Full Rate & Supplemental Membership Handbook

Celebrating More Than 130 Years of Excellence

EFFECTIVE JANUARY 1, 2019

INTRODUCTION

CARE Railroad Healthcare was developed from the original charter of the Gulf Colorado Employees Hospital Association in 1891 and the Atchison Railroad Employes' Association organized in 1884. Changes have been made through the years to respond to the needs and wishes of the members and as a result, on July 1, 1996, the Santa Fe Employees Hospital Association and the A. T. & S. F. Employes' Benefit Association merged and formed the Consolidated Associations of Railroad Employees (**CARE**).

Read your **CARE** handbook carefully and keep it where it can be found for reference. **CARE** will furnish additional copies at any time upon request. For your own benefit, we urge you to read your **CARE** handbook so that you will be aware of the benefits provided and the proper procedures to follow if the need should arise.

CONSOLIDATED ASSOCIATIONS OF RAILROAD EMPLOYEES
BOARD OF DIRECTORS

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CONSULTANT TO THE BOARD

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Vijay Mhatre, M.D.

Shelly Cumby
Chief Executive Officer

Debbie McCoy
Corporate Secretary

FOR QUESTIONS YOU MAY HAVE REGARDING BENEFIT COVERAGE, MEMBERSHIP and ELIGIBILITY, CLAIMS INQUIRIES, PROVIDER INFORMATION CALL THE:

CARE Office
Temple, Texas

Local Number
254.773.1330

Toll-Free Number
1.800.334.1330

Claims Fax Number
254.774.7652

TTY / TDD users call 711 for all states

Si necesita asistencia en Español, por favor llame al 254.773.1330, llamadas gratis llame al 1.800.334.1330

CARE Web Site . . . . www.carehealthplan.com

OTHER IMPORTANT TELEPHONE NUMBERS

Aetna Dental 1.877.277.3368

Precertification and Utilization Review 1.800.258.5055

Railroad Retirement Board - Main Number 1.877.772.5772

Railroad Retirement Board-Help Line 1.800.808.0772

United Healthcare 1.800.842.5252

Vision Service Plan 1.888.877.4782

If you would like a representative from CARE to speak to your union or retiree group, contact the CARE Administration Office at 1.800.334.1330.

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SUMMARY PLAN DESCRIPTION

Plan Name: Consolidated Associations of Railroad Employees (**CARE**) formerly the Santa Fe Employees Hospital Association and the A.T. & S.F. Employes' Benefit Association

Plan Sponsor: Consolidated Associations of Railroad Employees Health Care Trust Fund
4912 Midway Drive
P.O. Box 6130
Temple, Texas 76503-6130

Employer Identification Number: 75-6493465

Administration of Plan: The Plan is administered by Consolidated Associations of Railroad Employees, 4912 Midway Drive, Temple, Texas 76502 and any obligations created hereunder are performable in Bell County, Texas. **CARE** is NOT an insurance company and benefits provided to the members of this private entity are NOT insurance benefits and are NOT subject to assignment to doctors or hospitals except upon written approval of **CARE**.

Plan Year: January 1 through December 31

Plan Eligibility and Benefits: Generally, all employees and former employees of the Atchison Topeka & Santa Fe Railway Company and Burlington Northern Santa Fe Railway Company and/or individuals and employees of other subsidiary companies are eligible to enroll in **CARE**. Open Enrollments are held at the discretion of the **CARE** Board of Directors.

Membership in **CARE** for dependents is based on the primary or sponsoring member having or having had an employment connection with the Burlington Northern Santa Fe Railway Company.

Eligible Dependents may enroll:

- within 30 days of an Eligible Employee becoming a member of **CARE**;
- within 30 days of getting married;
- within 30 days of a "qualifying event" for the employee; or
- during an Open Enrollment.

Actively working Railway employees must carry membership with **CARE** in order to carry secondary coverage for dependents. Any Employee who discontinues membership will not be entitled to continue membership on any dependent, except as provided under COBRA. Any Retired Employee who discontinues membership with **CARE** will not be entitled to continue membership on any dependent. Membership for dependents of Retired employees may only be continued under one of the following circumstances:

- death of the sponsoring retired employee; or
- divorce or legal separation.

Those members entitled to Medicare coverage will be required to enroll in Medicare Part A and Part B.

Plan Contributions and Funding: The Plan is funded by membership contributions through a monthly dues assessment. It is the member's responsibility to ensure that dues are properly remitted to **CARE**. Members may remit dues monthly or quarterly direct to **CARE**. Bank draft is available for your convenience. Members will be notified in writing of any dues increase in connection with their Plan.

Plan Purpose: The purpose for which this Trust was formed was for the support of a benevolent and charitable undertaking in this: To provide for medical services for the employees and former employees of the Burlington Northern Santa Fe Railway Company, the A. T. & S. F. Railway Company and the Gulf, Colorado and Santa Fe Railway Company, employees of unions that represent Railway employees, individuals, or employees of other companies which the Board of Directors may from time to time decide to admit to said **CARE** Health Plan. Such service and care will be furnished in accordance with such rules and regulations as may from time to time be approved by the Board of Directors, provided, that at all times **CARE** shall conduct itself strictly as a nonprofit, charitable and benevolent organization and in compliance with all applicable provisions of Section 501(c) 9 of the Internal Revenue Act of 1954, as same may be amended, or the comparable section of any future Revenue Act.

The benefits provided by **CARE** are payable to the member or in the event of the member's death before payment, to the member's estate. The benefits are not subject to the liens of, or assignment to, any physician or healthcare providers except upon **CARE**'s written agreement.

All benefits are subject to the definition, limitations, and exclusions in this brochure and are payable when determined by the Plan to be medically necessary. Coverage is provided only for services and supplies which are listed in this brochure. No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan, or be used in the prosecution or defense of a claim under this Plan.

All benefits are based upon reasonable and customary charges. Those charges are compared with charges made by other providers for similar services and supplies under comparable circumstances in the same geographic area and which meet the Plan's established guidelines for that area. The Plan's guidelines have been developed statistically from actual claims received in each zip code area throughout the United States and are updated annually.

No one is authorized to contract any indebtedness against **CARE** in any manner other than as provided in these Rules and Benefits, except upon the written authority of **CARE**.

Summary Material Modification (SMM): An SMM is required anytime there is "material modification" in the terms of the plan or any change in the information required to be in the plan booklet. Material modifications include amendment provisions that establish new benefits, take away existing benefits, narrowing or expansion of the circumstances under which benefits are paid and should the plan terminate entirely. In addition, an SMM must be provided on a more accelerated basis for any "material reduction" in covered services or benefits provided under the plan. Should benefits be amended, reduced or eliminated, a summary of any provisions governing the benefits, rights and obligations of participants under the plan upon termination or amendment of the plan will be provided to participants.

Membership: Membership in **CARE**, as defined within this Plan, does not confer any voting right upon any person referred to as a "Member." **CARE** Bylaws confer the right to vote upon all **CARE** business on the Board of Directors. A copy of the current Bylaws is available to members upon written request to the Chief Executive Officer.

SUPPLEMENTAL PLANS FOR ACTIVE & EARLY RETIREMENT EMPLOYEES

It is the member's responsibility to ensure that dues are properly remitted to **CARE**. Members may remit dues monthly or quarterly direct to **CARE**. Payroll deduction and bank draft is available for your convenience.

PLAN DESCRIPTIONS

The following plans are for supplemental coverage only, you should follow the guidelines of your primary health carrier regarding eligibility, benefits, limitations, exclusions and other details of your Primary carrier.

Plan #3000 - Actively working Railway employees and their dependents whose primary coverage is through one of the Comprehensive Health Care Benefit (CHCB) or Managed Medical Care Programs listed are eligible to enroll in this supplemental plan: Aetna US Healthcare, Highmark Blue Cross/Blue Shield, United Healthcare GA23000, United Healthcare 0690100 or other Railroad-sponsored plans are eligible to enroll in this supplemental plan.

Plan #3000 - Retired employees and their dependents who have United Healthcare GA23111-E, United Healthcare GA107300 with Medicare Primary or any other Railroad-sponsored retiree plan are eligible to enroll in this supplemental plan.

Plan #3100 - Actively working Railway employees and their dependents whose primary coverage is through one of the following Managed Care Medical Programs (MMCP) plans listed are eligible to enroll in this supplemental plan: Aetna US Healthcare, Highmark Blue Cross/Blue Shield, United Healthcare GA23000, United Healthcare 0690100 or any other Railroad-sponsored plan.

Plan #5000 - Supplemental to United Healthcare GA46000 (Early Retirement 60/30) - Employees must contact United Healthcare to enroll for health coverage under GA46000. As information, both retired employees and dependents are eligible for this plan, however, we must have the retired employee as a member in order for the spouse to join.

Eligible Retiring Employees: To qualify for coverage under the Early Retirement 60/30 Plan, the eligible retiring union employee must retire at age 60 or over, (but not yet 65), with thirty or more years of service. Eligible retiring employees should follow the guidelines set by the plan administered by United Healthcare GA46000 prior to applying for membership in **CARE**. Retiring employees are eligible for benefits under this Plan only until the age of 65. At that time, retiring employees may transfer coverage to a Medicare supplemental plan with **CARE**. If you qualify for coverage under the Early Retirement 60/30 Plan, you should contact the **CARE** office for an application.
Eligible Dependents: Eligible dependents of early retirees are eligible for coverage under this Plan. In order for dependents to qualify for United Healthcare GA46000, the retiring employee must apply for his/her annuity within 30 days after leaving railway company employment.

Dependents enrolled in the Early Retirement 60/30 Plan are eligible for benefits under that plan ONLY until the eligible retiree reaches, or in the case of a widow(er), would have reached 65 years of age, or until the spouse becomes 65 years of age, whichever comes first. Dependents of eligible retirees who carry supplemental coverage under this plan and who are not yet eligible for Medicare, may apply for membership in Plan #5100 when the eligible retiree reaches, or in the case of a widow(er), would have reached 65 years of age. See Classification of Membership for Plan #5100 for additional information.

PLAN OUTLINES

PLAN #3000 - SUPPLEMENTAL COVERAGE TO ONE OF THE FOLLOWING COMPREHENSIVE HEALTH CARE BENEFIT (CHCB) PLANS Aetna US Healthcare, Highmark Blue Cross / Blue Shield, United Healthcare GA23000, United Healthcare 0690100 or any other Railroad-Sponsored plan.

Plan #3000 will reimburse you for up to $200 of your deductible in full for covered services, with the remainder of the deductible (if applicable) being reimbursed at 20%. **CARE** will reimburse you for the difference between the ***Amount Allowed**** and the Amount Paid by your primary carrier, not to exceed 20%. For members covered under a Managed Care Plan, **CARE** will reimburse you for any copayments charged by the Primary carrier. Should you receive medical services from an Out-of-Network provider through your Primary plan, **CARE** will reimburse you for the difference between the Amount Allowed and the Amount Paid by your Primary carrier, not to exceed 20%. The annual limit for this plan is $2,200 (including the deductible).

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PLAN #3000 - SUPPLEMENTAL TO UNITED HEALTHCARE GA23111-E (EARLY RETIREMENT 60/30)

This plan will reimburse you for up to $200.00 of your deductible in full for covered services, with the remainder of the deductible (if applicable) being reimbursed at 20%. **CARE** will reimburse you for up to 30% of the ***Amount Allowed**** by the GA23111-E plan. The annual limit for this plan is $2,200 (including the deductible).

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PLAN #3000 - SUPPLEMENTAL COVERAGE TO UNITED HEALTHCARE GA107300 WITH MEDICARE PRIMARY

This plan will also coordinate payment with United Healthcare GA107300 and Medicare. Between Medicare, United Healthcare GA107300 and **CARE**, the total payment of ALL charges will always be equal to Medicare's approved amount on billed charges. The annual limit for this plan is $2,200.

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PLAN #3100 - SUPPLEMENTAL COVERAGE TO ONE OF THE FOLLOWING MANAGED CARE MEDICAL PROGRAM (MMCP) PLANS Aetna US Healthcare, Highmark Blue Cross Blue Shield, United Healthcare GA23000, United Healthcare 0690100 or any other Railroad-sponsored plan.

Plan #3100 will reimburse up to $200 (individual); $400 (family) of the deductible in full for covered services. **CARE** will reimburse you for the difference between the ***Amount Allowed**** and the Amount Paid by your primary carrier, NOT TO EXCEED 20% and will reimburse you for any copayments charged by the Primary carrier. In addition, **CARE** will also reimburse up to $1,000 (individual); $2,000 (family) of the annual out-of-pocket maximum on allowed charges that are covered by the primary plan. The annual limit for this plan is $1,200 for individual and $2,400 for family (including the deductible).

** For the plans above, the **Amount Allowed** must have been considered for payment by the Primary carrier in order for* **CARE** *to consider for supplemental payment. For Precertification and Utilization Review, members in this Plan MUST follow the criteria established by the Primary Carrier.*

PLAN #5000 - SUPPLEMENTAL TO UNITED HEALTHCARE GA46000 (EARLY RETIREMENT 60/30)

This supplement will reimburse you for up to $100.00 of your deductible in full for covered services with the remainder of the deductible (if applicable) being reimbursed at 20%. This plan will reimburse the member for the difference between the ***Amount Allowed**** and the Amount Paid by the Primary carrier until the Lifetime Maximum under United Healthcare GA46000 has been reached.

** The **Amount Allowed** must have been considered for payment by the Primary carrier in order for* **CARE** *to consider for supplemental payment. For Precertification and Utilization Review, members in the Plan MUST follow the criteria established by United Healthcare GA46000.*

(*If you meet the Lifetime Maximum under United Healthcare GA46000, your coverage would then transfer to Plan #5500. For specific benefit information, refer to the Plan Outline for Plan #5500, page 6*).

HOW TO FILE CLAIMS

Where to Submit Claims: **CARE**, P. O. Box 6130, Temple, Texas 76503-6130

Plan #3000 or Plan #3100 Claim: Claims for this plan should first be filed with your Primary carrier for payment. Once your Primary carrier has issued payment, send a copy of the Explanation of Benefits from your Primary carrier to **CARE** for reimbursement. We MUST receive the member's copy of the Explanation of Benefits as this provides information regarding deductible and out-of-pocket amounts. We CANNOT process from the Provider's Explanation of Benefits.

GA23111-E Claim (Plan #3000): Claims for this plan should be filed first with United Healthcare under both GA46000 and GA23111-E plans for payment. Once both plans have issued payment, send a copy of the GA23111-E Explanation of Benefits to **CARE** for reimbursement. We MUST receive the member's copy of the Explanation of Benefits as this provides information regarding deductible and out-of-pocket amounts. We CANNOT process from the Provider's copy of Explanation of Benefits.

United Healthcare GA107300 / Medicare Claim (Plan #3000): Claims for this plan should first be filed to Medicare and then United Healthcare GA107300 for payment. Once Medicare and United Healthcare have issued payment send a copy of the Explanation of Benefits from both Medicare and the GA107300 plan to **CARE** for reimbursement.

Claims Filing Deadline for Plan #3000 and Plan #3100: Claims must be submitted as soon as possible and received by **CARE** NO LATER than one (1) year from the date your Primary and/or Secondary Carrier processed the claim. Incomplete information or an incorrect mailing address WILL result in the delay of payment.

GA46000 Claim (Plan #5000): Claims for this plan should be filed with United Healthcare GA46000 for payment. Once the United Healthcare GA46000 plan has issued payment, send a copy of the Explanation of Benefits to **CARE** for reimbursement. We MUST receive the member's copy of the Explanation of Benefits as this provides information regarding deductible amounts and lifetime maximums. We **CANNOT** process from the Provider's Explanation of Benefits.

For the above plans, always keep a copy of the bill and the explanation of benefits from your Primary Carrier for your records. Benefits paid under this plan are paid directly to the member regardless of any other insurance you may have.

Claims Filing Deadline for Plan #5000: Claims must be submitted as soon as possible and received by **CARE** NO LATER than one (1) year from the date your Primary Carrier processed the claim.

A claim is considered to have been received when the claim is delivered to the **CARE** office and complies with the requirements for all claims. Incomplete information or an incorrect mailing address WILL result in the delay of payment.

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PLAN #5500 - COVERAGE AFTER LIFETIME MAXIMUM BENEFITS UNDER UNITED HEALTHCARE GA46000 EXHAUSTED
Eligible Retiring Employees & Eligible Dependents

It is the member's responsibility to ensure that dues are properly remitted to **CARE**. Members may remit dues monthly or quarterly direct to **CARE**. Bank draft is available for your convenience.

PLAN DESCRIPTION

To qualify for coverage under this plan, eligible retiring employees or eligible dependents must have exhausted their lifetime maximum benefits through United Healthcare GA46000. All requirements for membership will have already been met when completing application for Plan #5000. Once enrolled in Plan #5500, **CARE** becomes your Primary coverage.

PLAN OUTLINE

Office Visit or Consultation Copayment	Emergency Room Visit Copayment	Calendar Year Deductible Out-of-Network Physicians, Clinics and Hospitals
$ 15.00	$ 50.00	$100.00
This Plan does NOT have an Annual Maximum, however, it does have a $200,000 Lifetime Maximum that has been accumulating since your coverage began in Plan #5000.		
Note: Plan #5500 does NOT have a prescription drug benefit.		

Physicians, Clinics and Hospitals: A detailed listing of In-Network Physicians, Clinics and Hospitals may be obtained by contacting **CARE**'s Provider Relations Department. To receive the maximum benefit from your Plan, a network of physicians, clinics and hospitals is maintained for your use.

Services Provided by In-Network Physicians, Clinics and Hospitals: In-Network claims will be paid by the Plan at 100% for covered services AFTER the applicable copayment has been met. It is the In-Network Provider's responsibility to file claims to **CARE** for reimbursement FOR ALL COVERED SERVICES.

Services Provided by Out-of-Network Physicians, Clinics and Hospitals: Out-of-Network claims will be paid by the Plan at 75% for covered services AFTER the applicable copayment and deductible have been met. It is often the member's responsibility to file claims to **CARE** for reimbursement FOR ALL COVERED SERVICES rendered by an Out-of-Network Physician, Clinic, or Hospital.

Maximum Out-of-Pocket Expense: An **Out-of-Pocket Expense** is a covered expense DISALLOWED by **CARE** for payment. To avoid out-of-pocket expenses, members should call or write before incurring any medical claims if uncertain of plan benefits. Charges that apply to the maximum out-of-pocket expense are the 25% cost sharing reduction in payments required when using Out-of-Network providers. After the 25% disallowed Covered Expenses reach $2,000 in a calendar year, the Plan will cover 100% of Reasonable and Customary charges for covered services for the balance of the year subject to annual and lifetime limits. The following DO NOT APPLY to the $2,000 Out-of-Pocket Expense:

- Charges greater than the $200,000 Lifetime Maximum
- Non-Covered Charges
- The Calendar Year Deductible
- The Copayment amount for each Office Visit or Consultation
- The Copayment for Emergency Room Visits
- Lifetime Limited Benefits
- Benefit Reductions due to failure to comply with Precertification
- Reasonable & Customary cutbacks

HOW TO FILE CLAIMS

Where to Submit Claims: CARE, P. O. Box 6130, Temple, Texas 76503-6130

To ensure proper claims payment, present your membership identification card (if applicable to your plan) to your provider at the time of service. If the provider has any questions, they can call our toll-free number 1.800.334.1330 for billing assistance.

How to File a Claim: We must receive the United Healthcare GA46000 explanation of benefits indicating the lifetime maximum has been exhausted and benefits have been denied. All claims must be in writing, should be itemized and include the following information:

- Patient's full name, social security number and/or **CARE** identification number
- ICD-10 codes (diagnosis codes)
- CPT-4 codes (procedure codes)
- Date(s) of service
- Name, address, and tax identification number of physician or institution providing services and National Provider Identifier (NPI) number

Claims Filing Deadline: Claims must be submitted as soon as possible and received by **CARE** NO LATER than one (1) year from the date the expense was incurred. It is your responsibility to ensure that claims are filed before this deadline. A claim is considered to have been received when the claim is delivered to the **CARE** office and complies with the requirements for all claims. Incomplete information or an incorrect mailing address WILL result in the delay of payment.

QUICK REFERENCE BENEFITS SUMMARY FOR PLAN #5500

This is a summary only, please refer to the Schedule of Benefits beginning on Page 11 for detail of benefits.

BENEFIT	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE	PREAUTHORIZATION AND/OR PRECERTIFICATION REQUIRED
Ambulance Transport	100%	100% after deductible	
Annual Out-of-Pocket	None	$2,000	
Artificial Limb	100%	75% up to $1,000 after deductible	
Chiropractic ▸ *Outpatient*	100% up to $400 in a calendar year after copay	75% up to $400 in a calendar year after copay & deductible	
Copayments ▸ *Office Visit or Consultation* ▸ *Emergency Room*	$ 15.00 $ 50.00		
Deductible	None	$ 100.00 Calendar Year Deductible	
Diabetic Supplies	80% of reasonable & customary charges		Preauthorization only
Dialysis ▸ *Outpatient*	100% after copay	75% after copay & deductible	
Emergency Room Care	100% after copay	75% after copay & deductible	
Gastric Stapling	100% after copay	75% after copay & deductible	Yes - Both required See Schedule of Benefits Page 13
Home Health Services	100%	75% after deductible	Preauthorization only

BENEFIT	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE	PREAUTHORIZATION AND/OR PRECERTIFICATION REQUIRED
Hospice	100% up to $6,000	100% up to $6,000 after deductible	Preauthorization only
Hospital Admissions	100%	75% after deductible	Precertification only
Lifetime Maximum	$200,000		
Mental Health	100% after copay	75% after copay & deductible	Preauthorization only
Orthopedic Braces	100%	75% up to $300 after deductible	Preauthorization only
Physical Therapy ▸ ***Outpatient***	100% after copay	75% after copay & deductible	
Physician Charges ▸ *Inpatient*	100%	75% after deductible	Precertification only
▸ *Outpatient* *(Eye Exams Included)*	100% after copay	75% after copay & deductible	Yes certain procedures require both
Day Surgery ▸ *Outpatient*	100% after copay	75% after copay & deductible	See Procedures List Page 25
Podiatry ▸ *Outpatient*	100% after copay	75% after copay & deductible	

PLAN #5500 LIFETIME LIMITED BENEFITS

This is a summary only, please refer to the Schedule of Benefits beginning on Page 11 for detail of benefits.

BENEFIT	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE	PREAUTHORIZATION AND/OR PRECERTIFICATION REQUIRED
Attempted Suicide/ Self-Inflicted Injury *The maximum reimbursement by the Plan is $5,000 in a Lifetime.*	80% after copay	80% after copay & deductible	
Cardiac / Pulmonary Rehabilitation ▸ *Outpatient Treatment is limited to one 4-week program in a Lifetime.*	80% after copay	80% after copay & deductible	Precertification only
Sleep Disorders ▸ *Outpatient Only* *The maximum reimbursement by the Plan is $1,500 in a Lifetime for Physician fees and testing.*	80% of the reasonable charge for covered services after copay	80% of the reasonable charge for covered services after copay & deductible	Preauthorization only
Speech Rehabilitation ▸ *Outpatient* *The maximum reimbursement by the Plan is $2,000 in a Lifetime.*	80% of the Physician's reasonable charge for covered services after copay	80% of the Physician's reasonable charge for covered services after copay & deductible	Preauthorization only
Transplant Services	See Schedule of Benefits - Page 17		

PLAN #5500 SCHEDULE OF BENEFITS

AMBULANCE SERVICE: The medical necessity for ALL ambulance service must be documented by the attending physician before benefits can be paid. Therefore, a copy of the transport papers or any pertinent medical documentation must accompany all claims submitted on the members' behalf. The Plan will cover reasonable & customary charges for appropriate and medically necessary-covered charges.

In-Network or Out-of-Network: 100% (after applicable deductible) for charges for the medically necessary ambulance transportation TO THE NEAREST FACILITY that can adequately provide such care.

ARTIFICIAL LIMB BENEFIT: A licensed physician must prescribe the artificial limb. The Plan will cover reasonable and customary charges for appropriate and medically necessary-covered services.

In-Network: 100% after applicable copayment
Out-of-Network: 75% after applicable copayment and/or deductible up to $1,000 in a calendar year

ATTEMPTED SUICIDE / SELF-INFLICTED INJURY - LIFETIME LIMITED BENEFIT: The Plan will reimburse 80% up to $5,000 in a lifetime for reasonable and customary charges for covered medical services for injuries which when viewed by a reasonable person appear to have been self-inflicted. The maximum reimbursement by the Plan is $5,000 in a lifetime for physician fees, facility charges and ancillary charges in connection to this event regardless if the services are provided In-Network or Out-of-Network.

If hospitalization or a 23-Hour (or over) observation is required as the result of a self-inflicted event, precertification is MANDATORY within 24 hours of the event.

CARDIAC / PULMONARY REHABILITATION - LIFETIME LIMITED BENEFIT: The Plan will cover reasonable and customary charges for one 4-week program in a lifetime after dismissal from the hospital for treatment of heart disease.

Precertification Required: Contact Spectrum Review Services, Inc. at 1.800.258.5055

In-Network or Out-of-Network: 80% after applicable copayment and/or deductible

CHIROPRACTIC (Outpatient): The Plan will cover reasonable and customary charges for appropriate and medically necessary-covered services up to $400 in a calendar year.

In-Network: 100% after applicable copayment up to $400 in a calendar year
Out-of-Network: 75% after applicable copayment and/or deductible up to $400 in a calendar year

DIABETIC SUPPLIES: Benefits are limited to Test Strips, Needles, Syringes and/or Lancets. Glucometers are NOT covered under this benefit. Most manufacturers offer rebates directly to the consumer on glucometers that make their cost very reasonable.

Preauthorization Required: Contact CARE Customer Service at 1.800.334.1330
Members must contact **CARE** to establish whether they have a diagnosis of Type I or Type II diabetes and currently using insulin or taking an oral Hypoglycemia medication. For specific details contact the **CARE** Customer Service Department at 1.800.334.1330. Failure to contact **CARE** will result in no payment being made by **CARE** for the supplies listed above.

DIALYSIS (Outpatient): This benefit is limited to eighteen (18) months during which time it will be the member's responsibility to enroll for Medicare (both Parts A & B) benefits for catastrophic illness. The Medicare program will then assume responsibility for a portion of the charges for the dialysis treatments.

Once the member qualifies for Medicare, **CARE** will supplement Medicare's payment for reasonable and customary charges for appropriate and medically necessary-covered charges. You must be enrolled in one of **CARE**'s Medicare Supplemental Plans in this instance. **PRIOR TO MEDICARE BECOMING PRIMARY**

In-Network: 100% after applicable copayment
Out-of-Network: 75% after applicable copayment and/or deductible

DURABLE MEDICAL EQUIPMENT - LIFETIME LIMITED BENEFIT: **CARE** will pay 80% of reasonable charges for a 3-month rental period of Durable Medical Equipment and initial supplies required to get the equipment operating up to $5,000 in a calendar year; and $10,000 in a lifetime. **CARE** will assist in setting up a contract with the supplier of the Durable Medical Equipment in the beginning of the rental period at which time the member has the option of purchasing the equipment. This Lifetime Limited Benefit DOES NOT apply to the $2,000 Maximum Out-of-Pocket Expense. **CARE** will work with the equipment supplier to get the best rental price for our member in every case. **CARE** has a contract with several nationwide Durable Medical Equipment companies to assist in getting the best price.

Preauthorization Required: The member and/or provider MUST contact the **CARE** Customer Service Department for Pre-Authorization. If Pre-Authorization is NOT obtained PRIOR to the rental of the Durable Medical Equipment, no benefits will be extended. Contact the **CARE** Customer Service Department at 1.800.334.1330.

Purchase Only Items: If a certain type of Durable Medical Equipment is a "Purchase Only" piece of equipment, the member's medical condition must warrant that the equipment is required for the member's lifetime. **CARE** would require a letter of medical necessity from the attending physician ordering the Durable Medical Equipment in this case. The letter of medical necessity would be reviewed by **CARE** to support medical necessity for the lifetime usage. In these few cases, **CARE** will pay 80% toward the initial purchase price for the Durable Medical Equipment and initial supplies to get the equipment operating up to $2,500 in a calendar year. The $2,500 will apply toward the Durable Medical Equipment $10,000 Lifetime Limit. This Lifetime Limited Benefit DOES NOT apply to the $2,000 Maximum Out-of-Pocket Expense.

Future supplies required to operate or maintain the Durable Medical Equipment and all maintenance contracts will be the member's responsibility to pay out of his/her pocket. This applies regardless if the equipment is rented or purchased by the member.

Covered Supplies which would fall under this benefit to be paid at 80% up to $5,000 in a calendar year; and $10,000 in a lifetime are the following: Colostomy or ileostomy bags; catheters. (These supplies may be purchased only and therefore will qualify for payment under this benefit).

A written prescription from the member's physician is required to include medical documentation to support medical necessity and must include:

- diagnosis;
- description and type of equipment needed;
- estimated length of time the equipment is needed.

<u>Covered Durable Medical Rental Equipment</u>
SUPPORT DEVICE: Wheelchairs

EQUIPMENT: Hospital beds, oxygen and equipment for administering oxygen (portable oxygen equipment is limited to the dependency of the oxygen use); nebulizers; C-PAP machines, TENS units, BI-PAP machines, Continuous Passive Motion machines (CPM).

<u>Durable Medical Equipment That is Not Covered</u>
- cost of repair and maintenance of Durable Medical Equipment
- biofeedback
- personal appliances such as glasses, sunglasses, lenses (except for implants), hearing aids, batteries, blood pressure monitors
- arch supports, lifts, inserts, special shoes, wrist splints, durable support hose, hernia supports, adhesive tape, antiseptic, first aid supplies, night splints
- crutches, walkers and canes
- the rental or purchase of appliances such as air conditioners, humidifiers, environmental control equipment, waterbeds, hot tubs, whirlpool tubs, shower stools, hand rails, exercise equipment for home use or portable commodes
- adult diapers, special pillows, mattresses, or items requested for personal comfort.

<u>GASTRIC STAPLING:</u> To qualify for benefits for Gastric Stapling, a patient must satisfy the usual criteria for surgical treatment of morbid obesity and have a documented failure of dietary control under adequate medical supervision for at least eighteen (18) months at one institution. Usual surgical criteria requires that patients are at least 100 pounds or 100% over body weight and have no significant psychiatric factors present in their medical history.

Adequate medical supervision will require at least six clinic visits in which dietary supervision is documented on the medical record by a Dietician, Internist, or Family Practice Physician during the twenty-four (24) months prior to the anticipated surgical procedure. This information must be submitted PRIOR to the anticipated surgical procedure to the **CARE** Medical Director for approval.

If the Medical Director disapproves the request, then **CARE** would not provide benefits. If approved, **CARE** would extend benefits with regard to Gastric Stapling under the appropriate Inpatient or Outpatient benefit. The Plan will cover reasonable and customary charges for appropriate and medically necessary-covered services.

Precertification Required: Contact Spectrum Review Services, Inc. at 1.800.258.5055
Preauthorization Required: Contact CARE Customer Service at 1.800.334.1330

In-Network: 100% after applicable copayment
Out-of-Network: 75% after applicable copayment and/or deductible

<u>HOME HEALTH SERVICES:</u> Home Health Care and Treatment are plans of continued care and treatment of an insured person who is under the care of a doctor, and whose doctor certifies that without the Home Health Care, confinement in a hospital or skilled nursing facility would be required. Your home health care treatment must be prearranged by **CARE** and your doctor. The Plan will cover reasonable and customary charges for appropriate and medically necessary-covered services.

Preauthorization Required: Contact CARE Customer Service at 1.800.334.1330
If authorization is NOT obtained, members must provide medical documentation from their attending physician supporting the medical necessity of the home care services.

In-Network: 100% after applicable copayment
Out-of-Network: 75% after applicable copayment and/or deductible

HOSPICE BENEFIT: To qualify for a Hospice Program, the physician must certify that the patient has a life expectancy of six (6) months or less. Benefits will be paid up to a maximum payment of $6,000 for either Inpatient or Outpatient care and treatment charged by Hospice. This limit will be inclusive of any type of durable medical equipment required for the patient, supplies needed, pain medication, counseling for the patient and the patient's immediate family and bereavement counseling. "Immediate Family" includes any member of the patient's family living in the same household.

Any counseling services given in connection with a terminal illness will not be considered as Mental Health Treatment. 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.

Preauthorization Required: Contact CARE Customer Service at 1.800.334.1330
If Preauthorization is NOT obtained prior to services being rendered, the expenses will NOT be covered. **CARE** will handle directly with Spectrum Review Services, Inc. to negotiate special rates for the Hospice services being provided.

In-Network or Out-of-Network: 100% up to $6,000 after applicable copayment and/or deductible

HOSPITAL ADMISSIONS (Inpatient): Hospital benefits will be paid only as long as in the opinion of the Utilization Review Committee or other regulatory committee of **CARE**, or if the hospital furnishing the services states the continued treatment is medically necessary. The Plan will cover reasonable and customary charges for appropriate and medically necessary-covered services.

Precertification Required: Contact Spectrum Review Services, Inc. at 1.800.258.5055
Failure to contact Spectrum Review Services, Inc. prior to non-emergency admissions or within 24 hours (the first business day) following an emergency admission, OR prior to a 23-hour (or over) observation will result in your benefits being reduced to 65%. This means that you will be responsible for 35% of ALL covered charges pertaining to that confinement.

In-Network: 100% of covered charges after applicable copayment and/or deductible for semi-private room and intensive care accommodations in a hospital and professional charges required while hospitalized.

Out-of-Network: 75% of covered charges after applicable copayment and/or deductible for semi-private room and intensive care accommodations in a hospital and professional charges required while hospitalized.

If a Private Room is required due to the nature of the illness and is deemed medically necessary and appropriate, **CARE** will require a letter of Medical Necessity from the attending physician in order to be considered for benefits. If a Private Room is at the patient's request, this is not deemed medically necessary and will not be considered for benefits by **CARE**.

MENTAL HEALTH BENEFIT: Benefits are payable for services provided by Psychiatrists, Licensed Psychologists and Licensed Clinical Social Workers (LCSW) only. (Marriage counseling, Group therapy and Family therapy are EXCLUDED). Court ordered treatment is NOT a covered benefit.

Preauthorization Required: Contact CARE Customer Service at 1.800.334.1330
If Preauthorization is NOT obtained prior to services being rendered, the expenses will NOT be covered.

In-Network: 100% after applicable copayment
Out-of-Network: 75% after applicable copayment and/or deductible

ORTHOPEDIC BRACES: Under this benefit, a written prescription from the physician or a letter of medical necessity is required. The Plan will cover reasonable and customary charges for appropriate and medically necessary-covered services.

Preauthorization Required: Contact CARE Customer Service at 1.800.334.1330

In-Network: 100% after applicable copayment
Out-of-Network: 75% after applicable deductible up to $300 in a calendar year.

OUTPATIENT BENEFIT (Day Surgery Procedures Included*): Routine Eye Examinations for glasses or contact lenses will be covered under this benefit according to the In-Network and/or Out-of-Network benefits.

*See list of Outpatient Day Surgery procedures on page 25.

Precertification Required: Contact Spectrum Review Services, Inc. at 1.800.258.5055
Refer to the list of Outpatient Day Surgery Procedures under the Precertification and Utilization Review Section. The Plan will cover reasonable and customary charges for appropriate and medically necessary-covered services. Failure to contact *Spectrum Review Services, Inc.* will result in your benefits being reduced to 65%. This means that you will be responsible for 35% of ALL covered charges pertaining to the scheduled outpatient procedure.

In-Network: 100% after applicable copayment
Out-of-Network: 75% after applicable copayment and/or deductible

PHYSICAL THERAPY (Outpatient): Physical Therapy services must be prescribed by a Licensed Physician and rendered by a Registered Physical Therapist, or a Licensed Physiotherapist. Physical Therapy services performed by a D. O. must comply with the precertification requirements for full benefit coverage. Refer to the *Exclusions* Section (pages 26-27) for physical therapy services which are NOT covered by **CARE**. The Plan will cover reasonable and customary charges for appropriate and medically necessary-covered services.

Covered charges, including but not limited to:
- Therapeutic exercise
- Hot/cold packs
- Electrical stimulation
- Whirlpool
- Ultrasound
- Massage
- Instructions for Home Exercise Program

In-Network: 100% after applicable copayment and/or deductible
Out-of-Network: 75% after applicable copayment and/or deductible

PODIATRY (Outpatient): Services must be provided by a Licensed Podiatrist. The Plan will cover reasonable and customary charges for appropriate and medically necessary-covered services.

In-Network: 100% after applicable copayment
Out-of-Network: 75% after applicable copayment and/or deductible

See list of Day Surgery Procedures on page 25 for foot surgeries that require precertification.

SLEEP DISORDERS (Outpatient) - LIFETIME LIMITED BENEFIT: The Maximum reimbursement by the Plan is $1,500 in a lifetime for Physician Fees and Testing. The Plan will cover reasonable and customary charges for appropriate and medically necessary-covered services.

Preauthorization Required: Contact CARE Customer Service at 1.800.334.1330

In-Network or Out-of-Network: 80% up to $1,500 after applicable copayment and/or deductible

SPEECH REHABILITATION (Outpatient) - LIFETIME LIMITED BENEFIT: The Plan will reimburse 80% of the Physicians reasonable and customary charges for appropriate and medically necessary-covered services by a physician or licensed therapist up to $2,000 in a lifetime.

In-Network or Out-of-Network: 80% after applicable copayment and/or deductible up to $2,000 in a lifetime.

SUBSTANCE ABUSE TREATMENT: Benefits are payable for services provided by Psychiatrists, Licensed Psychologists and Licensed Clinical Social Workers (LSW) only.

- A course of treatment is defined as: beginning on the first day you receive services (as either Inpatient or Outpatient) and continuing until you are not treated for that condition for 60 days.

If a member voluntarily discontinues a course of treatment against medical advice in an Inpatient or Outpatient program before it is completed, the member will NOT be entitled to further treatment in the Inpatient and Outpatient programs at the expense of the Plan.

- Court ordered treatment is NOT covered.
- Coinsurance amounts DO NOT apply to the Maximum Out-of-Pocket Expense.

The Plan will cover reasonable and customary charges for appropriate and medically necessary-covered services.

Preauthorization Required: Contact CARE Customer Service at 1.800.334.1330
Precertification Required: Contact Spectrum Review Services, Inc. at 1.800.258.5055
If Preauthorization and Precertification are NOT obtained prior to services being rendered, the expenses will NOT be covered.

In-Network: 100% after applicable copayment
Out-of-Network: 75% after applicable copayment and/or deductible

TRANSPLANT BENEFIT - LIFETIME LIMITED BENEFIT: Benefits are ONLY available for Preauthorized and Precertified services. Any and all services NOT authorized by **CARE** will be the member's responsibility. Definition of a Designated Transplant Facility: A facility which has entered into an agreement through a national organ transplant network to render covered transplant services, to which the Plan has access. The Designated Transplant facility will be determined by the Plan and may or may not be located within a member's geographic area. For Maximum coverage of Benefits, you are required to use a Designated Transplant Facility.

Preauthorization Required: Contact CARE Customer Service at 1.800.334.1330
Precertification Required: Contact Spectrum Review Services, Inc. at 1.800.258.5055
If Preauthorization and Precertification are NOT obtained prior to services being rendered, the expenses will NOT be covered.

- Services provided at a Designated Transplant Facility will be paid according to the contractual agreement in effect at time of transplant. Copayments will apply.

- Covered expenses in the Designated Transplant Facility include, but are not limited to, hospital charges, physician charges, organ procurement acquisition, tissue typing, donor search fees and ancillary services.

Definition of a Non-Designated Transplant Facility: A facility which has not entered into an agreement through a national network to provide covered transplant services to which the Plan has access.

- Services provided at a Non-Designated Transplant Facility will be paid at 75% up to a maximum of $100,000 of reasonable and customary charges. The Maximum Out-of-Pocket Benefit DOES NOT APPLY.

- The following WILL NOT be covered by **CARE** when services are provided at a non-Designated Transplant Facility:

  - Transportation and accommodation expenses;
  - Organ procurement acquisition;
  - Tissue typing, donor search fees and ancillary services.

Types of Approved Transplants at a Designated Transplant Facility:
Bone Marrow
- Autologous
- Allogeneic-related
- Allogeneic-unrelated
- Heart
- Lung
- Kidney
- Pancreas
- Liver

Exclusions:
- Animal to human transplants;
- Artificial or mechanical devices designed to replace human organs;
- Organ transplants considered experimental, investigational or unproven.

Limitations:

- A member is eligible for coverage under **CARE** for up to two transplants per lifetime or one transplant and one re-transplantation per lifetime. Multiple organ transplants performed at the same time such as liver/kidney are considered to be one transplant.

- If a member has undergone an evaluation and was not considered a transplant candidate, a second evaluation will be paid at 100% if the evaluation determines the member is a transplant candidate; and paid at 75% if the member is determined not to be a candidate. If a third evaluation is obtained and the evaluation determines the member is a transplant candidate, the evaluation will be covered at 100%, but at 0% if the evaluation determines the member is not a candidate for transplant.

Travel Expenses When Transplant is Performed at a Designated Transplant Facility: (Prior Approval is required by contacting **CARE**). When a transplant is performed at a Designated Transplant Facility, the Plan will provide transportation and lodging at 100% up to a maximum of $10,000 for:

- the most economical means of air transportation for the member (and one member of the immediate family when accompanying the patient for transplant services) to and from the Designated Transplant Facility when the distance to the Designated Transplant Facility from the member's home is at least 300 miles, or if less than 300 miles and a personal automobile is the approved mode of transportation, mileage will be paid at **CARE**'s reimbursement rate in effect at the time the trip is made; and

- necessary lodging for patient and one member of the immediate family at or near the Designated Transplant Facility. However, a daily maximum of $100 will apply toward lodging. Patients and companions are encouraged to use lodging facilities in close proximity to the medical treatment centers which are specifically provided for these purposes.

Plan #5100 - Replacement Plan for Dependents Losing Coverage Under the National Health & Welfare Plan (Including Plans GA23000 and/or GA46000)

It is the member's responsibility to ensure that dues are properly remitted to **CARE**. Members may remit dues monthly or quarterly direct to **CARE**. Bank draft is available for your convenience.

PLAN DESCRIPTION

This is a replacement plan for those dependents not wishing to continue GA23000 and/or GA46000 COBRA coverage. This plan has its own Schedule of Benefits and pays benefits at 80%. The lifetime maximum for this plan is $150,000.
All benefits are based upon reasonable and customary charges.

Eligible Dependents:

- Dependents of railway employees who have exhausted benefits under the National Health and Welfare Plan (GA23000) due to disability.
- Dependents of early retirees who retired at 60 and/or 61 years of age with 30 or more years of service who have exhausted their GA46000 COBRA coverage due to the early retiree reaching 65 years of age.

Eligibility Requirements: Eligible dependents of disabled employees may apply for membership in Plan #5100 when the dependent loses coverage under the National Health and Welfare Plan. The disabled employee or disability annuitant would be required to enroll in Plan #3000 as a supplement to his/her GA23000 coverage for the remainder of the time they qualify. Disabled employees or disability annuitants who become eligible for Medicare must be enrolled or enroll in a Medicare supplement plan with **CARE** in order for dependents to qualify for Plan #5100.

Eligible dependents of early retirees may apply for membership in Plan #5100 when the early retiree reaches, or in the case of a widow (er), would have reached 65 years of age. In order for dependents to qualify for this plan, the retiring employee upon reaching 65 years of age, must be enrolled or enroll in a Medicare supplement with **CARE**. *Refer to General Information (page 27) section for definition of eligible dependents.*

PLAN OUTLINE

The benefits are provided for covered services as outlined within the Schedule of Benefits Section of this brochure. All exclusions will comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as same may be amended, or the comparable section of any future Act. See General Information Section for specific details regarding HIPAA.

Deductible	Benefit
$100.00 Calendar Year Deductible	Plan pays benefits at 80%. All benefits are based upon reasonable and customary charges. The lifetime maximum for this plan is $150,000. If precertification is not received for those medical services which require it, a penalty of $300.00 will be assessed per occurrence.
Note: Plan #5100 does NOT have a prescription drug benefit.	

Services Provided by Physicians, Clinics, and Hospitals: In or Out-of-Network services does not apply to this plan. Claims will be paid by the Plan at 80% for covered services AFTER the applicable deductible has been met. All benefits are based upon reasonable and customary charges. It is the Provider's responsibility to file claims to **CARE** for reimbursement FOR ALL COVERED SERVICES.

HOW TO FILE CLAIMS

Where to Submit Claims: **CARE**, P. O. Box 6130, Temple, Texas 76503-6130

How to File a Claim: All claims must be in writing, should be itemized and include the following information:

- Patient's full name, social security number and/or **CARE** identification number
- ICD-10 codes (diagnosis codes)
- CPT-4 codes (procedure codes)
- Date(s) of service
- Name, address, and tax identification number of physician or institution providing services and National Provider Identifier (NPI) number

Claims Filing Deadline: Claims must be submitted as soon as possible and received by **CARE** NO LATER than one (1) year from the date the expense was incurred. It is your responsibility to ensure that claims are filed before this deadline.

A claim is considered to have been received when the claim is delivered to the **CARE** office and complies with the requirements for all claims. Incomplete information or an incorrect mailing address WILL result in the delay of payment.

PLAN #5100 SCHEDULE OF BENEFITS

BENEFIT	PLAN PAYS	PREAUTHORIZATION AND / OR PRECERTIFICATION REQUIRED
Allergy	80% after deductible	
Ambulance Transport ▸ *To the nearest hospital*	80% after deductible	
Anesthesia & Administration	80% after deductible	
Artificial Limbs & Eyes	80% after deductible	
Braces	80% after deductible	
Cardiac/Pulmonary Rehab ▸ *Treatment is limited to one 4-week program in a Lifetime*	80% after deductible	Yes - Both required
Chemotherapy / Radiation	80% after deductible	
Chiropractic	80% $400 in a calendar year after deductible	
Colostomy / Ileostomy Bags	80% after deductible	
Day Surgery ▸ *Outpatient*	80% after deductible	Yes Certain Procedures require both See procedure list - Page 25 *$300 Penalty if Precertification not obtained (refer to page 22)
Deductible	$100 Calendar Year Deductible	
Dental ▸ *Trauma Only* *(see Exclusions - pages 26-27)*	80% after deductible	Yes - Both required
Diagnostic Scanning (MRI, CT, EBI, PET, etc.)	80% after deductible	Yes - Both required

BENEFIT	PLAN PAYS	PREAUTHORIZATION AND / OR PRECERTIFICATION REQUIRED
Diagnostic Testing ▸ Outpatient lab, x-ray, etc.	80% after deductible	
Dialysis	80% after deductible	
Emergency Room Care	80% after deductible	
Eye Exam ▸ *One in a calendar year*	80% after deductible	
Hearing Exam ▸ *One in a calendar year*	80% after deductible	
Hospital Admissions ▸ *In-Patient (semi-private room)*	80% after Deductible	Yes - Both required *$300 Penalty if Precertification not obtained
Licensed Physicians & Nurses Services ▸ *Office visit, hospital visit, surgery, podiatry, etc.*	80% after deductible	
Lifetime Maximum	$150,000	
Mammogram ▸ *One in a calendar year*	80% after deductible	
Physical / Occupational / Speech Therapy	80% after deductible	

Precertification Penalty: * If care or services are received for which Precertification was not attempted, we will conduct a retrospective review to determine the Medical Necessity of such service. If such services are determined to be medically necessary, a per occurrence Precertification Penalty of $300.00 will be assessed. If the services are deemed to NOT be medically necessary, the claim will be returned and denied. Please refer to the Precertification and Utilization Review section on page 25 or those procedures which require precertification and/or preauthorization.

The **CARE** Health Plan provides benefits only for services and supplies that are medically necessary. The Plan reserves the right to determine medical necessity.

EXCLUSIONS FOR PLAN #5100
(WHAT THE PLAN DOES NOT COVER)

- Diabetic Supplies
- Durable Medical Equipment
- Dietary Consultation
- Hearing Aids
- Home Health Care
- Hospice
- Long Term Acute Care Facility
- Maternity / Pregnancy
- Oxygen
- Penile Implant or Penile Erection Device
- Prescription Drugs
- Skilled Nursing Facility
- Sterilization
- Sleep Disorders/Testing
- Substance Abuse/Chemical Dependency
- Temporomandibular Joint Syndrome (TMJ); including treatment and surgery of such
- Transplantation of Organs
- Weight Loss Program
- Any charge which, in the opinion of the **CARE** Health Plan, is NOT proper.
- For any other exclusion listed or so noted.
- Includes all exclusions listed as such under Exclusions (pages 26-27) in the **CARE** Health Plan Book.

PRECERTIFICATION AND UTILIZATION REVIEW
PLAN #5100 & PLAN #5500 ONLY
Provided by Spectrum Review Services, Inc.

Cardiac / Pulmomary Rehabilitation, Hospital Admissions, 23-Hour Observation, Outpatient Day Surgery Procedures, Substance Abuse Treatment and Second Opinions

Spectrum Review Services, Inc. Telephone Numbers: You may contact Spectrum Review Services, Inc. on their toll-free Number at 1.800.258.5055, 24 hours a day, 7 days a week. When contacting Spectrum Review Services, Inc., they will need the following information:

- Member's Benefit Plan Name (Consolidated Associations of Railroad Employees)
- Patient's Name, Date of Birth, and Social Security Number and/or **CARE** Identification Number
- Patient's Telephone Number
- Name of Provider of Medical Services
- Name of Hospital and/or Facility where services will be received
- Proposed Date of Admission and/or Surgery

CARE has a Pre-admission Review Program with Spectrum Review Services, Inc. which performs pre-admission, concurrent and retrospective review of cardiac/pulmonary rehabilitation, hospital confinements, 23-hour observation precertification, substance abuse treatment precertification, and outpatient procedure precertification. In addition, Spectrum Review Services, Inc. provides Case Management services.

Additional Information: The Precertification and Utilization Review Program was established to assist you in making informed decisions about your medical care. As long as you contact Spectrum Review Services, Inc. prior to hospitalization or other designated procedures, you will receive full benefits as described in the **CARE** Full Rate & Supplemental Membership handbook for your Plan as certified by Spectrum Review Services, Inc. The final decision about treatment is always left up to you and your doctor, however, all benefits will be paid according to the general rules and benefits of **CARE**.

The overall goals of Case Management are to coordinate health and community resources so that our seriously ill members receive the most appropriate care in a timely, cost effective manner. The goal is to work with all parties involved in the delivery of health care to promote an appropriate, cost-effective plan of treatment. The case manager's role is as facilitator for all parties involved in attaining these goals. Case Managers negotiate with providers of service on behalf of you, our member, to assist in keeping the costs down.

When appropriate, **CARE**'s Utilization Review Coordinator may consult with you, your family and doctor, in circumstances where you may require prolonged or alternative treatment, to fashion a treatment plan that addresses your medical care needs at a reasonable cost. The Utilization Review Coordinators may request or recommend in writing that in such situations the Plan Administrator approve benefits in excess of otherwise applicable benefit limitations contained in the Plan, or that the Plan pay benefits for certain expenses that would otherwise be excluded under the terms of the Plan. The Plan Administrator may approve the request in such a situation where he determines that such approval is in the best interest of the Plan. The decision whether to approve benefits in excess of otherwise applicable benefit limitations, or to approve otherwise excluded expenses, in the circumstances described above is discretionary in each case, and is binding on all Members and their beneficiaries. No such decision, or decisions, will operate as precedent with respect to any other case, nor will it operate as a defacto amendment of **CARE**.

Precertification is Mandatory for Both In-Network and Out-of-Network Provider Utilization for Plan #5500 & Plan #5100 for the following services:

Plan #5500 - Failure to contact Spectrum Review Services, Inc. prior to non-emergency admissions for ANY of the services as listed will result in your benefits being reduced to 65%. Benefit reductions due to failure to comply with Precertification WILL NOT BE applied to the Maximum Out-of-Pocket Expense and WILL NOT apply to the Calendar Year Deductible.

Plan #5100 - Failure to contact Spectrum Review Services, Inc. prior to non-emergency admissions for ANY of the services in Plan #5100 will result in a per occurrence Precertification Penalty of $300.00. If the services are deemed to NOT be medically necessary, the claim will be returned and denied. Refer to the Schedule of Benefits for Plan #5100 on pages 21-22.

Cardiac / Pulmonary Rehabilitation: Precertification is MANDATORY to qualify for Cardiac/Pulmonary Rehabilitation Treatment.

Hospital Admissions: Pre-admission review is MANDATORY for ALL Hospital Admissions. You may contact Spectrum Review Services, Inc. , 7 days a week, 24 hours a day, on their toll-free number 1.800.258.5055. IF you DID notify Spectrum Review Services, Inc., but received services beyond those certified by Spectrum Review Services, Inc., the charges on the Non-Certified days will be your responsibility to pay. You MUST contact Spectrum Review Services, Inc. prior to any non-emergency admission. If there is an emergency, you should contact Spectrum Review Services, Inc. within one working day following an emergency hospital admission. In the event that you are unable to contact Spectrum Review Services, Inc. yourself, you may have a friend, relative, or medical personnel call for you.

23-Hour Observation: Pre-admission review is MANDATORY if you are scheduled for an outpatient procedure which may result in a 23-hour (or over) observation as you will be staying overnight in the hospital. If your surgery or test is scheduled as a 23-hour (or over) observation (which includes an overnight stay in the hospital), Spectrum Review Services, Inc. will NOT certify the 23-hour (or over) observation if your surgery or test can safely be done on an outpatient basis, sometimes referred to as OUTPATIENT or DAY SURGERY (early admission and discharged that same day).

Outpatient Day Surgery Procedures: When your doctor has ordered one of the following Outpatient Procedures listed below, Spectrum Review Services, Inc. must be contacted PRIOR to the procedure being performed to precertify the procedure.

- Arthroscopy (ALL)
- Cardiac Catheterization
- Carpal Tunnel Release
- Eye Surgeries (ALL)
- Foot Surgeries
  - Bunionectomy
  - Hammer Toe Repair
- Hernia Repairs
- Knee Surgeries
- Lithotripsy
- Nasal Surgeries
  - Ethmoidectomy
  - Nasal Pharynx Procedures
  - Rhinoplasty/Septoplasty
  - Turbinectomy
- Varicose Vein Stripping

Substance Abuse Treatment: Preauthorization and Precertification is MANDATORY to qualify for Substance Abuse Treatment. FAILURE to contact the **CARE** Customer Service for Preauthorization or Precertification for Substance Abuse Treatment will result in denial of payment of ALL claims in connection with such treatment.

Second Opinions: Preauthorization to receive a second opinion must be given by **CARE** in order for the second opinion to be considered a covered charge.

EXCLUSIONS (WHAT THE PLAN DOES NOT COVER)

CARE provides benefits only for services and supplies that are medically necessary. **CARE** reserves the right to determine medical necessity. The fact that a Covered Provider has prescribed, recommended, or approved a service or supply does not, in itself, make it a covered benefit. In no event will benefits be payable for:

- Hospitalization, services or treatment not recommended by the Utilization Review Committee or other regulatory committee of **CARE** or of the hospital where confined. If hospitalization or treatment continues, it will be the member's responsibility to pay all of the charges, including professional services.
- Hospital admissions on Friday except in the case of an emergency.
- Hospital admissions for diagnostic testing only.
- Take-home items from an inpatient confinement such as drugs, medical supplies, appliances, medical equipment, personal appliances, personal comfort items (charges for television, radios, barber services, etc.).
- Any services performed under any other present or future laws enacted by the Congress of the United States or by the legislature of any state including Worker's Compensation.
- Any services required as a result of an act of war, declared or undeclared.
- For Skilled Nursing Facilities, Nursing Homes, Convalescent Homes, Homes for the Aged, Rest Homes or Long Term Acute Care facilities except that the member may receive outpatient physicians' services as provided in these Rules when residing in these institutions.
- For custodial treatment or services, regardless of who recommends them or where they are provided, which could be rendered safely and reasonably by a person not medically skilled and are designed mainly to help the patient with daily living activities (including, but not limited to: personal care, walking, getting in or out of bed, bathing, eating by spoon, tube or gastrostomy, exercising, dressing, homemaking such as preparing meals or special diets, acting as a companion or sitter, and/or supervising medication which can usually be self-administered).
- Special duty nurses or attendants.
- Medical services provided by a family member.
- Elective cosmetic surgeries (to improve appearance), drugs and all expenses related to such treatment, including, but not limited to, elective procedures such as Lasik or Radial Keratotomy.
- Monitored exercise programs, or programs for weight control, or surgeries for obesity except as noted.
- Vasectomies or reversals for vasectomies or complications resulting therefrom.
- Drugs or experimental procedures NOT APPROVED by the FDA.

- Dental services. **CARE** does NOT provide benefits for services of Dentists or Oral Surgeons, or treatment of periodontal or periapical disease, or any condition (other than a cyst or tumor) involving teeth, surrounding tissue or structure, or any expense in connection therewith except for dental services received within twelve (12) months as a result of severe trauma (chewing incidents are NOT considered to be accidental trauma).

- Electronic devices for pain, pain management, TENS, acupuncture, biofeedback, chelation treatments, massages not performed by a licensed physical therapist or physiotherapist.

- Personal appliances such as glasses, lenses (except for implants), hearing aids, batteries, arch supports, lifts, custom orthotics and/or shoe inserts, wrist splints, night splints, crutches, special shoes, durable support hose, hernia supports.

- Supplies such as colostomy or ileostomy bags, catheters and related supplies (unless your plan qualifies for the Durable Medical Equipment Benefit, see page 12).

- Medical records, filing fees, narratives, reports, or other associated documents.

- Lodging while receiving outpatient medical treatment.

- Charges by institutions which do not meet the definition of a "Covered Facility."

- Injuries or disabilities incurred while engaged in the commission of a felony or misdemeanor.

- The following physical therapy modalities including but not limited to: kinetic activities, aquatics or work hardening programs, therabands and sports cords.

- Medical services and/or tests obtained solely to comply with a requirement of a third party such as an employer, a judicial order, to obtain or maintain insurance, to attend an educational institution or obtain certification including but not limited to company ordered physical or mental examinations, drug testing, sleep studies nor any other tests or exam not deemed medically necessary.

- Diabetic Education or Instruction.

- Any charge which, in the opinion of **CARE**, is NOT proper.

- For any other exclusion listed or noted in this book.

As provided in the Health Insurance Portability and Accountability Act of 1996, no eligibility requirement of the Plan shall be given any effect to the extent that it discriminates on the basis of a health factor.

GENERAL INFORMATION

It is your responsibility to be informed and understand your health benefits. This book is the official statement of benefits available to all membership plans; Plan #3000, Plan #3100, Plan #5000, Plan #5500 and Plan #5100.

ALLOWABLE COVERED EXPENSE: The necessary, reasonable, and customary items of expense for health care when the item of expense is covered within **CARE**'s benefits.

- ♦ The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Covered Expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

- ♦ When benefits are reduced under a Primary plan because a covered person does not comply with the Plan provision, the amount of such reduction will NOT be considered an Allowable Covered Expense. Examples of such provisions are those related to precertification of admission or services.

ANNUAL MAXIMUM: This refers to the maximum amount in dollars that the health plan will pay in a calendar year. The annual maximum benefit restarts each year. Annual and lifetime maximum amounts vary according to Plan type. See your Plan for specific information.

CHANGE OF STATUS: If your change of status causes you to change plan coverage with **CARE**, benefits under your prior plan will cease on the effective date of your enrollment in the new plan, unless you are confined in a hospital or other covered facility or receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan. In that case, benefits under the new plan do not begin for that particular hospital stay (or other covered facility) until the day you are discharged from the hospital or other covered facility.

CLAIM: A claim is a request for health benefits made in accordance with a plan's reasonable procedure for filing benefit claims. A claim must be in the format discussed elsewhere in your Full Rate & Supplemental Membership handbook.

CLAIMANT / MEMBER: Any plan participant (member) or beneficiary making a claim. A duly authorized representative that is authorized to act on behalf of a claimant may file a claim. The duly authorized representative must present a form approved by the Plan and executed by the Claimant.

CLAIMS AND APPEAL PROCESS: There are four types of claims: Urgent, Pre-Service, Post-Service and Concurrent. An Urgent claim is a claim for medical care or treatment that, if normal pre-service standards are applied, would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be managed without the care or treatment that is the subject of the claim. A pre-service claim is any claim for a benefit for which the Plan requires approval before medical care is obtained. A post-service claim is any claim that is not a pre-service claim. A concurrent claim is a claim that is reconsidered after an initial approval was made and results in a reduced or terminated benefit. The Plan Administrator must notify a claimant of such a reconsideration of a benefit as soon as possible in order to have an appeal decided before the benefit is reduced or terminated.

The deadline for initial determination for each type of claim is as follows: Urgent claims - 72 hours from receipt of the claim; Pre-Service claims - 15 days from receipt of the claim and Post-Service claims - 30 days from receipt of the claim.

In the case of an urgent claim, the Plan must notify the claimant of the need for additional information within 24 hours of receipt of the claim. The claimant will be given 48 hours to respond. The deadline is suspended for 48 hours or until information is received. If a pre-service claim is received incomplete, you will receive written notice within 15 days advising you of additional information needed to process your claim. One 15-day extension is allowed if the Plan Administrator determines it is necessary due to matters beyond the control of the Plan and informs the claimant of the extension within the normal deadline. The claimant will be given 45 days to respond. If no response is received, the claim will be denied. If a post-service claim is received

incomplete, you will receive written notice within 30 days advising you of additional information needed to process your claim. One 15-day extension is allowed if the Plan Administrator determines it is necessary due to matters beyond the control of the Plan and informs the claimant of the extension within the normal deadline. The claimant will be given 45 days to respond. If no response is received, the claim will be denied.

Written notice of a Plan's denial of a claim must be provided within the determination time frames mentioned above to include: the reason for the denial; reference to the plan provisions on which the determination is based; a description and the explanation why additional information is needed to properly process the claim; a copy of the Plan's review procedures and time periods that the claimant needs to follow in order to appeal the claim; plus a statement that the claimant can bring suit under ERISA following the review; a statement that a copy of any internal rule, guideline, protocol or similar criteria which was relied upon is available at no cost upon request and for urgent care adverse benefit determinations, the notice must contain a description of the expedited review process applicable to urgent care claims.

You have 180 days after the receipt of the denial notice to appeal the denial of your claim. On an urgent claim, the Plan Administrator will render a decision within 72 hours from the receipt of the appeal. On a pre-service claim, the Plan Administrator will render a decision within 30 days from the date of receipt of your appeal. On a post-service claim, the Plan Administrator will render a decision within 60 days from the date of receipt of your appeal. In the case of a concurrent claim, the claimant must be given opportunity to appeal the review decision sufficiently in advance to allow an appeal and determination before the termination of the benefit. You may review the judgment documents used in deciding your claim and submit issues and comments in writing. All comments, documents, records and other information you submit will be taken into account during our review procedure. This decision will be furnished to you in writing with a full explanation for the decision to include: reason for the denial; reference to the plan provisions on which the denial was based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits; and a statement describing the appeal procedures afforded by the plan and the claimant's right to submit the information about the procedures, and a statement of the claimant's right to bring a lawsuit under ERISA.

Your appeal must be in writing and directed to the Plan Administrator. If you do not ask for an appeal within the above time frame, you lose your right to further appeal. If your claim was denied based on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate and you appeal the decision, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The medical expert consulted in regards to your appeal will not be the same individual consulted in connection with the initial denial, nor will they be the subordinates of such individual. These medical experts will be identified to you upon request.

Any questions or disputes on any matter that may arise which are not covered by **CARE**'s Rules and Benefits may be appealed to the Board of Directors who will make the final determination. You may not bring suit against your Plan for claims that are past one year old.

Appeals should be mailed to the: **CARE** Board of Directors, P.O. Box 6130, Temple, Texas 76503-6130

CLAIMS FILING DEADLINE FOR PLANS #5100 and #5500: All medical expense claims must be submitted as soon as possible and received by **CARE** NO LATER than one (1) year from the date the expense was incurred. It is your responsibility to ensure that your claims are filed before this deadline.

CLAIMS FILING DEADLINE FOR PLANS #3000, #3100 and #5000: All medical expense claims must be submitted as soon as possible and received by **CARE** NO LATER than one (1) year from the date your Primary or Secondary processed the claim. It is the member's responsibility to ensure that claims are filed before this deadline.

COINSURANCE: The percentage of each covered expense you are responsible for paying after you have met any applicable copayments and/or deductibles.

CONFIDENTIALITY: Medical and other information provided to the Plan is kept confidential and will be used by the Plan and its subcontractors only for internal administration of the Plan, coordination of benefit provisions with other plans, subrogation of claims, or by **CARE** and its subcontractors in reviewing or auditing a disputed claim.

COORDINATION OF BENEFITS (COB): Laws regulating coordination of benefits are set to establish the priority of claim payers, expedite claim payment, and reduce or eliminate duplication of payment, and thus prevent persons from profiting from injury. This Coordination of Benefits (COB) provision applies to this Plan when a member or the member's covered spouse/dependent has healthcare coverage under more than one plan.

If Coordination of Benefits applies, the order of Benefit Determination should be looked at first. Those specifications will determine whether the benefits of this Plan are determined before or after those of another plan. The benefits of this Plan:

- shall not be reduced, when, under the order of Benefit Determination, this Plan determines its benefits before another plan; but

- may be reduced when, under the order of Benefits Determination, another plan determines its benefits first.

This Plan determines its order of benefits using the first of the following Benefit Determination which applies:

1. Non-Dependent/Dependent: The benefits of the plan which covers the person as an employee, member, or subscriber (that is other than as a dependent) are determined before those of the plan which covers the person as a dependent.

2. Dependent Child/Parents not Separated or Divorced: Except as stated in Paragraph (3) of this section, when this Plan and another plan cover the same child as a dependent of different persons, called "parents";

    - the benefits of the plan of the parent whose birthday occurs first in a calendar year is primary; but
    - if both parents have the same birthday, the primary plan will be the one that has covered the child for a longer period time; however
    - if one plan uses the birthday rule and another plan uses a coordination system based on the gender of the parent, and the plans cannot agree on an order of benefits, the gender rule will be used to determine the priority of benefit payments.

The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.

3. Dependent Child/Parents Separated or Divorced: If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- First, the plan of the custodial parent;
- Second, the plan of the spouse of the custodial parent;
- Third, the plan of the non-custodial parent.

However, when specified in the divorce decree, the plan of the divorced parent whom the court has ordered to be responsible for health care of a dependent child will be Primary. The plan of the other parent shall be Secondary.

Joint Custody: If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expense of the child, the plans covering the child shall follow the order of benefit determination as outlined in Rule 2 above (Dependent Child/Parents not Separated or Divorced).

4. Active/Non-Active Railway Employee: A plan covering an Active Railway employee is primary over a plan covering a Non-Active employee, such as an employee who is laid off or retired.

5. Length of Coverage: When none of the rules above determines the priority of benefit payments, the plan that has covered the employee, beneficiary, dependent, or subscriber longer is primary.

Certain facts are needed to apply these Coordination of Benefit Rules. **CARE** has the right to decide which facts are needed. **CARE** may get needed facts from or give them to any other organization or person in the administration of the Plan. Each person claiming benefits under this Plan must give **CARE** any information needed to pay the claim.

Under NO circumstances will payment, when added to the benefits payable by the other Plan, exceed 100% of reasonable and customary charges.

COPAYMENTS: The flat fee you pay for certain services such as doctors' office visits, emergency room visits or prescription drugs at the time of service or purchase.

Plan #5500:
$ 15.00 - Office Visit or Consultation
$ 50.00 - Emergency Room

Copayments DO NOT apply to Plan #3000, Plan #3100, Plan #5000 or Plan #5100 for doctors' office visits and emergency room visits.

COSMETIC SURGERY: Any operative procedure or any portion of an operative procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

COST CONTAINMENT: You are encouraged to make the most effective use of health care services. **CARE** has negotiated Network Provider Agreements with certain Physicians, Clinics and Hospitals to provide primary Members with medical care for covered services at VIRTUALLY NO COST TO THE MEMBER.

COVERED FACILITIES: A Freestanding Ambulatory Facility is a facility which meets the following criteria: has permanent facilities and equipment for the primary purpose of performing surgical and/or renal dialysis procedures on an outpatient basis; provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility; does not provide inpatient accommodations; and is not, other than incidentally, a facility used as an office or clinic for the private practice of a physician or other professional.

A Hospital is a facility which is:

- accredited as a hospital under the Hospital Accreditation Program of the Joint Commission of Accreditation of Health Care Organization (JCAHO);

- operated pursuant to law, under the supervision of a staff of doctors, and with 24-hour a day nursing service, and which is primarily engaged in providing general inpatient care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or have such arrangements by contract or agreement; and

- Medicare approved.

In no event shall the term "Hospital" include a convalescent nursing home or any institution or part thereof which (a) is used principally as a convalescent facility, nursing facility, or facility for the aged; (b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living. Likewise, the term "Hospital" shall not include any institution or part thereof which constitutes a skilled nursing facility or long term acute care facility.

COVERED PROVIDERS: Doctors of Medicine (M.D.), Doctors of Osteopathy (D.O.), Doctors of Podiatric Medicine (D.P.M.), Doctors of Surgical Chiropody (D.S.C.), Doctors of Optometry (D.O.), Doctors of Chiropractic (D.C.), and Doctors of Psychology (Ph.D), Physicians' Assistants (P.A.), Nurse Practitioners, Licensed Clinical Social Workers (LCSW) when the services they provide are within the benefits included in this health program and when they are practicing within the scope of their license or certification.

DEDUCTIBLE: The amount you pay for covered services each year before the plan begins to pay benefits. The deductible is not to be collected by the provider of medical service at the time of service. Members will receive notification from **CARE** advising them of the amount payable to the provider of service.

DUTY OF COOPERATION: Maintaining membership in **CARE** and submitting medical claims for payment by **CARE** authorizes the provider of service to release medical information necessary to process such a claim. This information is kept strictly confidential.

ELIGIBLE DEPENDENTS:
- wife or husband
- a child from birth to 26 years of age regardless of full time student status, financial responsibility and marital status will be eligible to enroll. A dependent is not eligible to enroll if place of dependent's employment offers medical coverage. (Children include: Natural or adopted children and stepchildren).

ENROLLMENT: Individuals eligible to enroll as members of **CARE** must complete an application for membership which will be furnished by the Consolidated Associations of Railroad Employees.

Employees actively working for the Burlington Northern Santa Fe Railway Company and/or subsidiary companies and employed in a position that does not call for employee health care benefits to be provided by the Railroad Employees National Health and Welfare Plan are eligible for health care benefits with this hospital association. Eligible dependents may request membership in **CARE** during one of the following:

- within 30 days of the eligible employee becoming a member of **CARE**
- within 30 days of getting married
- during an Open Enrollment

An Employee who discontinues membership will not be entitled to continue membership on any dependent except as provided under COBRA. Any Retired Employee who discontinues membership will not be entitled to continue membership on any dependent. Membership for dependents of Retired employees may only continue under one of the following circumstances:

- death of the sponsoring retired employee; or
- divorce or legal separation.

EXPERIMENTAL OR INVESTIGATIONAL DRUG, DEVICE & MEDICAL TREATMENT OR PROCEDURE: A drug, device, or medical treatment or procedure is experimental or investigational:

- if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

- if reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

- if reliable evidence shows that the consensus among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

FRAUD - RULE VIOLATION

- Any member offering a recommendation for treatment based on fraud or who flagrantly or persistently violates **CARE** Rules or abuses the services of **CARE** will be expelled from **CARE**.

- Any member who knowingly and with intent to injure, defraud, or deceive **CARE** (or other insurance companies), gives incorrect or misleading information in making application for membership to **CARE**, or files a statement of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable by law AND may result in immediate expulsion from **CARE**.

GINA (Genetic Information Nondiscrimination Act): This rule outlines the requirements that health plans must follow to comply with the nondiscrimination provisions of HIPAA. GINA prohibits group health plans from adjusting group premium or contribution amounts on the basis of genetic information. In addition, GINA prohibits group health plans and health insurers from denying coverage to a health individual or charging a person higher premiums based solely on a genetic predisposition to developing a disease or disorder.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996 (HIPAA): The Health Insurance Portability and Accountability Act of 1996 (*HIPAA*) requires group health plans to mail certificates of creditable coverage to individuals who lose coverage under the plan. The Health Insurance Portability and Accountability Act of 1996 limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for late enrollees).

The 12-month (or 18-month) exclusion period is reduced by your days of creditable coverage under prior health coverage. A period of prior creditable coverage will be disregarded if you have a 63-day or longer break in creditable coverage after that period, excluding any waiting period for coverage or any period during which an individual's application for coverage was pending. You are entitled to a certificate that will show evidence of your prior health coverage. We will assist you, if necessary, in determining the amount of your prior creditable coverage, and in obtaining information, such as a certificate of creditable coverage, from your prior health insurer or health plan concerning your creditable coverage under that insurance policy or plan. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion.

We will give you a creditable coverage certificate when:
(a) Your coverage under the Plan would terminate in the absence of COBRA coverage; and when
(b) Your coverage under the Plan's COBRA coverage provisions terminates (if you elect coverage under those provisions); and when
(c) You ask us for a certificate, or someone else does so on your behalf, if the request is made at any time while you are covered by the Plan and up to 24 months after coverage ceases.

Requests for a creditable coverage certificate should be sent to the Consolidated Associations of Railroad Employees, Plan Administrator, 4912 Midway Drive, P. O. Box 6130, Temple, Texas 76503-6130. Requests must include:

(a) The name of the person for whom the certificate is requested;
(b) The name of the employee, if the person referred to above is a dependent;
(c) The address to which the certificate is to be mailed;
(d) If the request is being made on behalf of another person, evidence of the authority of the person making the request to receive the certificate; and
(e) The requester's signature.

IDENTIFICATION CARDS: To receive benefits, members may identify themselves by showing their **CARE** Health Plan identification card (if applicable to their plan).

Identification cards are not issued to members in Plan #3000, Plan #3100 or Plan #5000 as it is the member's responsibility to file claims directly to **CARE**. Benefits paid under Plan #3000, Plan #3100 and Plan #5000 are paid directly to the member regardless of any other insurance you may have.

Information on the Plan: Information requested by the Plan in connection with a claim MUST be furnished to **CARE** to determine available benefits.

IN-NETWORK PROVIDER: Each Physician, Hospital, and Clinic of our Preferred Provider Network is recommended on the basis of their participation in our Network. All Providers have been screened and credentialed; however, they are NOT employees of **CARE**. No further endorsement can be assumed by the Plan.

INTERPRETATION: CARE has the authority to construe the Plan and to determine all questions that arise under it. Such power includes, for example, the administrative discretion necessary to determine whether an individual meets the Plan's written eligibility requirements, or to interpret any other term contained in this Plan document. Further, to the extent that any Plan benefit is subject to a determination of medical necessity, reasonableness or the like, **CARE** will make that factual determination. **CARE**'s interpretations and determinations are binding on all employees, retirees, dependents and their beneficiaries.

LIFETIME LIMITED BENEFITS: Benefits for Attempted Suicide/Self-Inflicted Injury, Cardiac/Pulmonary Rehabilitation, Sleep Disorders, Speech Rehabilitation, Substance Abuse Treatment, and Transplants are subject to the Lifetime maximums as stated within this brochure for those designated benefits. Lifetime Limited Benefits DO NOT apply to the Annual Out-of-Pocket. Applicable copayments apply to the Lifetime Limited Benefits.

LIFETIME MAXIMUM: The most members are eligible to receive in benefits from a plan during the entire period they are covered. Members will be notified in writing in regards to any Lifetime Maximum Changes.

- ♦ The Lifetime Maximum for Plan #5100 for In-Network and/or Out-of-Network covered services is $150,000. Charges in excess of the $150,000 will be the member's responsibility to pay.

- ♦ The Lifetime Maximum for Plan #5500 for In-Network and/or Out-of-Network covered services is $200,000. Charges in excess of the $200,000 will be the member's responsibility to pay. As a reminder, the $200,000 Lifetime Maximum under Plan #5500 has been accumulating since coverage began in Plan #5000.

MEDICAL CHILD SUPPORT ORDERS: Medical child support orders, typically issued in divorce proceedings, may create or recognize the right of a child of a member to be covered under this Plan. Such an order must be "qualified" under federal law for this Plan to be bound by it. A description of the requirements such an order must satisfy, and this Plan's procedures for determining the qualified status of an order, can be obtained from the Plan Administrator.

Medically Necessary: Services or supplies provided by a hospital or covered provider of health care services which the Plan determines:

- ♦ are appropriate to diagnose or treat the patient's condition, illness, or injury at the level of care being provided;

- ♦ are consistent with standards of good medical practice in the United States;

- ♦ are not primarily for the personal comfort of the patient, the family or the provider;

- ♦ are not part of or associated with the scholastic education or vocational training of the patient;

- ♦ and in the case of inpatient care, cannot be provided safely on an outpatient basis.

MEDICAL TREATMENT: CARE does NOT guarantee a cure for any disease, illness, or injury, nor does it guarantee the results of treatment by any In-Network or Out-of-Network medical provider.

MICHELLE'S LAW: If continued coverage for a dependent child under an employer-sponsored group health plan is dependent on the child's status as a student and the child is no longer enrolled as a student due to a serious injury or illness, Michelle's Law prohibits that coverage from being terminated for one year after the date on which the child's medically necessary leave of absence begins unless, under the terms of the plan, coverage would otherwise terminate as of an earlier date.

This law will interact with COBRA (if applicable) in the following manner: the 36-month maximum coverage period would begin at the expiration of the one year extension under Michelle's Law. A written certification must be provided by the treating physician of the dependent child to the group health plan in order for the continuation coverage requirement to apply. The physician's certification must state that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

OPEN ENROLLMENT: A date determined by the **CARE** Board of Directors allowing former or retired Railway employees, spouses, or dependents to enroll for membership. Notification of an Open Enrollment will normally be announced in the **CARE** Newsletter, or by a notice sent to current members of **CARE**, or to persons who have requested membership in **CARE**. Membership in **CARE** is based on the primary or sponsoring member having an employment connection with the Burlington Northern Santa Fe Railway Company, individuals, and employees of other companies which the Board of Directors may from time to time decide to admit to **CARE**. Eligible dependents may request membership in **CARE**.

OUT-OF-NETWORK PROVIDER: Services provided by any physician, specialist, laboratory, therapist, hospital, etc., who is NOT under contract with **CARE** will be paid in accordance with the rules for Out-of-Network Physicians, Clinics, and Hospitals. This rule applies even if the Out-of-Network Physician, Clinic or Hospital was a referral by an In-Network Provider. This may result in the member being responsible for a sizable portion of the bill. It is important that you are aware PRIOR to the rendering of any services if your provider of service is an In-Network Provider with **CARE**.

OVERPAYMENTS: CARE will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayment.

PRECERTIFICATION AND UTILIZATION REVIEW: Spectrum Review Services, Inc. is a Pre-admission Review Program contracted by **CARE** to perform pre-admission, concurrent and retrospective review of; cardiac/pulmonary rehabilitation; hospital confinements; 23-hour observations; outpatient procedures; and substance abuse treatment and in addition provides Case Management.

PREFERRED PROVIDER ORGANIZATION (PPO): An arrangement between **CARE** and physicians, clinics, hospitals, health care institutions, or other health care professionals to provide services to you at a reduced cost. The PPO provides members with the opportunity to reduce their annual out-of-pocket expenses for care by selecting their health care facilities and providers from among a specific group of health care providers. Although preferred providers are not available in all locations, your use of them whenever possible helps contain health care costs and reduces your annual out-of-pocket.

REASONABLE AND CUSTOMARY: CARE allows benefits, unless otherwise indicated, to the extent that they are reasonable and customary. The reasonable and customary charge for any service or supply is the usual charge for the service or supply in the absence of benefit coverage. The usual charge may not be more than the general level of charges for illness or injury of comparable severity and nature made by other providers within the same geographic area in which the service or supply is provided.

SERVICES REQUIRED OUT OF THE U.S.A.: If you should be traveling in a foreign country and require medical attention, you should obtain a statement of charges, converted into American dollars along with current U.S. Diagnosis codes (ICD-10) and Procedure codes (CPT-4) and turn it into **CARE** for reimbursement. Payment will be made to you according to **CARE**'s benefits.

SUBROGATION: Subrogation means **CARE** has the right to recover any of its payments made because of:

- ♦ any injury to a covered member caused by an injury received either in the line of duty (employment) or as the direct result of a third party; and
- ♦ from which the covered member later recovers money from the third party or the third party's insurer by settlement, suit or otherwise.

The coordination of benefits among more than one type of insurance, for example: a health benefit plan and an auto insurance plan in the case of an injury during a car accident. A health plan and a third party are also included under subrogation.

SUBROGATION RULE OF CARE: If a covered member sustains an injury while on duty or which has been caused by a third party, **CARE** will pay benefits for the injury, subject to:

- ♦ **CARE** being subrogated in Bell County, Texas to any recovery or right of recovery that the covered member has against that third party, including the right to bring suit in the member's name;
- ♦ the member not taking any action which would prejudice **CARE**'s subrogation rights; and
- ♦ the member's cooperation in doing what is reasonably necessary to assist **CARE** in any recovery.

CARE will be subrogated only to the extent of **CARE** benefits paid because of that injury. The member will not settle or otherwise resolve the claim without protecting **CARE** fully in its subrogation rights. Settling or accepting money without protecting **CARE** will cause a loss of present and future benefits to the member.

Full details of the Subrogation Rights of **CARE** are stated in the *Subrogation Rule* Section.

TERMINATION OF MEMBERSHIP: Termination of membership in **CARE** will occur if:

- ♦ employee Members give written notice to their employer;
- ♦ employee Members terminate employment by resignation or retirement; and they choose to waive continuation of coverage with **CARE**;
- ♦ direct-pay Members give written notice to **CARE**. (Membership will terminate at the end of the month in which **CARE** receives the notice);
- ♦ a Member fails to make the required membership dues payment within the 30-day grace period;
- ♦ a Member, upon enrollment, provides **CARE** with inaccurate or fraudulent information; or,
- ♦ upon the death of a Member, membership will terminate at the end of the month in which the Member expired. Upon receipt of written proof, dues paid in advance of this date will be refunded to the spouse of the person, or the executor of the estate.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA): Eligible employees who take leaves of absence for the purpose of military service or training (as described in USERRA) may continue their coverage under the Plan (and that of their dependents, as well) for up to 24 months.

WOMEN'S HEALTH AND CANCER RIGHTS of 1998: The Women's Health and Cancer Rights Act of 1998 requires **CARE** to notify you of the coverage required by this act. When the need for such benefits is determined by the patient and the patient's attending physician, the mandate includes the following:

- ♦ Reconstruction of the breast on which a mastectomy has been performed.
- ♦ Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- ♦ Prostheses and treatment for physical complications of all stages of a mastectomy, including lymphedemas (sometimes referred to as swelling associated with the removal of lymph nodes).

Normal deductible, coinsurance, and/or copayment amounts applicable to your health coverage are also applicable to these benefits. The Consolidated Associations of Railroad Employees provides benefits for mastectomy services and related reconstructive services, therefore, this law will not affect your coverage or premiums. If you have any questions about the Plan's coverage of mastectomies and reconstructive surgery, please call the **CARE** office at 1.800.334.1330 and speak with a **CARE** Customer Service Representative.

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a member / participant of the Consolidated Associations of Railroad Employees (**CARE**), you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974* (*ERISA*). The Employee Retirement Income Security Act provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The Administrator may charge a reasonable fee for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage: You have a right to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduce or Eliminate Pre-existing Condition Limitation Periods: You have the right to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for Plan participants, the Employee Retirement Income Security Act imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you, and the other participants and beneficiaries. No one, including your employer, union, or other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under the Employee Retirement Income Security Act.

Enforce Your Rights: If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

The Directors are charged with the proper application of the Rules and Benefits of **CARE** as provided in Public Law 93-406, the Employee Retirement Income Security Act. Should you have any questions or need additional copies, you may write: Consolidated Associations of Railroad Employees, Plan Administrator, 4912 Midway Drive, P. O. Box 6130, Temple, Texas 76503-6130.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SUBROGATION AND REIMBURSEMENT

Benefits Subject to this Provision: This provision shall apply to all benefits provided under any section of the **CARE** Plan. Any payments a Member is required to make under this Section shall be made to the Plan's office in Bell County, Texas.

Statement of Purpose: *Subrogation* and *reimbursement* represent significant **CARE** Plan assets and are vital to the financial stability of the Plan. *Subrogation* and *reimbursement* recoveries are used to pay future claims by other **CARE** members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of **CARE**. The Plan Administrator has a fiduciary obligation under ERISA to pursue and recover these Plan assets.

Definitions

Another Party - "A*nother party*" shall mean any individual or entity, other than **CARE**, who is liable or legally responsible to pay expenses, compensation or damages in connection with a *covered member's* injuries or illness.

"*Another party*" shall include the party or parties who caused the injuries or illness; the liability insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a *covered member's* own insurance coverage, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other insurer; a workers' compensation insurer; governmental entity or any other individual, corporation, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

Covered Member - A "*Covered Member*" shall mean any employee or former employee who is duly enrolled for coverage under the **CARE** Plan, as well as any duly enrolled dependent of such an individual.

Solely for purposes of determining an individual's rights and obligations under this Subrogation and Reimbursement provision, a "*Covered Member*" shall also include but not be limited to any beneficiary, dependent, spouse or legal or personal representative of an individual described in the preceding paragraph, including parents, guardians, attorneys, trustees, administrators or executors of an estate of such an individual and the heirs of such an individual's estate.

Recovery - "*Recovery*" shall mean any and all monies identified or paid to the *covered member* through or from *another party* by way of judgment, award, settlement, covenant, release or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. A *recovery* exists as soon as any fund is identified as compensationfor a *covered member* from *another party*. Any *recovery* shall be deemed to apply, first, for *reimbursement* of **CARE**'s lien.

Subrogation - "*Subrogation*" shall mean **CARE's** right to pursue the *covered member's* claims for medical or other charges paid by the Plan against *another party*.

Reimbursement - "*Reimbursement*" shall mean repayment to **CARE** of recovered medical or other benefits that it has paid toward care and treatment of the injury or illness for which there has been a *recovery*.

Plan Administrator Discretion: The Plan Administrator has maximum discretion to interpret the terms of this provision.

When This Provision Applies: A *covered member* may incur medical or other charges related to injuries or illness caused in part or in whole by the act or omission of the *covered member* or another person; or *another party* may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the *covered member* may have a claim against that other person or *another party* for payment of the medical or other charges. In that event, the **CARE** Plan will be secondary, not primary, and the *covered member* agrees, as a condition of receiving benefits from **CARE**, to transfer to **CARE** all rights to recover damages in full for such benefits.

Duties of the Covered Member: When a right of recovery exists, and as a condition to any payment by **CARE** (including payment of future benefits for other illnesses or injuries), the *covered member* will execute and deliver all required instruments and papers, including a subrogation and reimbursement agreement provided by **CARE** as well as doing and providing whatever else is needed, to secure **CARE**'s rights of *subrogation* and *reimbursement*, before any medical or other benefits will be paid by **CARE** for the injuries or illness. The Plan Administrator may determine, in its sole discretion, that it is in **CARE**'s best interests to pay medical or other benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, **CARE** still will be entitled to *subrogation* and *reimbursement*. In addition, the *covered member* will do nothing to prejudice **CARE**'s right to *subrogation* and *reimbursement* and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines. A *covered member* who receives any *recovery* (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the portion of the *recovery* subject to the Plan's lien to **CARE** under the terms of this provision. A *covered member* who receives any such *recovery* and does not immediately tender the *recovery* to **CARE** will be deemed to hold the *recovery* in constructive trust for **CARE**, because the *covered member* is not the rightful owner of the *recovery* and should not be in possession of the *recovery* until **CARE** has been fully reimbursed.

The *covered member* must:

- Execute and deliver a subrogation and reimbursement agreement, if requested by the Plan Administrator;

- Authorize **CARE** to sue, compromise and settle in the *covered member's* name to the extent of the amount of medical or other benefits paid for the injuries or illness under the **CARE** Plan and the expenses incurred by **CARE** in collecting this amount, and assign to **CARE** the *covered member's* rights to *recovery* when this provision applies;

- Include the benefits paid by **CARE** as a part of the damages sought against another party.

- Immediately reimburse **CARE**, out of any *recovery* made from *another party*, the amount of

- medical or other benefits paid for the injuries or illness by **CARE** up to the amount of the *recovery* and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

- Notify **CARE** in writing of any proposed settlement and obtain **CARE**'s written consent before signing any release or agreeing to any settlement; and

- Cooperate fully with **CARE** in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by **CARE**.

First Priority Right of Subrogation and/or Reimbursement: Any amounts recovered will be subject to *subrogation* or *reimbursement*. In no case will the amount subject to *subrogation* or *reimbursement* exceed the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by **CARE** in collecting this amount. The Plan will be *subrogated* to all rights the *covered member* may have against that other person or *another party* and will be entitled to first priority *reimbursement* out of any *recovery* to the extent of the Plan's payments. In addition, **CARE** shall have the first priority lien against any *recovery* to the extent of benefits paid and to be payable in the future. **CARE**'s first priority lien supersedes any right that the *covered member* may have to be "made whole." In other words, **CARE** is entitled to the right of first *reimbursement* out of any *recovery* the *covered member* procures or may be entitled to procure regardless of whether the *covered member* has received full compensation for any of his or her damages or expenses, including attorneys' fees or costs; and regardless of whether or not the recovery is designated as payment for medical expenses or otherwise. Additionally, **CARE**'s right of first *reimbursement* will not be reduced for any reason, including attorneys' fees, costs, comparative or contributory negligence, limits of collectability or responsibility, characterization of recovery as pain and suffering or otherwise. As a condition to receiving benefits under the Plan, the *covered member* agrees that acceptance of benefits is constructive notice of this provision.

When a *Covered Member* Retains an Attorney: If the *covered member* retains an attorney, the Plan Administrator may require that attorney to sign the subrogation and reimbursement agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other illnesses or injuries. Additionally, the *covered member's* attorney must recognize and consent to the fact that this provision precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine against **CARE** in his pursuit of *recovery*. The Plan will not pay the *covered member's* attorneys' fees and costs associated with the recovery of funds, nor will it reduce its reimbursement pro rata for the payment of the *covered member's* attorneys' fees and costs.

An attorney who receives any *recovery* (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the *recovery* to **CARE** under the terms of this provision. As a possessor of a portion of the *recovery*, the *covered member's* attorney holds the *recovery* as a constructive trustee and fiduciary and is obligated to tender the *recovery* immediately over to the Plan. A *covered member's* attorney who receives any such *recovery* and does not immediately tender the *recovery* to **CARE** will be deemed to hold the

recovery in constructive trust for **CARE**, because neither the *covered member* nor his attorney is the rightful owner of the portion of the *recovery* subject to **CARE**'s lien.

When the *Covered Member* is a Minor or is Deceased or Incapacitated: The provisions of this subrogation and reimbursement provision apply with equal force to the parents, trustees, guardians, administrators, or other representatives of a minor *covered member* and to the heirs or personal and legal representatives of the estate of a deceased or incapacitated *covered member*, regardless of applicable law and whether or not the representatives have access or control of the *recovery*. No representative of a *covered member* listed here may allow proceeds from a *recovery* to be allocated in a way that reduces or minimizes **CARE**'s claim by arranging for others to receive proceeds of any judgment, award, settlement, covenant, release or other payment; or releasing any claim in whole or in part without full compensation therefore.

When a *Covered Member* Does Not Comply: When a *covered member* does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the *covered member* and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the **CARE** Plan by the amount due as a dollar for dollar satisfaction for the *reimbursement* to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by **CARE**. The reductions will equal the amount of the required *reimbursement*. If **CARE** must bring an action against a *covered member* to enforce the provisions of this section, then that *covered member* agrees to pay **CARE**'s attorneys' fees and costs, regardless of the action's outcome.

Recovery of Future Benefits: In certain circumstances, a *covered member* may receive a *recovery* that exceeds the amount of **CARE**'s payments for past and/or present expenses for treatment of the illness or injury that is the subject of the *recovery.* In other situations, a *covered member* may have received a prior recovery that was intended, in part or in whole, to be compensation for future expenses for treatment of the illness or injury that is the subject of a current claim for benefits under the Plan. In these situations, the Plan will not cover any present or future expenses related to the illness or injury for which compensation was provided through a current or previous *recovery*. The *covered member* is required to submit full and complete documentation of any such *recovery* in order for **CARE** to consider eligible expenses that exceed the *recovery.* To the extent a *covered member's recovery* exceeds the amount of the **CARE** lien, the Plan is entitled to a credit or cushion in that amount against any claims for future benefits relating to the illness or injury. In those situations following any *recovery* that exceeds the amount of **CARE**'s lien, the *covered member* will be solely responsible for payment of medical bills related to the illness or injury out of the remaining *recovery*. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

The Plan Administrator has sole discretion to determine whether expenses are related to the illness or injury to the extent this provision applies. Acceptance of benefits under the **CARE** Plan for an illness or injury which the *covered member* has already received a *recovery* may be considered fraud, and the *covered member* will be subject to any sanctions determined by the Plan Administrator*,* in its sole discretion, to be appropriate, including denial of present or future benefits under the Plan.

NOTICE OF PRIVACY PRACTICES

Effective Date of Notice: October 1, 2018

CARE, the "Plan" is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plan's uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1: Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures - Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations:

The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan has amended its plan documents to protect your PHI as required by federal law.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorization). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

The Plan may not and does not use your genetic information that is PHI for underwriting purposes.

Uses and disclosures that require your written authorization:

(1) Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

(2) Your written authorization generally will be obtained for any use or disclosure of PHI for marketing, which means a communication to encourage you to purchase or use a product or service. Marketing does not include communications about refill reminders or drugs you currently use, case management or care coordination, descriptions about your plan of benefits and related information, and information about treatment alternatives.

(3) Your written authorization would be required for any sale of PHI.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release:

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and

- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

<u>Uses and disclosures for which consent, authorization or opportunity to object is not required:</u>

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

1. When required by law.

2. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

3. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

4. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

5. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. When required for law enforcement purposes (for example, to report certain types of wounds).

7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

8. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

9. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization. Your authorization may be revoked in writing at any time, except to the extent that the Plan has relied upon it or as otherwise provided in the federal privacy rules.

<u>Section 2: Rights of Individuals</u>

Right to Request Restrictions on PHI Uses and Disclosures, and Receive Alternative Communications - You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the following officer: **CARE**, Attn: Privacy Office, 4912 Midway Drive, Temple, Texas 76502, Telephone: 254.773.1330.

Right to Inspect and Copy PHI - You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. Information will be provided in the form and format you request, if it is readily producible in such form and format; or if not, in a readable hard copy form or such other form and format as agreed to by you and the Plan.

Protected Health Information (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

Designated Record Set includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days of receipt of the request. A single 30-day extension in writing is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer: **CARE**, Attn: Privacy Office, 4912 Midway Drive, Temple, Texas 76502, Telephone: 254.773.1330.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI - You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to the following officer: **CARE**, Attn: Privacy Office, 4912 Midway Drive, Temple, Texas 76502, Telephone: 254.773.1330.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures - At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) based on your written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice upon Request - To obtain a paper copy of this Notice contact the following officer: **CARE**, Attn: Privacy Office, 4912 Midway Drive, Temple, Texas 76502, Telephone: 254.773.1330. This right applies even if you have agreed to receive the Notice electronically.

A Note About Personal Representatives - You may exercise your rights through a personal representative. Your ersonal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3: The Plan's Duties

The Plan is required by law to maintain the privacy of PHI, to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. In addition, the Plan may not and does not use your genetic information that is PHI for underwriting purposes.

This notice is effective beginning October 1, 2016 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided [to all past and present participants and beneficiaries] for whom the Plan still maintains PHI. If we make material changes to our privacy practices, copies of revised notices will be mailed to all members then covered by the Group Health Plan. Copies of our current notice may be obtained by contacting **CARE**, Attn: Privacy Office, 4912 Midway Drive, Temple, Texas 76502, Telephone: 254.773.1330.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice, in accordance with federal distribution rules. The notice and any revisions will also be posted on our Web site at www.carehealthplan.com.

Minimum Necessary Standard - When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:
- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services; uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section 4: Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following officer: **CARE**, Attn: Privacy Office, 4912 Midway Drive, Temple, Texas 76502, Telephone: 254.773.1330, debbiem@carehealthplan.com.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Filing instructions are available at:

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html.

The Plan will not retaliate against you for filing a complaint.

Section 5: Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer: **CARE**, Attn: Privacy Office, 4912 Midway Drive, Temple, Texas 76502, Telephone: 254.773.1330, debbiem@carehealthplan.com.

Conclusion - PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

Notice of Nondescriination and Accessibility Statement

CARE complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. **CARE** does not exclude people or treat them differently because of race, color national origin, age, disability or sex.

CARE

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Written information in other formats (large print, audio, accessible electronic formats, other format).
- Provides free language services to people whose primary language is not English, such as a Translator.

If you need these services, contact Debbie McCoy, Civil Rights Coordinator at 1.800.334.1330, Extension 407.

If you believe that **CARE** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Debbie McCoy, Civil Rights Coordinator at P. O. Box 6130, Temple, Texas 76503. Or call toll-free at 1.800.334.1330, TTY 711 for all States, Fax 254.774.8029 or email debbiem@carehealthplan.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Debbie McCoy, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:

U. S. Department of Health and Human Services

200 Independence Avenue SW

Room 509F, HHH Building

Washington, D. C. 20201

1.800.368.1019 or 1.800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

LEGAL PROCEEDINGS AND CHOICE OF CONTROLLING LAW
ALL LAWSUITS BROUGHT BY CARE OR BY ANY MEMBER ARISING OUT OF OR CONSTRUE THIS PLAN SHALL BE BROUGHT ONLY IN BELL COUNTY, TEXAS OR IN THE WACO DIVISION OF THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF TEXAS AND THE LAW OF THE STATE OF TEXAS WILL CONTROL TO THE EXTENT NOT OTHERWISE PREEMPTED BY ERISA.