Inactive Employee**

Former railroad or union employees who were covered as active employees under the Health & Welfare Plan, NRC/UTU Plan, or the Railway Labor Organizations Group Life and Hospital, Surgical and Medical Benefit Plan, who were terminated from active employment for one of the following reasons:

- Furlough as defined above under Furloughed Employee.
- Suspension or dismissal.
- Retirement.
- Termination of employment relationship for reasons other than retirement or dismissal.
- Disability.

### **Level of Care**

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

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

### **MBCR**

Massachusetts Bay Commuter Rail.

### **Medically Appropriate**

A Covered Health Service which has been determined by UnitedHealthcare to be the appropriate Level of Care that can safely be provided for the specific covered individual's diagnosed condition in accordance with the professional and technical standards adopted by UnitedHealthcare .

### **Medicare**

The Health Insurance for The Aged and Disabled program under Title XVIII of The Social Security Act as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97), 1967 (Public Law 90-248) and 1972 (Public Law 92-603), as such program is currently constituted and as it may be later amended.

## **Multiple Surgical Procedures**

Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Covered Expenses for multiple surgical procedures are limited as follows:

- Covered Expenses for a secondary procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
- Covered Expenses for any subsequent procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

## **Nurse-Midwife**

A person who is certified to practice as a Nurse-Midwife and who:

- Is licensed as a registered nurse by the appropriate board of nursing having responsibility for such licensure under the laws of the jurisdiction where such person renders services, and
- Has completed a program for the training of Nurse-Midwives approved by the appropriate regulatory authority having responsibility for such programs under the laws of the jurisdiction where such program is provided.

## **NRC/UTU Plan**

National Railway Carriers and United Transportation Union Health & Welfare Plan.

## **Person Eligible Under Medicare**

An Employee or Dependent who is enrolled under Medicare Parts A and B or has been eligible to enroll under Medicare Parts A and B.

Under Plans E and M only, if the basis for Medicare coverage is end stage renal disease, an Employee or Dependent shall not be a Person Eligible Under Medicare until the end of a 30 month period beginning with the first day of the person's Medicare eligibility.

## **Physician**

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Chiropractic (D.C.).
- Doctor of Chiropractic (D.C.).
- Doctor of Dental Surgery (D.D.S.).
- Doctor of Medical Dentistry (D.M.D.).
- Doctor of Optometry (O.D.).
- Doctor of Osteopathy (D.O.).
- Doctor of Podiatry (D.P.M.).
- Physician's Assistant when operating under the direction of one of the above Physicians.

## **Policy**

The entire agreement issued to the Policyholder, that includes the following:

- the Group Policy.
- this Certificate of Coverage.
- Amendments.
- Riders

These documents make up the entire agreement that is issued to the Policyholder.

## **Policyholder**

The following organizations collectively constitute the Cooperating Railway Labor Organizations to whom the policy is issued.

- International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers
- International Brotherhood of Electrical Workers
- National Conference of Firemen and Oilers
- International Association of Machinists and Aerospace Workers
- Sheet Metal Workers' International Association
- Transportation Communications International Union
- Brotherhood of Maintenance of Way Employees Department
- Brotherhood of Railroad Signalmen
- UNITE HERE
- Brotherhood of Locomotive Engineers and Trainmen
- United Transportation Union
- American Train Dispatchers Association
- Transportation Workers Union

## **Preferred Provider**

A provider who has agreed to discount his or her charges for Covered Services under Plans A, B, C, E and M.

## **Psychologist**

A person who specializes in clinical psychology and fulfills one of the following requirements:

- A person licensed or certified as a psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Wherever reference is made to a licensed physician, it will also include a psychologist.

### **Reasonable Charge**

An amount measured and determined by UnitedHealthcare by comparing the actual charge with the charges made for similar services and supplies provided to individuals of similar age, sex, circumstances and medical condition in the locality concerned.

In determining the Reasonable Charge for a service or supply that is:

- unusual; or
- not often provided in the same area; or
- provided by only a small number of providers in the area.

Factors such as the following may be taken into account:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a Facility; and
- the prevailing charge in other areas.

### **Skilled Nursing Facility**

It is an institution which meets the following tests:

- It is operated under the applicable licensing and other laws.
- It is under the supervision of a Physician, or registered graduate nurse (R.N.), who is devoting full time to supervision.
- It is regularly engaged in providing room and board and continuously provides 24 hour a day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or sickness.
- It maintains a daily medical record of each patient who is under the care of a Physician.
- It is authorized to administer medication to patients on the order of a Physician.
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

### **Student**

The term "Student" as used herein is limited to the Employee's unmarried children 19 years of age but under 25 years of age, who have their legal residence with the Employee, and who are wholly dependent upon the Employee for maintenance and support and who are registered students in regular, full-time attendance at an accredited secondary school, college or university or institution for the training of nurses.

### **Transplant Facility**

A Hospital that UnitedHealthcare specifically designates as a transplant facility. A Transplant Facility has entered into an agreement with UnitedHealthcare to render Covered Health Services for the treatment of specified diseases or conditions. A Transplant Facility may or may not be located within your geographic area. The fact that a Hospital is a network hospital does not mean that it is a Transplant Facility.

**Treatment Center**

An institution which does not qualify as a Hospital but which does provide a program of effective medical and therapeutic treatment for alcoholism and/or chemical dependency and meets all the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a Physician and UnitedHealthcare.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and board
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

**Urgent Care Center**

A facility that provides Covered Health Services that are required to prevent serious deterioration of one's health, and that are required as a result of an unforeseen sickness, injury, or the onset of acute or severe symptoms.

# XII

## CLAIM INFORMATION

### HOW TO FILE A CLAIM FOR BENEFITS

#### PLANS A, B AND C

In order for UnitedHealthcare to process your medical claims as fast as possible, the following steps should be taken when you incur medical expenses:

- Send your medical bills to UnitedHealthcare, P.O. Box 30985, Salt Lake City, UT 84130.
- Generally, medical bills will include information such as employee name, employee address and name of patient which are needed to process your claims. In addition to these items of information, it is very important that the employee's **social security number, policy number "GA-23111"** and **nature of illness or injury** appear on each submission of bills to avoid any unnecessary delay in the payment of your claim.

Upon receipt of your claim, UnitedHealthcare will immediately furnish any additional form required in accordance with the kind of claim presented. In most cases, additional forms will not be required.

#### PLAN F

Claims under Plan F are paid in UnitedHealthcare's office at P.O. Box 30304, Salt Lake City, UT 84130. For expenses not covered under Medicare, send itemized bills to Salt Lake City. Be sure to include the Employee's social security number and the policy number (GA-23111).

To submit claims for expenses also covered under Medicare, the provider of services must first file a claim with Medicare. The Medicare contractor will then send an Explanation of Medicare Benefits (EOMB).

If your Medicare claim is paid in any Medicare office where UnitedHealthcare has arranged for an automatic transfer of Medicare claim information, you will not have to file a separate claim to receive Plan F benefits. Instead, after Medicare processing has been completed, these claims will automatically be filed under Plan F.

If your Medicare claim is not paid in any Medicare office where UnitedHealthCare has arranged for an automatic transfer of Medicare claim information, you will have to file a separate claim with UnitedHealthcare to receive Plan F benefits. To do so, send a copy of the Explanation of Medicare Benefits (EOMB) you receive to UnitedHealthcare's Salt Lake City office. Be sure to include the Employee's name, social security number and policy number (GA-23111) on the EOMB.

You can always know whether your Medicare claim has been automatically transferred to Plan F, or whether you have to file a separate claim to receive Plan F benefits, by looking at your EOMB. Your EOMB will have a message telling you that your claim was forwarded. The message may not specifically tell you that your claim was transferred to UnitedHealthcare, but it will make some reference that it was sent to another carrier. If you do not receive this message on your EOMB, you will have to file a separate claim to receive Plan F benefits.

#### PLAN E

Benefits will be paid under Plan E automatically with no additional action required on your part. Follow the instructions in your GA-46000 booklet for submission of claims.

## **PROOF OF LOSS**

UnitedHealthcare may:

- require bills for Hospital confinement and other services as part of the proof of claim.
- examine you or your Dependent in connection with the claim.

You should submit a request for payment of Eligible Expenses within 90 days after the date of service. If you do not provide this information to UnitedHealthcare within one (1) year of the date of service, Eligible Expenses for that Covered Health Service will be denied or reduced, at the company's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient stay at a Facility, the date of service is the date your inpatient stay ends.

If your state of residence requires that you have more time to furnish proof, you will have the time allowed by your state.

## **PAYMENT OF CLAIMS**

Employee and Dependents Health Benefits are payable to the Employee.

Employee and Dependents Health Benefits which are assigned will be paid to the assignee. The Employee will receive notice of payment of assigned benefits.

All benefits will be paid upon receipt of proper written proof.

## **ACTIONS**

You may not sue on your claim before 60 days after proof of claim has been furnished to UnitedHealthcare or more than three years from the time proof of claim is required.

If your state of residence requires that you have more time to bring suit, you will have the time allowed by your state.



## **IMPORTANT MESSAGE FOR AMTRAK RETIREES AND CERTAIN OTHER RETIREES COVERED UNDER PLAN E**

Most retired employees covered under Plan E are also covered under The Railroad Employees National Early Retirement Major Medical Expense Benefit. These retirees are **not affected** by this Important Message.

Retirees affected by this Important Message are:

- Amtrak retirees covered under AmPlan Early Retirement Benefits, and
- retirees covered under any other plan which is accepted by UnitedHealthcare as offering benefits equivalent to The Railroad Employees National Early Retirement Major Medical Benefit Plan.

These plans are referred to below as your Primary Plan.

### **PLAN E CLAIM SUBMISSION**

To submit claims under Plan E, follow these two steps:

1. First, file a claim under your Primary Plan.
2. After you receive an Explanation of Benefits (EOB) from your Primary Plan, send an itemized bill with a copy of the EOB to UnitedHealthcare, P.O. Box 30985, Salt Lake City, UT 84130- 0985. Be sure to include the employee's name, social security number, policy number (GA-23111) and nature of the illness or injury with each claim submission.

### **PLAN E CLAIM DETERMINATIONS**

Both the Cooperating Railway Labor Organizations, who are the policyholder under GA-23111, and UnitedHealthcare, desire a consistency in coverage under the Primary Plan and Plan E. Therefore, as long as the covered Employee or Dependent has not exhausted his or her lifetime Maximum Benefit under the Major Medical Benefit of the Primary Plan, any coverage determination as described below, made under the Primary Plan, will also be a coverage determination by UnitedHealthcare under Plan E:

- whether an expense is a Covered Expense;
- whether an Exclusion applies
- the interpretation of all Definitions, including but not limited to:
  - whether a service or supply is a Covered Health Service, and
  - whether a charge is a Reasonable Charge.

If the covered Employee or Dependent exhausts his or her lifetime Maximum Benefit under the Major Medical Benefit of the Primary Plan, all coverage determinations from that point forward will be made by UnitedHealthcare as described in this Certificate. These determinations may not necessarily be consistent with the determinations made by the Primary Plan.

### **COBRA CONTINUATION UNDER THE PRIMARY PLAN**

Any dependent who elects to continue Primary Plan coverage under COBRA may also continue coverage under Plan E, provided you notify UnitedHealthcare within 30 days of the COBRA election. If you elect to continue Plan E, you must also notify UnitedHealthcare when COBRA coverage ends.

**Expenses incurred after Primary COBRA coverage ends for any reason are not Covered Expenses under Plan E. Any Plan E benefits paid for expenses incurred after Primary Plan COBRA coverage ends, due to your failure to notify UnitedHealthcare, are subject to recovery by UnitedHealthcare.**

## **IMPORTANT MESSAGE FOR RETIREES OF MASSACHUSETTS BAY COMMUTER RAIL COVERED UNDER PLAN M**

The Massachusetts Bay Commuter Rail Early Retirement Plan is referred to below as your Primary Plan.

### **PLAN M CLAIM SUBMISSION**

To submit claims under Plan M, follow these two steps:

1. First, file a claim under your Primary Plan.
2. After you receive an Explanation of Benefits (EOB) from your Primary Plan, send an itemized bill with a copy of the EOB to UnitedHealthcare, P.O. Box 30985, Salt Lake City, UT 84130- 0985. Be sure to include the employee's name, social security number, policy number (GA-23111 Plan M) and nature of the illness or injury with each claim submission.

### **COBRA CONTINUATION UNDER THE PRIMARY PLAN**

Any dependent who elects to continue Primary Plan coverage under COBRA may also continue coverage under Plan M, provided you notify UnitedHealthcare within 30 days of the COBRA election. If you elect to continue Plan M, you must also notify UnitedHealthcare when COBRA coverage ends.

Expenses incurred after Primary COBRA coverage ends for any reason are not Covered Expenses under Plan M. Any Plan M benefits paid for expenses incurred after Primary Plan COBRA coverage ends, due to your failure to notify UnitedHealthcare, are subject to recovery by UnitedHealthcare.

## NOTES







Printed in U.S.A.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by UnitedHealthcare Insurance Company, United HealthCare Services, inc. or their affiliates.

105-1085 6/10 Consumer

© 2010 United HealthCare Services, Inc.  
UHCEW483079-000