CSX Corporation Medical, Dental
and Prescription Drug Plan
Summary Plan Description
As of January 1, 2017

Active Management Employees
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Introduction

Your CSX Corporation Medical, Dental, and Prescription Drug Plan (the Plan) is a valuable employee benefit that includes medical, prescription drug and dental benefits to help you stay healthy and pay for the cost of a serious illness or injury. As the cost of health care continues to rise, it is more important than ever to understand your health benefits and learn to use the tools that can help you make the most of your health care dollars.

The CSX Corporation Medical, Dental, and Prescription Drug Plan allows you to:

- Cover yourself and eligible family members;
- Elect medical and prescription drug coverage; and
- Elect dental coverage.

The Medical Plan

The CSX Corporation Medical, Dental, and Prescription Drug Plan gives active employees the opportunity to elect to participate in the Consumer Driven Health Plan (CDHP) with a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA), as eligible. This arrangement combines a comprehensive high deductible medical plan with the opportunity for a tax-favored account that you can use to pay for qualified medical expenses. Your account can grow from year-to-year and be used to save for future health care expenses.

The CDHP, HSA, and HRA are all administered by Aetna. For information about the Medical Plan options for retired employees, refer to When You Retire.

The Dental Plans

The CSX Corporation Medical, Dental, and Prescription Drug Plan gives active employees the opportunity to elect to participate in one of two dental options: the PPO Dental Plan and the DMO Dental Plan.

The PPO Dental Plan is a Preferred Provider Organization dental plan. You have access to a network of dentists and other dental care providers who deliver dental care for negotiated charges. You have the freedom to choose any licensed provider when you need care – you can choose network providers for lower out-of-pocket expenses, or out-of-network providers for higher out-of-pocket expenses.

The DMO Dental Plan is a Dental Maintenance Organization (DMO) dental plan. The DMO gives you and your family access to a network of primary care dentists (PCDs), and other dental specialists, who deliver dental care at contracted rates. Each provider in the network is called a network provider. The DMO Plan covers care only when the care is provided by your PCD or when your PCD refers you to a participating network dental specialist and the care is approved by Aetna. This plan is fully insured by Aetna and administered by CVS Caremark Health. This plan is only available to active employees who reside within Aetna designated DMO network locations.
The information in this Summary Plan Description (SPD) has been prepared as a general explanation of the benefits available to you under the Dental DMO Plan. In the event there is any inconsistency between this summary and the controlling Certificate, the terms of the Certificate are controlling. You can contact Aetna directly at 1-800-874-1458 for further plan details or to obtain a copy of the plan Certificate.

For information about dental coverage for retired employees, refer to When You Retire.

**In This Booklet**

You need information and tools to help you get the most out of your medical and dental benefits. This booklet explains:

- Who is eligible for the Plan;
- Definitions you need to know;
- What is covered by each Plan and any limits that may apply;
- What is not covered by each Plan; and
- How you share the cost of your covered services through features such as copays, coinsurance, and deductibles.

**The CSX Corporation Health and Welfare Plan**

The benefits described in this booklet are part of the CSX Corporation Health and Welfare Plan. This booklet constitutes the Summary Plan Description (SPD) required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The SPD and the CSX Corporation Health and Welfare Plan document together constitute the Plan. In the event of any conflict between this booklet and the Plan document, the terms of this booklet control.

Words and phrases that appear in **bold face** are defined in the **Glossary**.
Important Contacts

When you have questions or need more information about the Plan, help is just a phone call or click away. Here’s what you can do:

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<td>• You have questions about the Plan’s medical or dental benefits.</td>
<td>Phone: 1-800-874-1458</td>
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<td>• You have questions about your PayFlex health fund account.</td>
<td>Online: <a href="http://www.aetna.com">www.aetna.com</a></td>
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<td>• You are required to obtain preauthorization for a service (precertification).</td>
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<td>• You have a question about a claim.</td>
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<td>Aetna Navigator™</td>
<td>Use Aetna Navigator when you need:</td>
<td>Online: <a href="http://www.aetna.com">www.aetna.com</a></td>
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<td></td>
<td>• Eligibility or claim status information.</td>
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<td>• To locate a medical or dental provider.</td>
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<td></td>
<td>• To print a digital ID card.</td>
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<td>• Information from Member Services.</td>
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<td></td>
<td>• Copies of claim forms.</td>
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<td>• Access to tools that help you manage your health care.</td>
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<td>CVS Caremark Health Member</td>
<td>Contact CVS Caremark when you need to:</td>
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<td>Services</td>
<td>• Order or refill medications.</td>
<td>Phone: 1-866-273-8571</td>
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<td>• Check prescription drug pricing and coverage.</td>
<td>Online: <a href="http://www.caremark.com">www.caremark.com</a></td>
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<td>• Locate a participating retail pharmacy.</td>
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<td>• Request a prescription drug claim form.</td>
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<td>Contact ConsumerMedical when you need help to:</td>
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<td>• Confirm the diagnosis that you’ve been given.</td>
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<td>• Understand your treatment options.</td>
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<td>• Get to leading doctors and hospitals for your care.</td>
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<td>• Learn how to shop for your care.</td>
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<td>• Build a strong support network.</td>
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ConsumerMedical
- Phone: 1-888-361-3944
- Online: [www.consumermedical.com](http://www.consumermedical.com)
Tools to Help You Use Your Plan

To help you manage your health care dollars and make informed decisions about your care, the Claims Administrators offer you online tools and resources.

Aetna Navigator™

Aetna Navigator™ is Aetna’s benefits and health information website. Use Navigator as your online resource for personalized benefits and health information. You can use this interactive website to complete a variety of self-service transactions online. Once registered on Aetna Navigator, you’ll have access to secure, personalized features, such as benefits and claim status, as well as specific health and wellness information.

With Aetna Navigator, you can:

- Obtain a Health assessment;
- Print instant eligibility information;
- Print a digital ID card;
- Download copies of claim forms;
- Check the status of a claim;
- Find benefit balances; and
- Contact Aetna Member Services.

Aetna Navigator also gives you access to useful tools that help you manage your health care:

- DocFind®, Aetna’s online provider directory. DocFind gives you the most recent information on Aetna’s network doctors, hospitals, and other providers including Teladoc. For each doctor or other health care provider, you can learn about his or her credentials and practice, including education, board certification, languages spoken, office location and hours, and parking and handicapped access. You can also provide feedback on a PCP, specialist, or other medical professional after receiving services, using the online survey available at DocFind.

- WellMatch, a transparency tool to make it easier for you and your family members to shop for health care services based on quality and costs, understand how to best use health benefits, and manage your health care spending.

- InteliHealthSM, Aetna’s award-winning health website. With InteliHealth, you can search on a wide variety of topics, from specific health conditions and their treatment to the latest developments in disease prevention, wellness, and fitness.

- Estimate the Cost of Care, a tool that allows you to research the costs of office visits, medical tests, and selected medical procedures in your area.
• **Hospital Comparison Tool** helps you compare area hospitals on measures that are important to your health.

• **Healthwise® Knowledgebase**, an innovative decision-support tool that provides information on thousands of health-related topics to help you make better decisions about health care and treatment options. You can access Symptom Checker, an interactive body map to help you learn about symptoms, through the Healthwise® Knowledgebase. Symptom Checker gives you guidance about symptoms – possible causes, home remedies, when to call a doctor, and how to prepare for your visit to the doctor.

• **Health History Report**, an easy-to-understand summary of doctor visits, tests, treatments, and other health-related activity, based on claim activity. The information is organized by categories such as *Names of Doctors* and *Medical Care*. You can print your Health History Report and share it with your doctor.

You can access Aetna Navigator at [www.aetna.com](http://www.aetna.com). Click on the Aetna Navigator under the Menu, then log into Aetna Navigator where prompted.

**Clinical Policy Bulletins**

Aetna uses its Clinical Policy Bulletins (CPBs) as a resource when making benefit and claim decisions. CPBs are written on selected health care topics, such as new technologies and new treatment approaches and procedures. The CPBs describe whether Aetna has determined that a service or supply is medically necessary, based on clinical information.

You can find the CPBs at [www.aetna.com](http://www.aetna.com). Click on Members: public information / Health Coverage Information / Clinical Policy Bulletins, then follow the instructions to search for the information you’re seeking. The language of the CPBs is technical, because it was developed for use in benefit administration, so you should print a copy and review it with your doctor if you have questions.

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**Keep in Mind**

- The CPBs are just one resource that Aetna uses to decide whether care is medically necessary. Aetna also takes clinical information about the patient into account.

- The CPBs define whether a service or supply is medically necessary, but they do not define whether the service or supply is covered by the Plan. This booklet describes what is covered and what is not covered by the Plan.

- If you have questions about your coverage, you can contact Aetna Member Services at 1-800-874-1458.
Eligibility

This section describes who is eligible for coverage, how to enroll for coverage, and when coverage goes into effect.

Who Is Eligible

Active Employee

You are eligible for the Plan if you are a non-union full-time employee employed by CSX or its participating affiliates and you are regularly scheduled to work at least 40 hours per week as an hourly or salaried employee. A list of participating affiliates is available from the Plan Administrator upon request.

If you are a permanent, part-time employee who is regularly scheduled to work at least 20 hours per week, you are eligible to participate in the CDHP with no company contribution to the HSA or HRA.

Dependent

When you enroll in the Plan, you may also enroll your legal spouse and your eligible children.

Spouse means the person to whom you are married as of the applicable date, whether same-sex or opposite-sex, provided that the marriage was legally recognized in the state or jurisdiction in which it took place, regardless of the married couple’s place of residence.

An eligible child, who can be covered as a dependent up to the child’s 26th birthday, is:

- A natural or adopted child, a child placed for adoption with you, and a child for whom you have been granted permanent legal guardianship.
- A stepchild.
- A child under a Qualified Medical Child Support Order.
- An unmarried child who is not able to earn a living because of a mental or physical disability which started prior to the date such child reached age 19 who depends chiefly on you for support and maintenance. Coverage for such child has no age limit on eligibility and thus may continue past age 26. See If Your Child Is Handicapped.

Disabled Employee

If you become disabled, you are no longer eligible for coverage as an active employee. You may be eligible for coverage as a disabled employee under the CSX Corporation Retired or Disabled Employee Medical, Dental and Prescription Drug Plan.

You are an eligible Disabled Employee if:

- You were regularly assigned to a position classified by CSX as a full-time, salaried position; and
You were occupying that position immediately prior to the onset of disability; and

You are approved for long-term disability benefits under the CSX Corporation Long Term Disability Plan.

Retiree

If you retire, you are no longer eligible for coverage as an active employee under this Plan. You may be eligible for coverage as a retired employee under the CSX Corporation Retired or Disabled Employee Medical, Dental and Prescription Drug Plan.

You are an eligible retiree if you were hired or promoted from a contract position prior to January 1, 2003, and if immediately prior to retirement:

- You were regularly assigned to a position classified by CSX as a full-time, salaried position;
- You were either occupying that position or were totally disabled under the CSX Corporation Long Term Disability Plan before January 1, 2010;
- You were at least fifty five (55) years old and you were employed by CSX or one of its affiliated companies for at least ten (10) years prior to retirement or you were a retiree who selected the “2 Plus 1 Option” under the Voluntary Separation Incentive Program in 2014; and
- You were not dismissed from service for cause.

For details about coverage options for eligible retired employees, refer to the section of this SPD titled When You Retire.

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<td>- A foster child or grandchild is not eligible for coverage, unless you have legally adopted the child or have been granted permanent legal guardianship.</td>
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<td>- You cannot be covered as both an employee and a dependent under the Plan or any similar plan sponsored by CSX.</td>
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<td>- Two employees cannot cover the same child.</td>
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<td>- If you and your spouse are both eligible for coverage sponsored by CSX as employees, and you wish to cover your dependent children, one spouse must enroll for family coverage, and the other spouse must decline coverage.</td>
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<td>- Under no circumstances should a family unit elect an enrollment that would result in a Company contribution combined with a wellness incentive that is greater than $2,400.</td>
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If Your Child Is Adopted

Coverage for your legally adopted child is effective on the date the child is adopted or placed with you for adoption if you request coverage for the child from the Plan Administrator in writing within 31 days after the placement.
If you do not enroll the child within 31 days after placement, you must wait until the next open enrollment period to add the child as a dependent.

Proof of dependent eligibility may be required when you enroll your dependents. CSX reserves the right to request updated proof periodically to ensure your dependents continue to meet the eligibility guidelines of the Plan.

If Your Child Is Disabled

Disabled unmarried children may be covered beyond age 26 when not able to earn his/her own living because of a mental or physical disability that started prior to the date he/she reached age 19. For this purpose, you child is disabled if:

- He or she is not able to earn his or her own living because of a mental or physical disability which started prior to the date he or she reached age 19 as a dependent under the Plan; and

- He or she depends chiefly on you for support and maintenance.

You must provide proof of your child’s handicap no later than 31 days after the child’s coverage would otherwise end.

Coverage for a handicapped child ends on the first to occur of the following:

- The child’s handicap ceases;
- You fail to provide proof that the handicap continues;
- The child fails to have an examination required by Aetna; or
- The child’s coverage as a dependent under the Plan ceases for any reason other than attainment of the maximum age for dependent coverage. If coverage drops, the dependent may not re-enroll at a later date.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is an order from a state court or authorized agency requiring a parent to provide health care benefits to one or more children, which meets certain requirements. Coverage under the Plan can be extended to a child who is covered by a QMCSO if:

- Your child meets the definition of an eligible dependent under the Plan; and

- You request coverage for the child within 31 days after the later of the date of the order or the date on which you become eligible for coverage under the Plan.

Coverage will not be effective for any period when you or the child is not otherwise eligible for coverage. You can obtain a copy of the QMCSO procedures by contacting the Plan Administrator.
Enrollment and Changes

Participation in the Plan is not automatic for existing employees, you must enroll in order to get the coverage you want. You and your dependents can enroll:

- Within 31 days after the date you become eligible for coverage;
- During the annual enrollment period; or
- Within 31 days after a “change in status event”

New Employees

As a new employee, you must enroll within 31 days after first becoming eligible. If you do not enroll within this period, you will be automatically enrolled for employee-only coverage in the Consumer Driven Health Plan option and you will be charged with a tobacco surcharge. If you are automatically enrolled into this option, you will not be eligible for a company contribution to a Health Savings Account or Health Reimbursement Arrangement. You will not be eligible to change your Medical Plan option or enroll for dental coverage until the next annual enrollment period, unless you have a change in status event.

Annual Enrollment

During the annual enrollment period, you have a chance to review your coverage needs for the upcoming year and change your coverage choices, if necessary. The choices you make during annual enrollment will be in effect for the following plan year.

Changing Coverage Mid-Year

In general, you may not make a mid-year change in your plan elections or coverage levels. However, there is an exception to this rule for certain family or work-related changes, which are called “change in status events.” The following are examples of change in status events:

- Marriage or divorce;
- Legal separation or annulment;
- Birth, adoption, placement of a child for adoption, or being granted permanent legal guardianship;
- Gaining or losing custody of a child;
- Death of dependent;
- Loss of eligibility by a child under the Plan;
- Change in employment status which results in the beginning or ending of employer-provided coverage;
● A significant change in or termination of a medical plan offered by your spouse’s employer, which had covered you, your spouse and/or your children;

● Move in or out of a medical or dental plan network service area after coverage election is made;

● A significant change in cost of coverage, increase in deductibles, co-payments or out-of-pocket cost sharing amounts during the plan year; or

● COBRA coverage is exhausted.

If you have a change in status during the year:

− You may enroll or disenroll yourself or an eligible dependent in coverage;

− You may change your coverage category (single or family); and

− You may change your dental coverage option.

If you make a change, it must be consistent with the change in status. For example, if you already have family coverage and add a new dependent, you cannot change plans or delete/add dependents that are not consistent with the change in status. A preferred physician no longer participating in the plan does not qualify as a change in family status.

When you have a change in status event, you must report and make your election change(s) through the Employee Gateway (Health, Pay & Benefits > My Pay & Benefit Tools > My Benefits) within 31 days after the event. Otherwise, you must wait until the next annual enrollment period.

Keep in Mind

| The change in coverage you request must be consistent with, and due to, the change in status event. |

Late Enrollment

If you do not enroll yourself and/or a dependent for medical and dental coverage when first eligible or during an annual enrollment period, you may be able to enroll if you experience an event that creates special enrollment rights.

Loss of Other Health Care Coverage

If you waived enrollment for yourself or your dependents (including your spouse) because of other health coverage, you may be able to enroll yourself or your dependents in this Plan in the event you or the dependents become ineligible for that other coverage. You must request enrollment within 31 days after the other coverage ends.

New Dependents

You and your dependents may qualify for a late enrollee exception if:
– You didn’t enroll when you were first eligible for coverage;
– You later acquire a dependent, as defined under the Plan, through marriage, birth, adoption, placement for adoption, or permanent legal guardianship; and
– You elect coverage for yourself and any such dependent within 31 days after acquiring the dependent.

If you miss the 31 day deadline, you must wait until the next annual enrollment period to make any changes to your coverage.

**Medicaid or SCHIP Eligibility**

You and your dependents may qualify for a late enrollee exception if:

– You or your dependent loses eligibility for Medicaid or coverage under a state children’s health insurance program (SCHIP) or become eligible for a state premium assistance subsidy through Medicaid or SCHIP; and
– You elect coverage for yourself and any such dependent within 61 days after that event.

**Other Changes**

You may also make a mid-year change in your plan elections or coverage levels if you experience any other change in status event that is permitted under applicable Treasury regulations, as determined by the Plan Administrator.

**Changes in Contributions**

Any change in your required contribution will be made effective with the payroll period following your notification (on the required form) to the Plan Administrator of the change in your plan elections or coverage levels.

**When Coverage Begins**

Your coverage goes into effect on the date you become eligible for coverage. Dependent coverage is effective on the date that your coverage is effective.

You must notify the CSX Compensation & Benefits Department of a change in family status or late enrollment event by completing a Family Status enrollment change on the Employee Gateway.

**Paying for Coverage**

The cost of coverage under this Plan is currently shared by you and CSX Corporation or one of its subsidiaries. You pay these contributions through pre-tax deductions from your pay under a “salary reduction agreement.” This agreement authorizes CSX to deduct your contributions from your gross pay before federal income taxes, state income taxes (in most cases), and Social Security or Railroad Retirement taxes are computed and withheld. This results in lower pay
subject to taxes and thus, lower taxes. Pre-tax payment of your medical contributions does not affect your other CSX benefits. However, your Social Security or Railroad Retirement benefits may be slightly reduced if your taxable wages are reduced below the applicable wage base for these programs.

**Tobacco Usage Surcharge**

Tobacco use is the most preventable cause of chronic disease in this country. To control medical costs, CSX is encouraging all employees and their dependents to stop tobacco use and is providing a reward to those who do. If you or your covered dependent are a tobacco user, you must pay a tobacco surcharge to enroll in the Medical Plan as set forth in your enrollment materials. Any applicable surcharge will be deducted through payroll deduction in the same frequency as current Plan premiums.

If you, your spouse, or your covered dependent stops using tobacco products for at least ninety (90) consecutive days during the year, then you may stop paying the applicable surcharge by sending an email to csxconnect@csx.com stating that you and any covered dependents have been tobacco free for at least ninety (90) days. Notification must be received by CSXConnect by the 10th of the month to be effective as of the first of the following month.

CSX is committed to helping you achieve your best health. Rewards for participating in this tobacco usage wellness program are available to all employees. If you or a covered dependent uses tobacco products and is unable to stop using such products, a reasonable alternative standard to avoid the surcharge may be available to you. Contact the CSX Compensation & Benefits Department at (800) 633-4045. We will work with you (and, if you wish, with your doctor) to find a reasonable alternative that is right for you in light of your health status.
Overview of Your Medical Benefits

This section describes important features of the Plan. To learn how these features apply to the medical option you have selected, refer to the applicable Summary of Benefits.

The Fundamentals

It is important to understand how the Plan works before you need care. These key terms are the foundation of the Plan:

**Medically Necessary Services and Supplies**

The Plan pays benefits only for medically necessary services and supplies.

A service or supply furnished by a particular provider is medically necessary if the Claims Administrator determines that it is appropriate for the diagnosis, care, or treatment of the disease or injury involved. To be appropriate, the service or supply must be:

- As likely to produce a significant positive outcome (and no more likely to produce a negative outcome) as any alternative service or supply, considering the patient’s overall health condition;

- A diagnostic procedure that is as likely to result in information that could affect the course of treatment in a positive manner (and no more likely to produce a negative outcome) as any alternative diagnostic procedure, service, or supply;

- No more costly than any alternative service or supply, taking into account all health expenses incurred in connection with the service or supply;

- Consistent with current standards of medical or health practice, and must require the technical skills of a medical, mental health, or dental professional;

- Provided in the appropriate setting; and

- Not primarily for the convenience of the patient, the patient’s family, or the patient’s physician or other provider.

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

- Information provided about the patient’s health status;

- Reports in peer-reviewed medical literature;

- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;

- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
● The opinion of health professionals in the generally recognized health specialty involved; and

● Any other relevant information brought to the Claims Administrator’s attention.

**Negotiated Charge**

Network providers have agreed to charge no more than the negotiated charge for a service or supply that is covered by the Plan. You are not responsible for amounts that exceed the negotiated charge when you obtain care from a network provider.

**Availability of Providers**

Aetna cannot guarantee the availability or continued participation of a particular provider. Either Aetna or any network provider may terminate the provider contract or limit the number of patients accepted in a practice.

**Non-Occupational Coverage**

The Plan does not cover an illness or injury that is work-related. This means that the Plan does not cover any *illness* or *injury* related to employment or self-employment including any *injuries* that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers’ compensation, or an occupational illness or similar program under local, state or federal law.

A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers’ compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered “non-occupational” regardless of cause.

**Recognized Charge**

The Plan pays out-of-network benefits only for the part of a covered expense that is recognized. A *recognized charge* is the lower of:

● The provider’s usual charge to provide a service or supply; or

● The charge that the Claims Administrator determines to be the prevailing charge level made for the service or supply in the geographic area where it is provided.

To determine the recognized charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, the Claims Administrator also may take into consideration:

● The complexity of the service or supply;

● The degree of skill needed to provide it;

● The provider’s specialty;
● The range of services or supplies provided by a facility; and
● The prevailing charge in other areas.

In some circumstances, the Claims Administrator may have an agreement with a provider (either directly or indirectly through a third party) which sets the rate that the Claims Administrator will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in such agreement.

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**Keep in Mind**

If your health care provider charges more than the **recognized charge**, you will be responsible for any expenses incurred that are above the recognized charge.

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**Cost Sharing**

You share the cost of medical care with the Plan by paying deductible, coinsurance, and copayments.

**Copayment (copay)**

A copayment (or copay) is a flat fee that you must pay at the time you receive a service. Refer to the *Summary of Benefits* charts for more information about when copays apply.

**Calendar Year Deductible**

You must satisfy the **deductible** shown in the *Summary of Benefits* before the Plan begins to pay benefits for certain expenses. There is no individual deductible. Instead, all covered family coinsurance amounts apply toward the family deductible. The **family deductible** applies to you and your family as a group. When the combined deductible expenses incurred by you and your covered family members reach the family deductible, you and your family will be considered to have met your individual deductibles for the rest of that calendar year. Non covered charges and amounts over the recognized charge for a service do not apply toward the deductible.

**Coinsurance**

Once you have met the deductible, you pay a portion of the covered expenses you incur (your **coinsurance** or copay). The *Summary of Benefits* shows the coinsurance paid by the Plan; you are responsible for the remainder.

**Out-of-Pocket Maximum**

The Plan puts a dollar limit on the amount you must pay for copays, deductible and coinsurance expenses in any given Plan year, called the out-of-pocket maximum. Your payments for both Medical and Prescription Drug benefits (but not Dental) count toward your out-of-pocket maximum.

There are two types of out-of-pocket maximums.
• The individual out-of-pocket maximum applies to you as an individual. When an individual’s copays, deductible, and coinsurance expenses reach the maximum, the Plan will pay 100% of covered medical expenses for that individual for the remainder of the calendar year. The amount of the individual out-of-pocket maximum may differ if you have individual or family coverage.

• The family out-of-pocket maximum applies to you and your family as a group and applies in addition to the individual out-of-pocket maximum. When the combined copays, deductible, and coinsurance expenses incurred by you and your covered family members reach the family maximum, the Plan will pay 100% of covered medical expenses for all covered family members for the remainder of the calendar year.

• Note that beginning January 1, 2016, if you and your family are covered, once a covered individual meets the individual out-of-pocket maximum for the year, then the Plan will pay 100% of covered medical expenses for that individual for the remainder of the calendar year even if the family out-of-pocket maximum has not yet been met.

Non-covered charges and amounts over the recognized charge for a service do not apply toward out-of-pocket maximums.

Precertification

Precertification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the Plan. It also allows the Claims Administrator to coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning) and to register you for specialized programs or case management when appropriate.

Precertification starts with a telephone call to Member Services. If you use a network provider, your provider will make this call for you. If you intend to receive care from an out-of-network provider, you must make the call.

**When You Need to Precertify Care**

Services listed in the following chart must be precertified.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>When to Precertify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-network inpatient hospital or treatment facility confinement</td>
<td>• Non-emergency admission: at least 14 days prior to admission</td>
</tr>
<tr>
<td></td>
<td>• Urgent admission: before you are scheduled to be admitted</td>
</tr>
<tr>
<td></td>
<td>• Emergency admission: within 48 hours or as soon as reasonably possible</td>
</tr>
<tr>
<td>Type of Service</td>
<td>When to Precertify</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Out-of-network hospital alternatives:</strong></td>
<td></td>
</tr>
<tr>
<td>• Skilled nursing facility care</td>
<td>• Inpatient confinements: same as hospital inpatient confinement (above)</td>
</tr>
<tr>
<td>• Home health services</td>
<td>• Non-emergency care: at least 14 days in advance or as soon as reasonably possible.</td>
</tr>
<tr>
<td>• Hospice care – inpatient and outpatient</td>
<td>• Emergency care: as soon as reasonably possible.</td>
</tr>
<tr>
<td>• Private duty nursing</td>
<td></td>
</tr>
</tbody>
</table>

| **Network provider services or care:** |                                                                                     |
| • Surgical treatment of temporomandibular joint (TMJ) disorder. | • Non-emergency admission or care: at least 14 days prior to admission or care.      |
| • Transplant procedures.         | • Urgent admission or care: before you are scheduled for admission or care.         |
| • Bariatric surgery.             | • Emergency admission or care: within 48 hours or as soon as reasonably possible.   |
| • Inpatient behavioral health care. | Please refer to the individual description of each procedure or service for more information about precertification |
| • Inpatient care of mother and newborn child in excess of 48 hours after vaginal delivery or 96 hours after a cesarean section. |                                                                                     |
| • Surgery to treat gender dysphoria. |                                                                                     |

The Claims Administrator will notify you, your **physician**, and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days must be certified. You, your physician, or the facility will need to call the Claims Administrator at the number on your ID card no later than the final authorized day. The Claims Administrator will review and process the request for an extended stay. You and your physician will receive a copy of this letter.

**If You Don’t Precertify**

If you don’t call when required, a penalty will be applied to your covered charges. The Plan will pay a lower coinsurance share for covered expenses, which means that your out-of-pocket cost will be higher, because your coinsurance share will be greater.

Refer to the **Summary of Benefits** to find out the penalty that applies to your medical option.
Keep in Mind

- The Plan pays benefits for covered medical expenses only. If a service or supply you receive is not covered by the Plan, benefits will not be paid for it — whether or not the service has been precertified.
- If you transfer from union to management service, the Plan will accept a precertification approved by a health insurance company contracting with the Railroad National Health & Welfare Plan if:
  - The authorization was granted within 60 days immediately preceding your transfer date;
  - You provide the Claims Administrator with copies of documentation supporting the approval; and
  - The transfer date will be the same as the effective date of medical plan coverage with Aetna.

Precertification for Behavioral Health Benefits

Precertification is required for inpatient mental health and substance abuse treatment under the same rules as other treatments.

What to Do in an Emergency

You have coverage 24 hours a day, 7 days a week, anywhere inside or outside the plan’s service area, if care is needed to treat an emergency medical condition.

An emergency medical condition is a recent and severe condition, sickness, or injury, including (but not limited to) severe pain, which would lead a prudent layperson (including the parent or guardian of a minor child or the guardian of a disabled individual) possessing an average knowledge of medicine and health, to believe that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy;
- Serious impairment to a bodily function(s);
- Serious dysfunction to a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the unborn child.

Examples of medical emergencies include:

| heart attack or suspected heart attack, | loss of consciousness, |
| poisoning or suspected poisoning, | suspected overdose of medication, |
| severe shortness of breath, | severe burns, and |
| uncontrolled or severe bleeding, | high fever (especially in an infant) |
When emergency care is medically necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency physician in your treatment.

- If you are admitted to an inpatient facility, notify your physician as soon as reasonably possible.

- Follow-up care after treatment of an emergency or urgent medical care condition is not considered an emergency or urgent condition and is not covered as part of any emergency room visit. Once you have been treated and discharged, you should contact your physician for any medically necessary follow-up care. Refer to your Schedule of Benefits for cost sharing information applicable to your plan.

<table>
<thead>
<tr>
<th>Keep in Mind</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should not be provided by an emergency room facility.</td>
</tr>
</tbody>
</table>

Your ID Card

You will receive a digital ID card when you enroll in the medical plan. You are encouraged to carry a printed copy of your digital ID card with you at all times. Present the card to medical providers before receiving services. If your card is lost or stolen, please utilize Aetna Navigator to print a copy of our digital ID card.
The Consumer Driven Health Plan (CDHP)

The CDHP combines medical coverage with either the Health Savings Account (HSA) or the Health Reimbursement Arrangement (HRA). The medical coverage has a high deductible, so your out-of-pocket expenses are potentially higher. You can use the balance in your Participant Account to pay for qualified medical expenses (including medical plan deductible expenses) or you can allow the account to accumulate over time and use the funds to pay for future expenses.

Your CDHP Medical Coverage

The CDHP medical coverage is a Preferred Provider Organization (PPO) plan. A PPO is a network of physicians, hospitals, and other health care providers who deliver health care for negotiated charges. Each provider in the network is called a network provider. Providers who are not included in the network are called out-of-network providers.

The CDHP gives you the freedom to choose network or out-of-network providers when you need health care. The CDHP’s reimbursement level is the same, whether you choose a network provider or an out-of-network provider; however, there are advantages to obtaining care from a network provider:

- You are likely to save money when you use network providers because they have agreed to provide services for negotiated charges. The Plan pays a percentage of the negotiated charge and you pay the balance. You are not responsible for amounts that exceed the negotiated charge. When you use out-of-network providers, the Plan pays the same percentage of the recognized charge, and you pay the balance, but you are also responsible for any amount that exceeds the recognized charge.
- When your care is provided by a network provider, you don’t have to file claim forms. When you receive care from an out-of-network provider, you must pay for the services when they’re rendered, then file a claim for reimbursement.

Your network provider is responsible for precertification. You must obtain precertification for required services if you decide to use an out-of-network provider.

PPO Provider Information

To find a network provider in your area:

- Use DocFind®, Aetna’s online provider directory, at www.aetna.com. Log on to Aetna Navigator, then click on Find Health Care in DocFind®. Follow the prompts for the type of search you want, the area in which you want to search, the type of provider you are seeking, and the number of miles you are willing to travel. When asked to select a plan category, click on Aetna Standard Plans, then choose Open Choice® PPO. You can select a provider in the PPO network based on geographic location and/or hospital affiliation.
- Call Member Services. A member service professional can help you find a network provider in your area. The toll-free number for Member Services is 1-800-874-1458.
Getting Care Away From Home

- **Non-emergency**: If you are away from home and need medical care in a situation that is not an emergency, call Member Services at 1-800-874-1458.

- **Emergency**: When a medical emergency occurs, get qualified care immediately at the nearest hospital emergency room. If you are admitted to the hospital from the emergency room, call Member Services at 1-800-874-1458 (or ask someone to call for you) to precertify the admission.

Summary of Benefits

Understanding the terms listed below is key to using your benefits to your best advantage. These terms, along with other important terms, are described in *Overview of Your Medical Benefits* and defined in the *Glossary* at the back of this booklet.

- The Plan pays benefits only for **medically necessary** care.

- The **deductible** is the part of your covered expenses you pay before the Plan starts to pay benefits each year.

- Your **coinsurance** is the percentage of your covered expenses that you pay after you have satisfied the Plan's calendar year deductible.

- **Precertification** is a process that determines whether the services being recommended are covered expenses under the Plan. Precertification is required for inpatient care and certain alternatives to inpatient care.

**Cost Sharing**

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$1,700</td>
</tr>
<tr>
<td>Employee plus family</td>
<td>$3,400</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
</tr>
<tr>
<td>The Plan will pay 100% of covered expenses for the remainder of the year when the combined copay, deductible, and coinsurance amounts paid by you reach the individual out-of-pocket maximum or when you and your covered family members reach the family out-of-pocket maximum.</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,850 per individual, with a maximum of $8,000 for the family</td>
</tr>
<tr>
<td><strong>Maximum Lifetime Benefit</strong></td>
<td>Unlimited</td>
</tr>
</tbody>
</table>
### Covered Care

**Keep in Mind**

There is no individual deductible. Instead, coinsurance amounts of all covered family members apply toward the family aggregate deductible.

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>In-Network (Based on negotiated charge)</th>
<th>Out-of-Network (Based on recognized charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WELLNESS CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Physical Exam (employee, spouse and children age 18 and over)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• one exam per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Child Visits (includes immunizations and inoculations)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• Birth-12 months: 7 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 13-24 months: 3 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 25-36 months: 3 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 3-18 years: 1 visit per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Annual OB/GYN Exam (includes one Pap smear and related lab fees)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• one exam each calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Mammogram</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• one mammogram each calendar year for women age 35 and over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Prostate Screenings</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• one Prostate Specific Antigen and Digital Rectal Exam per calendar year for males</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Sigmoidoscopy or Colonoscopy</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• one sigmoidoscopy every 5 years beginning at age 50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• one colonoscopy every 10 years beginning at age 50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Lung Cancer Screening</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• one screening per calendar year beginning at age 55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Care</td>
<td>In-Network (Based on negotiated charge)</td>
<td>Out-of-Network (Based on recognized charge)</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Routine Vision Exams</td>
<td>Not covered (other than vision screenings for children covered as preventive care)</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100% with no copay or deductible</td>
<td>100% with no deductible</td>
</tr>
<tr>
<td>The following items as required under federal law:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• evidence-based items or services rated A or B by the US Preventive Services Task Force</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• immunizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• preventive care and screenings for infants, children &amp; adolescents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• preventive care and screenings for women</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PRECERTIFICATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Precertification Penalty</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precertification is required for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• hospital inpatient confinements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• alternatives to hospital inpatient confinements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your network provider is responsible for the precertification process.</td>
<td></td>
<td>Plan’s benefit is 40% after deductible if precertification is not obtained</td>
</tr>
<tr>
<td><strong>OFFICE VISITS</strong></td>
<td></td>
<td>Plan Pays</td>
</tr>
<tr>
<td><strong>Physician Office Visit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Allergy Testing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Allergy Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(serum, injections)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Short-term Rehabilitation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(speech, occupational, physical therapy, autism treatment)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• combined maximum of 60 visits per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Pays 85% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Pays 85% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Care</td>
<td>In-Network (Based on negotiated charge)</td>
<td>Out-of-Network (Based on recognized charge)</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-----------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 30 visits per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Medically necessary services for the diagnosis and treatment of autism spectrum disorders, including Applied Behavioral Analysis (ABA).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FAMILY PLANNING</td>
<td>Plan Pays</td>
<td></td>
</tr>
<tr>
<td>Infertility Services</td>
<td></td>
<td>85% after deductible</td>
</tr>
<tr>
<td>(diagnosis and treatment of the underlying condition only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary Sterilization</td>
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<tr>
<td>(except for tubal ligation)</td>
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<tr>
<td>Maternity Care</td>
<td></td>
<td>A separate deductible will apply to newborn charges incurred after the period of time described in the Federal Notices section.</td>
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<tr>
<td>(except as covered under Preventive Care, such as prenatal preventive care and lactation support)</td>
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<tr>
<td>Tubal Ligation</td>
<td></td>
<td>100% with no deductible</td>
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<tr>
<td>(including associated ancillary services)</td>
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<tr>
<td>HOSPITAL CARE</td>
<td>Plan Pays</td>
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<tr>
<td>Hospital Care</td>
<td></td>
<td>85% after deductible</td>
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<tr>
<td>(room and board covered up to the facility’s semi-private room rate)</td>
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<tr>
<td>Hospital Outpatient Care</td>
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<tr>
<td>SURGERY AND ANESTHESIA</td>
<td>Plan Pays</td>
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<tr>
<td>Inpatient Surgery</td>
<td></td>
<td>85% after deductible</td>
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<tr>
<td>Outpatient Surgery</td>
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<tr>
<td>Anesthesia</td>
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<tr>
<td>ALTERNATIVES TO HOSPITAL CARE</td>
<td>Plan Pays</td>
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<tr>
<td>Skilled Nursing Facility Care</td>
<td></td>
<td>85% after deductible</td>
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<tr>
<td>- up to a maximum of 120 days per calendar year</td>
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<tr>
<td>Home Health Care</td>
<td></td>
<td>85% after deductible</td>
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<tr>
<td>- up to 120 visits per year</td>
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<tr>
<td>Hospice Care</td>
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<tr>
<td>Type of Care</td>
<td>In-Network (Based on negotiated charge)</td>
<td>Out-of-Network (Based on recognized charge)</td>
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<tr>
<td>Private Duty Nursing</td>
<td></td>
<td>85% after deductible</td>
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<tr>
<td>• up to 70 8-hour shifts per calendar year</td>
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<tr>
<td>BEHAVIORAL HEALTH CARE</td>
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<tr>
<td>Inpatient Mental Health and Substance Abuse Treatment</td>
<td></td>
<td>85% after deductible</td>
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<tr>
<td>Outpatient Mental Health and Substance Abuse Treatment</td>
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<tr>
<td>EMERGENCY CARE</td>
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<tr>
<td>Emergency Care</td>
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<td>85% after deductible</td>
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<tr>
<td>Non-Emergency Care in an Emergency Room</td>
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<td>50% after deductible</td>
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<tr>
<td>Ambulance</td>
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<td>85% after deductible</td>
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<tr>
<td>URGENT CARE</td>
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<tr>
<td>Urgent Care Center</td>
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<td>85% after deductible</td>
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<tr>
<td>Care received at Walk-in Clinics</td>
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<tr>
<td>Teladoc Telemedicine Providers</td>
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<td>OTHER COVERED EXPENSES</td>
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<tr>
<td>Diagnostic X-ray and Lab Tests</td>
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<td>85% after deductible</td>
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<tr>
<td>Durable Medical Equipment</td>
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<tr>
<td>Hearing Exams and Hearing Aids</td>
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<tr>
<td>Up to $900 per ear every 36 months</td>
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**Prescription Drug Coverage**

Your coverage includes a prescription drug program that covers prescription drugs taken on an outpatient basis. The prescription drug program is described in the *CSX Prescription Drug Program* section of this booklet.

**Health Savings Account**

The PayFlex Health Fund HSA is an interest-bearing account established on your behalf that works with the CDHP. The PayFlex Health Fund HSA option is available to employees who are enrolled in the CDHP who meet the HSA eligibility requirements described below. Employees who do not meet these requirements may be eligible for the HRA for TRICARE/VA described later in this booklet.
Overview

The PayFlex Health Fund HSA gives you a way to use your health care dollars wisely and to meet your health and financial needs now and in the future:

- **Flexibility**: You can use the funds in your account to pay for current medical expenses, including expenses that your insurance may not cover, or save the money in your account for future needs, such as:
  - Health insurance or medical expenses if unemployed;
  - Medical expenses after retirement (before Medicare);
  - Out-of-pocket expenses when covered by Medicare; or
  - Long-term care expenses and insurance.

- **Savings**: You can save the money in your account for future medical expenses and grow your account through investment earnings.

- **Control**: You make all the decisions about:
  - How much money to put into the account (subject to IRS allowed limits);
  - Whether to save the account for future expenses or pay current medical expenses;
  - Which medical expenses to pay from the account;
  - Which company will hold the account;
  - Whether to invest any of the money in the account; or
  - Which investments to make.

- **Portability**: Accounts are completely portable, meaning you can keep your HSA even if you:
  - Change jobs;
  - Change your medical coverage;
  - Become unemployed;
  - Move to another state; or
  - Change your marital status.

- **Ownership**: Funds remain in the account from year to year. There are no “use it or lose it” rules for HSAs.
• **Tax Saving:** An HSA provides you triple tax savings:
  
  - Tax deductions when you contribute to your account;
  - Tax-free earnings through investment; and
  - Tax-free withdrawals for qualified medical expenses.

**HSA Eligibility**

Section 223(a) of the Internal Revenue Code allows a deduction for contributions to an HSA for an “eligible individual.” To be an eligible individual and qualify for an HSA, you must meet all of the following requirements:

- You are enrolled in a high deductible health plan. The CDHP is considered a high deductible health plan.

- You (as the account holder) are not enrolled in any other health coverage that is not a high deductible health plan. This does not apply to your covered dependent who is not the account holder. However, you can be an eligible individual if your spouse has non-HDHP coverage, as long as you are not covered by that plan. Other types of coverage such as specific injury insurance or accident, disability, dental care, vision care, or long-term care coverage are permitted.

- You are not enrolled in Medicare or TRICARE.*

- You cannot be claimed as a dependent on someone else’s tax return.

*If you are not eligible for an HSA because you (1) are enrolled in Medicare and receiving a monthly Social Security or Railroad Retirement annuity or (2) are enrolled in TRICARE, you may be eligible for the CDHP with an HRA (described below).

You can make contributions to the PayFlex Health Fund HSA while covered under the CDHP.

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<tr>
<td>If you are covered by a health FSA that pays or reimburses all qualified medical expenses, you are not an eligible individual for purposes of making contributions to an HSA. This will apply if, for example, you are covered by a health FSA sponsored by your spouse’s employer. You can only be an eligible individual if you are covered by a “limited purpose” or “post-deductible” health FSA.</td>
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**HSA Contributions**

Contributions to your PayFlex Health Fund HSA can be made by you, your employer or both. However, the total contributions are limited annually. If you make a contribution, you can deduct the contributions (even if you do not itemize deductions) when completing your federal income tax return, if they are initially made on an after-tax basis.
Funding Your Account

Your account is funded from contributions by you (if you choose to contribute) and CSX Corporation (if you are an eligible active full-time employee).

CSX contributes:

- Up to $1,000 to your account each year when you enroll if you elect coverage for yourself only;
- Up to $2,200 each year when you enroll if you elect employee plus child(ren) coverage; or
- Up to $2,000 each year when you enroll if you elect employee plus spouse and child(ren) coverage.

If you are not enrolled for the full calendar year, the above employer contributions are prorated for the number of full months you are enrolled in the plan.

CSX will fund an additional $200 to your account each year if you complete an Aetna Health Assessment through Aetna Navigator at www.aetna.com and obtain a biometric screening from the CSX Wellness Center, Quest Diagnostics, or your own physician. In addition, CSX will fund $200 to your account each year if your spouse (if any) completes an Aetna Health Assessment and obtains a biometric screening. Your spouse can get a biometric screening at Quest Diagnostics or through their physician. To be eligible for these additional contributions, you must have opened a PayFlex Health Fund HSA prior to the first day of the applicable Plan Year.

You may also contribute to your PayFlex Health Fund HSA through regular payroll deduction or by check or funds transfer directly to PayFlex.

The annual maximum in 2017 for all contributions (employee and employer) to an HSA is:

- If you elect coverage for yourself only: $3,400
- If you elect family coverage: $6,750

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<tr>
<td>- If your payroll contributions, plus the Company’s contribution, are less than the annual maximum, you may choose to send in additional tax deductible contributions to PayFlex to make up the difference at any point during the year.</td>
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<tr>
<td>- Contributions to the account must stop once you are enrolled in Medicare. However, you can keep the money in your account and use it to pay for medical expenses tax-free.</td>
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Catch-Up Contributions

If you are age 55 or older, you may make an additional “catch-up” contribution to your PayFlex Health Fund HSA each year until you are eligible for Medicare. This catch-up contribution must be made directly to PayFlex and cannot be payroll deducted.
The 2017 maximum annual catch-up contribution is $1,000.

**Determining Your Contribution**

Your eligibility to contribute to a PayFlex Health Fund HSA for each month is generally determined by whether you have CDHP coverage on the first day of the month. Your maximum contribution for the year is the greater of:

1. *The full contribution.* The full contribution is the maximum annual contribution for the type of medical coverage you have on December 1.

2. *The prorated amount.* The prorated amount is 1/12 of the maximum annual contribution for the type of CDHP coverage you have times the number of months you have that type of coverage. If your contribution is greater than the prorated amount, and you fail to remain covered by the CDHP for the entire following year, the extra contribution above the prorated amount is included in income and subject to an additional 10 percent tax.

Here are two examples to help you understand the contribution rules:

- If you have family CDHP coverage from January 1, 2017 until June 30, 2017, then your Plan coverage ends, you are allowed an HSA contribution of 6/12 of $6,750, or $3,375 for 2017.

- If you have family CDHP coverage from January 1, 2017 until June 30, 2017, and have self-only CDHP coverage from July 1, 2017 to December 31, 2017, you are allowed an HSA contribution of 6/12 of $6,750 plus 6/12 of $3,400, or $5,075 for 2017.

Contributions can be made directly to PayFlex as late as April 15 of the following year.

**Qualified Medical Expenses**

You can use the money in the account to pay for any “qualified medical expense” permitted under federal tax law. This includes most medical care and services, as well as dental and vision care. In general, you cannot use the funds in your HSA to pay for medical insurance premiums, except under specific circumstances, including:

- Any health plan coverage while receiving federal or state unemployment benefits.

- COBRA continuation coverage after leaving employment with a company that offers health insurance coverage.

- Qualified long-term care insurance.

- Medicare premiums and out-of-pocket expenses, including deductibles, co-pays, and coinsurance for:
  - Part A (hospital and inpatient services)
  - Part B (physician and outpatient services)
Part C (Medicare HMO and PPO plans)

Part D (prescription drugs)

You can use the money in the account to pay for medical expenses for yourself, your spouse, or your dependent children. You can pay for expenses of your spouse and dependent children even if they are not covered by the Plan.

Any amounts used for purposes other than to pay for qualified medical expenses are taxable as income and subject to an additional 20 percent tax penalty. Examples of expenses that are not qualified include:

- Medical expenses that are not considered “qualified medical expenses” under federal tax law (i.e., cosmetic surgery);
- Other types of health insurance unless specifically described above;
- Medicare supplement insurance premiums; and
- Expenses that are not medical or health-related.

After you turn age 65, the additional tax penalty no longer applies. If you become disabled and/or enroll in Medicare, the account can be used for other purposes without paying the additional penalty.

**Using the Funds in Your Account**

You will be given a PayFlex HSA debit card when you enroll in the CDHP with an HSA. You can use your debit card to pay for qualified expenses from your PayFlex HSA. A complete list of HSA-qualified expenses can be found at:


If you do not have your debit card with you when paying for qualified expenses, you can reimburse yourself from your account. You can also choose to pay those expenses out-of-pocket and save your HSA funds for future health-related or other qualified expenses.

**Keep in Mind**

- Save receipts from all transactions associated with HSA contributions and withdrawals for your tax records.

**Save for Future Health Care Expenses**

Your account can grow. Unused funds earn tax-free interest, with no minimum balance requirement. If you have money left in your account at the end of the year, it is rolled over to the following year and continues to accrue interest. Once your PayFlex Health Fund HSA exceeds $1,000, you can invest your HSA funds in certain investments through PayFlex.
You own your PayFlex Health Fund HSA. If you change plans or terminate employment with CSX Corporation, you can keep your account but become responsible for any administration fees.

**Tax Advantages**

Not only can you save money for the future, your PayFlex Health Fund HSA can help you save money on your taxes now!

- Contributions you make to your PayFlex Health Fund HSA through payroll deduction are made with pre-tax dollars. That lowers your taxable income, so you pay lower federal income taxes and Social Security taxes.
- If you make contributions to your HSA using after-tax dollars (money that has already been subject to income tax), your contributions are tax-deductible.
- The money you withdraw from your HSA to pay for qualified expenses is not taxable.
- The interest on your HSA funds is tax-free.

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<th>Keep in Mind</th>
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<tr>
<td>• You can track your account activity online by logging in to Aetna Navigator at <a href="http://www.aetna.com">www.aetna.com</a>.</td>
</tr>
<tr>
<td>• Call Aetna Member Services at 1-800-874-1458 if you have any questions about your PayFlex Health Fund HSA.</td>
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**What Happens to My PayFlex Health Fund HSA When I Die?**

If you are married, your spouse will become the owner of your account. Your spouse can use it as if it were their own HSA. If you are not married, the account will no longer be treated as an HSA upon your death. The account will pass to your beneficiary or become part of your estate (and be subject to any applicable taxes).

**Aetna Health Reimbursement Arrangements**

Participants who are ineligible for the PayFlex Health Fund HSA because they (1) are enrolled in Medicare and are receiving a Social Security or Railroad Retirement annuity, (2) are enrolled in TRICARE, or (3) or have received Veterans health Benefits in the past 90 days may be eligible for a Health Reimbursement Arrangement (“HRA”).

The Plan Sponsor credits amounts to the HRA throughout the plan year. The account may be utilized to pay qualified out-of-pocket healthcare expenses including, but not limited to, copays, deductibles, prescription drugs, dental care, vision care, chiropractic care, and certain over-the-counter items.
Eligibility

The HRA is available only to Participants who are not eligible to participate in the HSA because they (1) are enrolled in Medicare and receiving a Social Security or Railroad Retirement annuity, or (2) are enrolled in TRICARE.

HRA Accounts

CSX will establish a separate recordkeeping account for each Participant who is enrolled in an HRA. Company credits will be credited separately to each individual’s HRA account.

Funding Your Account

Your HRA account is funded by CSX Corporation. Annual credits to the account (which are credited pro rata on a monthly basis are):

- Up to $1,000 to your account each year when you enroll if you elect coverage for yourself only;
- Up to $2,200 each year when you enroll if you elect employee plus child(ren) coverage; or
- Up to $2,000 each year when you enroll if you elect employee plus spouse and child(ren) coverage.

If you are not enrolled for the full calendar year, these amounts are prorated for the number of full months you are enrolled in the plan.

Reimbursements

You can be reimbursed from your HRA account for any “qualified medical expense” permitted under federal tax law. This includes most medical care and services, as well as dental and vision care. Refer to www.irs.gov for an up-to-date list of qualified medical expenses.

You can be reimbursed from your HRA account for medical expenses for yourself, your spouse, or your dependent children. You can pay for expenses of your spouse and dependent children even if they are not otherwise covered by your Plan.

A Participant may be reimbursed only after the qualified medical expense is incurred. A Participant may not obtain reimbursement for expenses incurred prior to an HRA account being established for the Participant or after the date on which the Participant’s eligibility for the HRA ends. However, the Participant may request reimbursement within 180 days after the date that his eligibility for the HRA ends for qualified medical expenses incurred prior to the date that his eligibility ends.

If the qualified medical expense was incurred at a network provider, then the reimbursement request is automatically filed. If the qualified medical expense is incurred outside the network or over-the-counter, then a Participant can complete a claim form and submit it to Aetna. Claim forms are available in the Aetna Navigator accessible at www.aetna.com.
**Accounting**

A Participant’s HRA account will be debited by the amount of qualified medical expenses incurred. The maximum amount of reimbursement at any time during the plan year may not exceed the amount credited to the HRA account.

The HRA account reimburses qualified medical expenses only to the extent that such expenses are not paid by any prepaid health coverage, group health plan, medical insurance, or otherwise and not attributable to a deduction allowed under Section 213 of the Internal Revenue Code for any prior taxable year.

Any unused balance in a Participant’s HRA account at the end of the plan year shall remain in the HRA account and be available for reimbursement of qualified medical expenses incurred in future years.

If the Plan Administrator determines that any Participant has directly or indirectly received excess reimbursements or has received reimbursements that are taxable to the Participant, then the Plan Administrator will notify the Participant of the excess amount and the Participant will be required to repay upon receipt of such notification. In addition, the Plan Administrator may offset the excess reimbursement against any other qualified medical expenses submitted for reimbursement (regardless of the plan year in which submitted). A Participant shall indemnify and reimburse CSX for any liability that CSX may incur for making such payments, including, but not limited to, the failure to withhold taxes from such reimbursements.

**Termination, Retirement or Death of a Participant**

Upon the termination of employment or the death of a Participant, any remaining balance in his or her HRA account is immediately forfeited; provided, however, that no later than 180 days after the Participant’s death, the Participant’s estate or representative may submit claims for reimbursements for qualified medical expenses that were incurred prior to the Participant’s death. Only in the event of a Participant’s retirement and election to participate in the CDHP under the CSX Corporation Retired or Disabled Employee Medical, Dental and Prescription Drug Plan is the Participant able to roll over the balance in his or her HRA account.
What the CDHP Covers

The Plan pays benefits only for services and supplies that are covered by the Plan and medically necessary. Aetna determines whether a covered medical expense is medically necessary. Services and supplies listed here as covered expenses will not be covered if Aetna determines that they are not medically necessary to treat your disease or injury, even if they are prescribed, provided, recommended, or approved by your physician or another health care provider.

Wellness Benefits

The Plan covers certain preventive care services; however, frequency limits may apply. Refer to the Summary of Benefits for the frequency limits that apply to these services. The Plan is required by law to cover the following preventive care services:

- Evidence-based items or services rated A or B by the US Preventive Services Task Force;
- Immunizations;
- Preventive care and screenings for infants, children and adolescents; and
- Prevent care and screenings for women.

Periodic Physical Exams

Covered expenses include charges made by your physician for routine physical exams. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control.

A dependent child's exam must include:

- An initial hospital check up and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
● Exams given during your stay for medical care;
● Services not given by a physician or under his or her direction; or
● Psychiatric, psychological, personality or emotional testing or exams.

**Regular Gynecological Exams**

The Plan covers one gynecological exam, including a Pap smear, per calendar year.

**Cancer Screenings**

The Plan covers:

● One mammogram each calendar year for women age 35 and over;
● One digital rectal exam (DRE) and prostate specific antigen (PSA) test per calendar year for men;
● One annual fecal occult blood stool test beginning at age 50;
● One colonoscopy every 10 years beginning at age 50;
● One sigmoidoscopy every 5 years beginning at age 50; and
● One lung cancer screening each calendar year beginning at age 55.

**Screening and Counseling Services**

The Plan covers charges made by your physician in an individual or group setting for the following:

● **Obesity and/or Healthy Diet.** Screening and counseling services to aid in weight reduction due to obesity including:
  - Preventive counseling visits and/or risk factor reduction intervention;
  - Nutrition counseling; and
  - Healthy diet counseling visits provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

● **Misuse of Alcohol and/or Drugs.** Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

● **Use of Tobacco Products.** Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing
tobacco or nicotine including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products containing tobacco. Coverage includes

- Preventive counseling visits;
- Treatment visits; and
- Class visits.

- **Sexually Transmitted Infections.** Covered expenses includes the counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic Risks for Breast and Ovarian Cancers.** Covered expenses include the counseling and evaluation services to help you assess your breast and ovarian cancer susceptibility.

Benefits for these screening and counseling services above are subject to any visit maximums shown in the *Summary of Benefits* above. Unless otherwise specified, these screening and counseling services are not covered as preventive care to the extent the services are otherwise covered under any other part of this Plan.

**Physician Services**

**Office, Home, and Hospital Visits**

The Plan covers:

- Charges for a physician’s visit to your home to treat an illness or injury;
- Charges for surgical and non-surgical visits to a physician’s office to treat an illness or injury, including allergy testing and treatment;
- Physician visits while you are confined in a hospital; and
- Visits to your obstetrical care provider and related diagnostic testing during your pregnancy and following delivery.

**Family Planning**

The Plan covers family planning services, including:

- Voluntary sterilization;
- Contraceptive implants and devices, including the associated office visit; and
- Diagnosis and treatment of the underlying cause of infertility.
Treatment of Infertility

The Plan covers charges made by a hospital or physician for services to diagnose and treat the underlying cause of infertility. To be eligible, your physician must diagnose you as infertile, and the diagnosis must be documented in your medical records.

Infertility Service Limits

The Plan does not cover:

- Ovulation induction and intrauterine insemination;
- Infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Infertility services for covered females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm;
- The purchase of donor eggs;
- The care of the donor required for donor egg retrievals or transfers;
- The services of a gestational carrier or surrogate, including programs for gestational carriers or surrogate parenting for the member or gestational carrier;
- Donor egg retrieval or fees associated with donor egg programs;
- Cryopreservation and storage, transfer or thawing of cryopreserved eggs and embryos, including any associated services
- Home ovulation prediction kits;
- Prescription drugs, including injectable infertility medications; or
- Any advanced reproductive technology (ART) procedures or services related to such procedures, including (but not limited to) in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and intra-cytoplasmic sperm injection (ICSI).

Prenatal Care

Prenatal care will be covered for services received in the office of a physician, obstetrician or gynecologist. Such coverage is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams (i.e., maternal weight, blood pressure, fetal heart rate check, and fundal height). Unless otherwise specified, these prenatal care benefits are limited to the extent such services are otherwise covered under this Plan or constitute a pregnancy expense (other than prenatal care as described below).
**Maternity Care**

The Plan pays benefits for pregnancy-related expenses on the same basis as it would for a medical condition including that preventive care items such as prenatal care and lactation support are paid as preventive care. For inpatient care of the mother and newborn child, benefits will be payable for a minimum of:

- 48 hours after a vaginal delivery; or
- 96 hours after a cesarean section.

Precertification is not required for the first 48 hours of hospital confinement after a vaginal delivery or 96 hours after a cesarean delivery. Any days of confinement over these limits must be precertified. You, your doctor, or other health care provider can request precertification by calling the number on your ID card.

To be covered, expenses must be incurred while you are covered by the Plan. Any pregnancy benefits payable by a previous group medical plan will be subtracted from the benefits payable under this Plan.

**Comprehensive Lactation Support and Counseling Services**

The Plan covers comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy, or at any time following delivery, for breast-feeding by a certified lactation support provided. These services are covered whether provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in the *Summary of Benefits* above.

The Plan also covers the rental or purchase of breast feeding equipment for purposes of lactation support (pumping and storage of breast milk) as follows.

- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a hospital.
- The purchase of:
  - An electric breast pump (non-hospital grade), the purchase of which is covered once every three years; or
  - A manual breast pump, the purchase of which is covered once per pregnancy.

Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump. Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility. Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna. Unless otherwise specified, these services are not covered to the extent otherwise covered under the Plan.
Short-Term Therapy Services

The Plan covers short-term therapy services when prescribed by a physician. The services have to be performed on an outpatient basis by a licensed or certified physician, occupational therapist or speech therapist.

If you are home-bound, therapy services may be provided in your home.

Covered therapy is limited to the following types of therapy services:

- **Speech therapy**, if the therapy is:
  - Expected to restore the speech function or correct a speech impairment resulting from illness or injury, including:
    - Autism;
    - Brain injury due to organic brain lesion (aphasia);
    - Cerebral thrombosis; or
    - Removal of vocal chords.
  - For delays in speech function development as a result of a gross anatomical defect present at birth.

Speech function is the ability to express thoughts, speak words, and form sentences. Speech impairment is difficulty expressing one’s thoughts with spoken words. Additionally, the coverage for speech therapy is available for the treatment of Pervasive Developmental Disorders/Autism Spectrum Disorders, Down’s Syndrome, and Cerebral Palsy (as an exception to the above non-chronic condition coverage criteria).

- **Physical therapy**, provided the therapy expects to significantly improve, develop, or restore physical functions lost or impaired as a result of an acute illness, injury, or surgical procedure.

- **Occupational therapy**, provided the therapy expects to significantly improve, develop, or restore physical functions lost or impaired as a result of an acute illness, injury, or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.

- **Autism Spectrum Disorder therapy**, provided the therapy is for the diagnosis and treatment (including routine behavioral health services such as office visits or therapy and Applied Behavioral Analysis) of Autism Spectrum Disorder when ordered by a physician, licensed psychologist, or licensed clinical social worker, as part of a treatment plan and the covered member to age 21 is diagnosed with Autism Spectrum Disorder. Applied Behavioral Analysis is an educational service that is the process of
applying interventions that systematically change behavior and are responsible for the observable improvement of behavior.

The therapy should be expected to result in significant, objective, measurable physical improvement of a lost or impaired body function (including the restoration of the level of an existing speech function) within 60 days from the date the therapy begins.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

The Plan does not cover:

- Any services that are not provided in accordance with a specific treatment plan;
- Services not performed by a physician or under the direct supervision of a physician;
- Services provided by a physician or physical, occupational, or speech therapist who resides in your home or who is a member of your family, or a member of your spouse’s family;
- Services and supplies that a school system is required by law to provide;
- Speaking aids or training in the use of such aids; or
- Special education to teach you, if your ability to speak has been lost or impaired, to function without that ability. This includes (but isn’t limited to) lessons in sign language.

**Spinal Disorder Treatment**

The Plan covers charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

**Hospital Care**

The Plan covers charges made by a hospital for room and board and other hospital services and supplies when you are confined as an inpatient. Room and board charges are covered up to the hospital’s semi-private room rate.

Room and board charges include:

- Services of the hospital’s nursing staff;
- Admission fees;
- General and special diets; and
• Sundries and supplies.

The Plan also covers other services and supplies provided during your inpatient stay, such as:

• Ambulance services when the service is owned by the hospital;
• Physician and surgeon services;
• Operating and recovery rooms;
• Intensive or special care facilities;
• Administration of blood and blood derivatives, but not the cost of the blood or blood product;
• Radiation therapy, physical therapy, and occupational therapy;
• Oxygen and oxygen therapy;
• X-rays, lab tests, and diagnostic services;
• Medications; and
• Social services planning.

Keep in Mind

- Room and board charges for a private room during your stay that exceed the hospital’s semi-private room rate are not covered unless a private room is medically necessary because of a contagious illness or a weak or compromised immune system.
- If a hospital does not itemize room and board charges, as well as other charges, Aetna will assume that 40 percent of the total is for room and board and 60 percent is for other charges.

Surgery

Outpatient Surgery

The Plan covers outpatient surgery in:

• The office-based surgical facility of a physician or dentist;
• A surgery center; or
• The outpatient department of a hospital.

The surgery must meet all of the following requirements:

• The surgery is not expected to:
- Result in extensive loss of blood,
- Require major or prolonged invasion of a body cavity, or
- Involve major blood vessels.
- The surgery can be performed adequately and safely only in a surgery center or hospital; or in an office-based surgical facility.
- The surgery is not normally performed in a physician’s or dentist’s office.

The Plan covers the following outpatient surgery expenses:
- Services and supplies provided by the hospital, surgery center, or office-based surgical facility on the day of the procedure; and
- The operating physician’s services for performing the procedure, related pre- and post-operative care, and administration of anesthesia.

The Plan does not cover:
- The services of a physician who renders technical assistance to the operating physician.
- Charges made during a stay in a hospital.

### Keep in Mind

The Plan covers reconstructive and cosmetic surgery if the surgery is needed to:
- Improve the function of a body part that is malformed:
  - As the result of a birth defect, such as a harelip or webbed fingers or toes,
  - As the result of an illness, or
  - As the direct result of a covered surgery.
- Repair an injury, if the surgery is performed in:
  - The calendar year of the accident that caused the injury, or
  - The following calendar year.
- Improve, alter, or enhance the appearance of a body part that is malformed as the result of a birth defect. These services are covered although they are not for the diagnosis or treatment of an injury or illness.
- Treat gender dysphoria if medically necessary.

### Anesthesia

The Plan will pay for the administration of anesthetics by a physician or registered nurse anesthetist in connection with a covered procedure.
Oral Surgery

The Plan covers oral surgery, as follows:

- When needed as the result of accidental injury, including:
  - Care of a jaw fracture, dislocation, or wound.
  - Treatment of accidental injury to sound natural teeth or tissues of the mouth.

You must be covered by the Plan at the time of the injury, and treatment must take place in the calendar year of the injury or in the next following year.

- To remove a cyst or tumor;
- To treat temporomandibular joint (TMJ) disorder; and
- Orthognathic (jaw) surgery.

**Keep in Mind**

If you and your physician are considering jaw surgery or surgery for a TMJ disorder, you are encouraged to contact Aetna Member Services before the surgery is performed. Claims for surgical treatment of TMJ disorder must be approved by an Aetna Medical Director.

The Medical Director will review your proposed treatment, and Aetna will let you know what benefits will be paid by the plan based on the information provided. You and your physician can then decide how to proceed. The advance review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid to help you make an informed decision about your care.

The Medical Plan does not cover:

- Treatment of teeth lost or damaged in the course of biting or chewing;
- Fillings, crowns, dentures, or bridgework;
- Dental implants;
- Routine tooth removal that does not require cutting of the bone;
- In-mouth appliances, except as needed to treat accidental injury;
- Non-surgical periodontal treatment;
- Dental cleaning, scaling, planning, or scraping;
- Myofunctional therapy; or
- Root canal therapy, unless related to the treatment of injury.
Refer to the section of this Summary Plan Description describing the Dental Plan for a description of oral surgery expenses that are covered under the Dental Plan.

**Transplant Services**

The Plan covers:

- Evaluation;
- Compatibility testing of prospective organ donors who are family members;
- Charges for activating the donor search process with national registries;
- The direct costs of obtaining the organ. Direct costs include surgery to remove the organ, organ preservation and transportation, and hospitalization of a live donor provided that the expenses are not covered by the donor’s group or individual health plan;
- **Physician** services or transplant team for transplant expenses;
- **Hospital** inpatient and outpatient supplies and services; and
- Follow-up care.

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<thead>
<tr>
<th>Keep in Mind</th>
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<tbody>
<tr>
<td>- To ensure coverage, all transplant procedures need to be precertified by Aetna. Refer to <em>Overview of Your Medical Benefits</em> for details about precertification.</td>
</tr>
<tr>
<td>- Refer to the <em>Special Programs</em> section to learn about the National Medical Excellence Program.</td>
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</table>

As part of the transplant benefit, the Plan does **not** cover:

- Services and supplies provided to a donor when the recipient is not covered by this Plan;
- Outpatient drugs, including biomedicals and immunosuppressants, except as provided above;
- Home infusion therapy, except as provided above; or
- Harvesting of organs, bone marrow or stem cells for storage purposes.

Aetna offers a wide range of support services to those who need a transplant or other complex medical care. If you need a transplant, you or your physician should contact Aetna’s National Medical Excellence Program® at 1-877-212-8811. A nurse case manager will provide the support and help as you and your physician make informed decisions about your care. Refer to *Special Programs* for more information about the National Medical Excellence Program.
The Institutes of Excellence™ Network (IOE)

Through the IOE network, you have access to a provider network that specializes in transplants. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need.

You can receive care for the conditions listed in the following chart through the IOE Program.

<table>
<thead>
<tr>
<th>Transplants</th>
<th>Other Complex Medical Conditions</th>
</tr>
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<tbody>
<tr>
<td>bone marrow</td>
<td>cancer treatment</td>
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<tr>
<td>cochlear</td>
<td>coronary artery bypass surgery</td>
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<tr>
<td>corneal</td>
<td>cranial/facial reconstructive surgery</td>
</tr>
<tr>
<td>heart</td>
<td>head or spinal injury rehabilitation</td>
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<tr>
<td>heart and lung</td>
<td>neurosurgery</td>
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<tr>
<td>intestinal (small bowel)</td>
<td>pediatric open heart surgery</td>
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<tr>
<td>kidney</td>
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<tr>
<td>kidney and pancreas</td>
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<td>liver</td>
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<td>lung</td>
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<tr>
<td>pancreas</td>
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Treatment of Severe Obesity

The Plan covers one surgical procedure to treat morbid obesity within a two-year period. If you qualify under your physician’s care for bariatric surgery, you will be required to use an Aetna Institute of Quality Bariatric Surgery provider. Institutes of Quality® (IOQ) Bariatric Surgery facilities are a national network of health care facilities designated based on measures of clinical performance, access, and efficiency for bariatric surgery. Bariatric surgery, also known as weight loss surgery, refers to various surgical procedures to treat people living with morbid, or extreme obesity. Contact Aetna at 1-800-874-1458 for Institutes of Quality Bariatric Surgery facilities.

You must meet all of the following criteria to be eligible for coverage:

- You have been morbidly obese for at least five years;
- You are age 18 or older, or you have documentation that your bone growth is complete;
- Your previous weight reduction efforts have not succeeded; and
● You have completed either:
  – A six-month physician-supervised nutrition and exercise program within two years prior to the surgery, or
  – A multidisciplinary surgical preparatory regimen.

The Claims Administrator will determine whether all of the criteria have been met before approving coverage of the surgery.

### Keep in Mind

- Treatment guidelines are subject to change. Consult Aetna’s Clinical Policy Bulletins (CPB) for current information. The CPBs can be found on Aetna’s website ([www.aetna.com](http://www.aetna.com)). Click on Members: public information / Health Coverage Information / Clinical Policy Bulletins.

### Alternatives to Hospital Care

**Home Health Care**

The Plan covers home health care services when ordered by a **physician**, provided you are transitioning from a **hospital**, and the services are in lieu of a continued inpatient stay.

**Home health care** expenses are covered if:

- the charge is made by a **home health care agency**;
- the care is given under a home health care program; and
- the care is given to a person in his or her home.

**Home health care** expenses are charges for:

- part-time or intermittent care by an **R.N.**, or by an **L.P.N.** if an **R.N.** is not available;
- part-time or intermittent home health aide services for patient care;
- physical, occupational and speech therapy; and
- medical supplies, drugs and medicines prescribed by a **physician** and lab services provided by or for a **home health care agency** to the extent they would have been covered under this **Plan** if the person had been confined in a **hospital** or convalescent facility.

Benefits will be paid for no longer than the Home Health Care Maximum Number of Visits in any one calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.
Keep in Mind

The plan does not cover:
- services or supplies that are not a part of the home health care program;
- services of a person who usually lives with you or is a member of your family;
- services of a social worker;
- transportation; or
- services that are considered custodial care.

Hospice Care

Covered expenses include charges made by the following furnished to you for hospice care when given as part of a hospice care program.

Facility Expenses

The charges made by a hospital, hospice or skilled nursing facility for:
- **Room and Board** and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you by the facility on an outpatient basis.

Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a Hospice Care Agency for:
- Part-time or intermittent nursing care by a R.N. or L.P.N. for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day;
- Medical social services under the direction of a physician. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs;
- Physical and occupational therapy;
- Consultation or case management services by a physician;
- Medical supplies;
● Prescription drugs;
● Dietary counseling; and
● Psychological counseling.

Charges made by the providers below if they are not an employee of a Hospice Care Agency and such Agency retains responsibility for your care:

● A physician for a consultation or case management;

● A physical or occupational therapist;

● A home health care agency for:
  
  − Physical and occupational therapy;
  
  − Part time or intermittent home health aide services for your care up to eight hours a day;
    
    o Medical supplies;
    
    o Prescription drugs;
    
    o Psychological counseling; and
  
  − Dietary Counseling.

Limitations

Unless specified above, the following charges are not covered under this benefit:

● Daily room and board charges over the semi-private room rate;

● Funeral arrangements;

● Pastoral counseling;

● Financial or legal counseling, including estate planning and the drafting of a will; and

● Homemaker or caretaker services. (These are services that are not solely related to your care and include, but are not limited to: sitter or companion services for either you or other family members; transportation; or maintenance of the house).

Keep in Mind

Inpatient hospice care and home health care must be precertified by Aetna. Refer to How the Plan Works for details about precertification.
Private Duty Nursing

The Plan covers charges made by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for private duty nursing if a person’s condition requires skilled nursing services and visiting nursing care is not enough.

The Plan pays benefits for up to 70 shifts of private duty nursing care per calendar year. A “shift” consists of up to 8 hours of skilled nursing care.

The Plan does not cover:

- Any care that does not require the education, training, and technical skills of a R.N. or L.P.N. This would include transportation, meal preparation, charting of vital signs, and companionship activities;
- Any private duty nursing care provided on an inpatient basis;
- Care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting;
- Nursing care that consists only of skilled observation, except for up to 4 hours per day up to 10 days in a row when observation is needed after:
  - A change in patient medication,
  - Treatment by a doctor for an emergency condition, or the appearance of symptoms that indicate such treatment may be needed,
  - Surgery, or
  - Release from inpatient confinement; or
- Any service provided only to administer oral medicines, except where the law requires medication to be administered by a R.N. or L.P.N.

Skilled Nursing Facility

The Plan covers charges made by a skilled nursing facility during your stay, up to the maximum shown in the Summary of Benefits, including:

- Room and board, up to the semi-private room rate. The Plan covers up to the private room rate if it is appropriate due to an infectious illness or a weak or compromised immune system; and
- General nursing services.

You must meet all of the following conditions:

- The skilled nursing facility admission will take the place of an admission to, or continued stay in, a hospital;
● There is a reasonable expectation that your condition will improve sufficiently to permit discharge to your home within a reasonable amount of time; and

● The illness or injury is severe enough to require constant or frequent skilled nursing care on a 24-hour basis.

**Behavioral Health Care**

The Plan covers the treatment of **mental illness** and substance abuse by behavioral health providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan;
- The treatment plan is supervised by an appropriate behavioral health provider; and
- The treatment plan includes follow-up treatment.

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<th>Keep in Mind</th>
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<tr>
<td>● Not all types of services are covered. For example, educational services and certain types of therapies are not covered.</td>
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<tr>
<td>● Precertification is required for inpatient behavioral health care. See <em>Precertification</em> for more information.</td>
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</tbody>
</table>

**Treatment of Mental Illness**

The Plan covers the charges made by a **physician** for inpatient or outpatient treatment of a mental illness.

**Inpatient**

The Plan covers the services of a physician provided while you are a full-time inpatient in a **hospital** or **residential treatment facility**, appropriately licensed by the Department of Health or equivalent.

**Outpatient**

The Plan covers short-term evaluation and crisis intervention mental health services provided on an outpatient basis.

**Substance Abuse Treatment**

The Plan covers the charges made by a **physician** for inpatient or outpatient treatment of a mental illness. The Plan does **not** cover substance abuse treatment if the primary purpose of the treatment plan is:

- Detoxification and the aftereffect of a specific drinking or drug abuse episode; or
- Maintenance care, such as the provision of an environment free of alcohol or drugs.

**Inpatient**

The Plan covers the services of a physician provided while you are a full-time inpatient in a hospital or residential treatment facility that is appropriately licensed by the Department of Health or equivalent.

The Plan covers inpatient treatment:

- For medical complications of alcoholism or drug abuse in a hospital. Medical complications include detoxification, cirrhosis of the liver, delirium tremens, and hepatitis.
- For alcoholism or drug abuse in a hospital or residential treatment facility. Treatment in a hospital is covered by the Plan only when the hospital does not have a separate treatment facility section.

**Outpatient**

The Plan covers effective treatment of substance abuse you receive when you are not a full-time inpatient in a hospital or treatment facility.

**Other Covered Health Care Services**

**Ambulance Services**

The Plan covers the services of a professional ambulance. Conditions of coverage vary depending on the type of vehicle used.

**Ground Ambulance**

The Plan covers charges for transportation:

- In a medical emergency to the first hospital where treatment is given;
- In a medical emergency from one hospital to another hospital when the first hospital does not have the required services or facilities to treat your condition;
- From hospital to home or to another facility when other means of transportation would be considered unsafe; and
- Transportation while confined in a hospital or skilled nursing facility to receive medically necessary inpatient or outpatient treatment when an ambulance is required for safe and adequate transport.

**Air Ambulance**

The Plan covers charges for transportation by air ambulance from one hospital to another hospital in a medical emergency when:
The first hospital does not have the required services or facilities to treat your condition; and

- The condition is unstable, and requires medical supervision and rapid transport.

### Keep in Mind

The Plan will not cover expenses or charges incurred to transport you:

- if ambulance service is not required by your physical condition,
- if the type of ambulance service provided is not required for your physical condition, or
- by any form of transportation other than a professional ambulance service.

### Chemotherapy

The Plan covers chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and in other limited circumstances.

### Durable Medical and Surgical Equipment

The Plan covers the rental of durable medical and surgical equipment (DME) or, in lieu of rental:

- The initial purchase of DME if:
  - There is a long term need, and
  - The equipment cannot be rented or is likely to cost less to buy than to rent.
- Repair of purchased equipment.
- Replacement of equipment you bought if:
  - The replacement is needed because of a change in your physical condition, and
  - It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

Durable medical and surgical equipment is equipment suitable for use in the home that is made to withstand prolonged use and is mainly used in the treatment of an illness or injury. It is not normally of use to people who do not have an illness or injury. Examples of covered durable medical and surgical equipment include wheelchairs, crutches, and oxygen for home use.

### Keep in Mind

The Plan limits coverage to one item of equipment, plus the accessories needed to operate the item, for the treatment of each illness or injury.
The following items are not considered durable medical and surgical equipment:

- Equipment used to alter air quality or temperature;
- Exercise and training devices;
- Whirlpools;
- Portable whirlpool pumps;
- Sauna baths;
- Massage devices;
- Over-bed tables;
- Elevators;
- Communication aids;
- Vision aids; and
- Telephone alert systems.

**Medical Supplies**

The Plan covers certain medical supplies for the treatment of illness and injuries, such as ostomy supplies and syringes for the administration of covered medications. Refer to *What the CDHP Does Not Cover* for details about excluded medical supplies.

**Prosthetic Devices**

The Plan covers internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been removed or damaged by illness or injury.

The Plan covers the first prosthesis you need to replace all or part of any lost or impaired:

- Internal body part or organ; or
- External body part.

The list of covered devices includes:

- Artificial arm, leg, hip, knee or eye;
- External breast prosthesis and the first bra made solely for use with it after a mastectomy;
- Breast implant after a mastectomy;
- Ostomy supplies;
- Cardiac pacemaker; and
- Durable brace that is specially made for and fitted for you.

The Plan does **not** cover expenses and charges for, or expenses related to:

- Eyeglasses, contact lenses, dental aids, vision aids, or communication aids;
- Orthopedic shoes, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies; except orthotics when medically necessary; or
- Trusses, corsets, and other support items.

**Repair or Replacement of Prosthesis**

The Plan covers replacement costs for a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

**Radiation Therapy**

The Plan covers the treatment of illness by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

**Clinical Trials**

The Plan covers **experimental or investigational** drugs, devices, treatments or procedures under “an approved clinical trial” only when you have cancer or a terminal illness, and all of the following conditions are met.

- Standard therapies have not been effective or are inappropriate;
- Aenta determines, based on published, peer-reviewed scientific evidence that you may benefit from the treatment; and
- You are enrolled in an “approved clinical trial” that meets the below criteria.

An “approved clinical trial” meets the following criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This
requirement does not apply to procedures and treatments that do not require FDA approval.

- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.

- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization

- The trial conforms to standards of the NCI or other applicable federal organization.

- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.

- You are treated in accordance with the protocols of that study.

The Plan will cover charges made by a provider for “routine patient costs” furnished in connection with your participation in an approved clinical trial for cancer or other-life threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709. Coverage under this section is limited by the terms of the What the CDHP Does Not Cover section below.
What the CDHP Does Not Cover

The Plan does not cover every health care service or supply, even if prescribed, recommended, or approved by your physician or dentist. The Plan covers only the services and supplies that are described in What the CDHP Covers.

The Plan does not cover the following:

- Acupuncture and acupuncture therapy, except when performed by a physician as a form of anesthesia in connection with covered surgery.
- Artificial organs.
- Bioenergetic therapy.
- Blood, blood plasma, or other blood derivatives or substitutes, and any related services, including processing, storage or replacement costs, and the services of blood donors. For autologous blood donations, only administration and processing costs are covered.
- Cancelled or missed appointment charges.
- Carbon dioxide therapy.
- Charges incurred due to injuries received in an accident involving any motor vehicle for which no-fault insurance is available, regardless of whether any such policy is designated as secondary to health coverage.
- Charges that exceed recognized charges for a service or supply given by an out-of-network provider, as determined by the Claims Administrator;
- Charges that exceed the recognized charge for a service or supply given by an in-network provider.
- Chelation therapy (except for heavy metal poisoning).
- Counseling services, including marriage, family, career, social adjustment, pastoral and financial counseling, except as specifically described in What the CDHP Covers.
- Court ordered services, including those required as a condition of parole or release.
- Custodial care.
- Dental services and supplies, except as described in What the CDHP Covers.
- Disposable outpatient supplies, including sheaths, bags, elastic garments, bandages, syringes, blood or urine testing supplies, and home test kits, except as specifically provided in What the CDHP Covers.
● Educational services (except in the form of Applied Behavioral Analysis, as defined in What the CDHP Covers, as provided for the treatment of Autism Spectrum Disorders and other behavioral health conditions, as prescribed by a physician) including:
  
  – Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
  
  – Evaluation or treatment of learning disabilities, minimal brain dysfunction, learning and behavioral disorders, training or cognitive rehabilitation (regardless of the underlying cause); and
  
  – Services, treatment, and educational testing related to behavioral (conduct) problems, learning disabilities, and delays in developing skills.

● Examinations and treatments, including special medical reports, not directly related to treatment:
  
  – Required by employers as a condition of employment,
  
  – Which an employer is required to provide under a labor agreement, or
  
  – Required by any law of a government, insurers, schools, camps, courts, licensing authorities, or other third parties.

● Experimental or investigational drugs, devices, treatments, or procedures, except as described in What the CDHP Covers. This exclusion includes:
  
  – Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e., protocol induced costs);
  
  – Services and supplies provided by the trial sponsor without charge to you; and
  
  – The experimental invention itself (except medically necessary investigational devices and promising experimental or investigational interventions for terminal illness in certain clinical trials in accordance with Aetna’s claim policies).

● Food items, nutritional supplements, vitamins, medical foods, and formulas, even if they are the sole source of nutrition.

● Foot care: Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:
  
  – Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
  
  – Shoes (including orthopedic shoes), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury.
● Full body CT scans.
● Hair analysis.
● Home births.
● Household improvements and equipment, including the purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses, waterbeds, ramps, elevators, handrails, stair glides, and swimming pools.
● Hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery.
● Implantable drugs.
● Infertility treatment, including expenses related to artificial insemination, in vitro fertilization, or embryo transfer, except as specifically provided in What the CDHP Covers.
● All self-injectable and certain specialty drugs. These would fall under your Prescription Drug Plan through CVS Caremark.
● Lovaas therapy.
● Maintenance care, except as specifically provided in What the CDHP Covers.
● Megavitamin therapy.
● Outpatient drugs and medicines, except as described in What the CDHP Covers.
● Plastic, reconstructive, and cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in What the CDHP Covers.
● Primal therapy.
● Private duty nursing, except as specifically provided in What the CDHP Covers.
● Psychodrama.
● Purging.
● Recreational therapy.
● Rolfing.
- Routine eye exams, routine dental exams, routine hearing exams, and other preventive services and supplies, except as specifically provided in *What the CDHP Covers*. These services may be covered under the dental and vision plans available to you in addition to your medical plan.

- Sensory or auditory integration therapy.

- Services and supplies for which payment was made under Medicare Parts A and B, or would have been made if you had claimed benefits. This exclusion applies if you are eligible for Medicare, even if you do not apply for or claim benefits. It does not apply if, in accordance with federal law, this Plan is primary and Medicare is the secondary payer of your health care expenses.

- Services and supplies for which you do not have a legal obligation to pay, or for which no charge would be made if you did not have coverage under the Plan. Examples include:
  - Care in charitable institutions,
  - Care for conditions related to military service,
  - Care while in the custody of a governmental authority, and
  - Any care that a public facility is required to provide.

- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury.

- Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

- Services and supplies provided in connection with treatment of an occupational illness or occupational injury.

- Services and supplies provided in connection with treatment or care that is not covered under the Plan.

- Services and supplies related to the care, treatment, removal, or replacement of teeth, and the care or treatment of the gums, jaws, and other structures supporting the teeth, except as specifically provided in *What the CDHP Covers*.

- Services and supplies that are not **medically necessary** for the diagnosis, care, or treatment of the disease or injury involved, as determined by Aetna. This applies even if the services or supplies are prescribed, recommended, or approved by your attending physician or dentist.

- Services and supplies that are not prescribed, recommended, or approved by your attending physician or dentist.
• Services and supplies that are primarily intended to enhance athletic or sexual performance, or enhance lifestyle.

• Services performed where there is no evidence of pathology, dysfunction, or disease, except as specifically provided in connection with covered routine care and cancer screenings.

• Services furnished by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law, or any household member.

• Services of a resident physician or intern rendered in that capacity.

• Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills are not covered by the Plan.

• Sexual dysfunction treatment, including therapy, supplies, and counseling, when not caused by organic disease.

• Sleep therapy.

• Smoking cessation programs, treatments, medications, and aids that are not preventive care. However, smoking cessation medications are covered under the prescription drug plan. In addition, CSX Health & Wellness offers a smoking cessation program. Call CSX Health & Wellness at 1-866-845-3757 for information.

• Thermograms and thermography.

• Transportation costs, except as described in What the CDHP Covers.

• Treatment for obesity or for diet or weight control, except as described in Treatment of Severe Obesity. The Plan does not cover weight reduction programs and supplies such as diet programs, special foods, jaw wiring, and exercise equipment.

• Treatment in a federal, state, or governmental facility, including care and treatment provided in a hospital owned or operated by any federal, state, or other governmental entity, except to the extent required by applicable laws.

• Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.

• Vision-related services and supplies. The Plan does not cover:
  – Acuity tests,
  – Anti-reflective coatings,
  – Contact lenses or their fitting,
  – Eyeglasses,
- Eye surgery for the correction of vision, including radial keratotomy, LASIK, and similar procedures,
- Orthotics,
- Services to treat errors of refraction,
- Special supplies such as nonprescription sunglasses and subnormal vision aids,
- Tinting of eyeglass lenses,
- Vision therapy, and
- Vision training.
Coverage for prescription drugs is an important part of your health care coverage. The CSX Prescription Drug Program covers prescription drugs that are to be taken on an outpatient basis. This plan is administered by CVS Caremark.

**Summary of Benefits**

<table>
<thead>
<tr>
<th>In-Network Pharmacy</th>
<th>Mail Order (up to 90-day supply)</th>
<th>Retail Pharmacy (up to 30-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs</td>
<td>$25 co-pay</td>
<td>$10 co-pay</td>
</tr>
<tr>
<td>Preferred Brand-Name (on formulary)</td>
<td>$60 co-pay</td>
<td>$25 co-pay</td>
</tr>
<tr>
<td>Non-Preferred Brand Name (not on formulary)</td>
<td>$100 co-pay</td>
<td>$45 co-pay</td>
</tr>
</tbody>
</table>

When obtaining prescription drugs from an **out-of-network pharmacy**, reimbursement is limited to the discounted charge. Reimbursement is 100% up to the amount that the Plan would have paid if you had used an in-network pharmacy, less your co-pay.

The Plan includes a list of preferred drugs that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered under the prescription drug program, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan’s Formulary. The Plan’s Formulary is updated periodically and subject to change. To get the most up-to-date Plan Formulary list go online to [www.caremark.com](http://www.caremark.com). Drugs that are excluded from the Plan’s Formulary are not covered under the Plan unless approved in advance through a Formulary exception review process managed by CVS Caremark. The review process is based on whether the drug requested is (1) medically necessary and essential to the Covered Person’s health and safety and/or (2) all Formulary drugs comparable to the excluded drug have been tried by the Covered Person. If approved through the review process, the applicable Formulary co-pay or coinsurance would apply for the approved drug based on the Plan’s cost share structure. Absent such approval, Covered Persons selecting drugs excluded from the Formulary will be required to pay the full cost of the drug without any reimbursement under the Plan. If the Covered Person’s Physician believes that an excluded drug meets the requirements described above, the Physician should take the necessary steps to initiate a Formulary exception review.

The Formulary list will continue to change from time to time. For example:

- A drug may be moved to a higher or lower cost-sharing Formulary tier.
- Additional drugs may be excluded from the Formulary.
- A restriction may be added on coverage for a Formulary-covered drug (e.g. prior authorization).
A Formulary-covered brand name drug may be replaced with a Formulary-covered generic drug.

Please be sure to check before the drug is purchased to make sure it is covered on the Formulary, as you may not have received notice that a drug has been removed from the Formulary. Certain drugs even if covered on the Formulary will require prior authorization in advance of receiving the drug. Other Formulary-covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as Step-Therapy. As with all aspects of the Formulary, these requirements may also change from time to time.

How the Prescription Drug Program Works

You have two ways to fill prescriptions: at a retail pharmacy or by mail order through CVS Caremark.

Retail Pharmacy

The Retail Pharmacy Program is intended for purchases of medication needed to treat short-term or acute illnesses. Prescriptions filled at retail pharmacies are limited to 30 days or a 100-unit dosage, whichever is less.

You can fill your prescriptions at the pharmacy of your choice:

- **Network pharmacies**: You may fill your prescription for up to a 30-day supply at a pharmacy that belongs to CVS Caremark’s pharmacy network. When you use a network pharmacy, your out-of-pocket expenses are lower and there are no claim forms to complete. Simply show your ID card and pay the appropriate cost share at the time of your purchase.

- **Out-of-network pharmacies**: You also may fill prescriptions at out-of-network pharmacies, but you will pay more out of your own pocket when you do (except when a drug is prescribed for an emergency condition). You will also need to file a claim for drugs purchased at an out-of-network pharmacy.

<table>
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<th>Keep in Mind</th>
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<tbody>
<tr>
<td>You can find a list of network pharmacies by calling CVS Caremark or by visiting on-line at <a href="http://www.caremark.com">www.caremark.com</a>.</td>
</tr>
</tbody>
</table>

**Mail Order Prescriptions – CVS Caremark Maintenance Choice Program**

If you take a long-term maintenance prescription drug, you will be required to use the mail order program beginning with your fourth 30-day supply. You will have a maximum retail allowance of one 30-day supply plus two refills. Once you’ve exhausted your retail refill allowance, additional refills will be covered only through mail order. CVS Caremark At-Home Delivery is easy-to-use and saves you money.

- To order by mail, send your original prescription, together with an order form and a check, money order, or credit card number for the applicable payment to CVS.
Caremark. Order forms are available on the CSX Gateway under Health, Pay & Benefits > Benefits forms.

Specialty or Biotech Drugs may be dispensed up to a 90-day supply when filled through CVS Caremark Specialty Mail Service Pharmacy. Contact the CVS Caremark Specialty Pharmacy at 1 (800) 237-2767.

Refills are simple, too. When you receive your original prescribed medication from the mail-service program, you will also receive refill information. You can order refills by mail, by phone, or online at www.caremark.com

<table>
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<th>Keep in Mind</th>
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<tbody>
<tr>
<td>The prescription drug copayments apply toward the out-of-pocket maximum under the Plan. Prescription drug copayments do not apply toward the deductible.</td>
</tr>
</tbody>
</table>

What the Prescription Drug Program Covers

The Program covers:

- Federal legend drugs – drugs that require a label stating: “Caution: Federal law prohibits dispensing without prescription”;
- Any other drug which under the applicable state law may be dispensed only upon the written prescription of a physician;
- Insulin;
- Insulin needles and syringes;
- Over-the-counter diabetic supplies, up to 100 days or a quantity of 100, whichever is less per claim;
- Smoking deterrents; up to a 180-day supply of Chantix and up to a 90-day supply for other drugs over a rolling 12-month period for a maximum of three courses of treatment per lifetime;
- Oral contraceptives; and
- Drugs to treat erectile dysfunction, up to 8 units per month.

There are, however, certain restrictions and exclusions. The following medications may only be purchased through the mail order program:

- Prescription vitamins to treat illness or disease – only if determined to be medically necessary;
- Fertility drugs – only if determined to be medically necessary; and
● Growth hormones – only if determined to be medically necessary.

What the Prescription Drug Program Does Not Cover

The Program does not cover the following prescription drug expenses:

● Administration or injection of any drug.

● Anorexiants.

● Any drug dispensed by a mail order pharmacy other than CVS Caremark At-Home Delivery or CVS Caremark Specialty Pharmacy.

● Any drug entirely consumed when and where it is prescribed.

● Any drug that does not, by federal or state law, require a prescription, such as an over-the-counter drug or equivalent over-the-counter product, other than insulin or certain preventive care drugs, even when a prescription is written for it.

● Any drug provided by a health care facility, whether or not you are an inpatient there. Also, any drug provided on an outpatient basis by a health care facility if benefits are paid for it under any other part of this plan or another plan sponsored by CSX.

● Any prescription refilled in excess of the number of refills specified by the physician.

● Any refill of a drug dispensed more than one year after the latest prescription for it, or as permitted by law where the drug is dispensed.

● Contraceptive jellies, creams, foams, or devices (some non-oral contraceptive methods are covered as preventive care under the CDHP).

● Devices of any type (such as a spacer or nebulizer) used in connection with a prescription drug. Note that some devices may be covered as durable medical equipment or as part of another benefit.

● Drugs for which the cost is recoverable under any worker’s compensation or occupational disease law of any state or governmental agency.

● Drugs furnished by any other drug or medical service for which no charge is made.

● Drugs labeled experimental or for investigational use or its equivalent designation; drugs not approved by the FDA.

● Drugs to promote or stimulate hair growth or for cosmetic purposes only.

● Immunization agents.

● Less than a 30-day supply of any prescription filled through the Plan’s mail order service.
● Mifeprex.

● More than a 30-day supply of a prescription filled at a retail pharmacy.

● More than the number of refills specified by the prescribing doctor. CVS Caremark may require a new prescription or proof of need if the prescriber has not specified the number of refills or if the frequency or number of refills seems excessive under accepted medical practice standards.

● More than 8 unit doses per 30-day supply for any drugs used to treat erectile dysfunction, impotence, or sexual dysfunction or inadequacy (except Yohimbine).

This exclusion applies whether or not the drug is delivered in oral, injectable, or topical forms (including but not limited to gels, creams, ointments, and patches). If the drug is not taken orally, CVS Caremark will determine the dosage covered based on the comparable cost for a 30-day supply of pills.

● Nutritional supplements (unless they are the only source of nutrition in a life-sustaining situation).

● Obesity or weight control drugs.

● Oral and injectable fertility drugs prescribed for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.

● Prescription vitamins when used as a dietary supplement or to prevent a vitamin deficiency.

● Services and supplies for which payment was made (or would have been made if you had claimed benefits) under Medicare Parts A, B, or D. This exclusion applies if you are eligible for Medicare, even if you do not apply for or claim benefits. It does not apply for Part D if not enrolled or Parts A and B if, in accordance with federal law, this Plan is primary and Medicare is the secondary payer of your health care expenses.

● Therapeutic devices or appliances.

**Quality Care**

CVS Caremark Clinical Pharmacists may perform an evaluation of a participant's pharmaceutical therapies for the identification of potential reduced out-of-pocket expenses, simplified pharmaceutical therapy plan, prevention of side effects caused by unnecessary or inefficient prescribing, and the identification of over- or under-drug utilization. You may contact CVS Caremark Customer Care at (866) 273-8571 for more information.

**Covered Drugs Subject to Prior Authorization**

Prior Authorization determines benefit coverage or the appropriateness of drug therapy based on strict FDA approved and evidence based criteria for drugs that would otherwise not be covered by the Plan. Your pharmacist will inform you at the point-of-sale if your drug requires Prior Authorization and instruct you to have your physician contact the CVS Caremark Prior Authorization department.
Authorization Unit. You may contact CVS Caremark Customer Care at (866) 273-8571 if you have questions regarding whether your drug requires prior authorization.

**Specialty Medications**

Specialty Medications (including self-administered injectables, physician administered injectables and certain oral medications) are required to be filled through the CVS Caremark Specialty Pharmacy. The CVS Caremark Specialty Pharmacy offers medications for many chronic conditions including multiple sclerosis, rheumatoid arthritis, hemophilia, Gaucher disease, cystic fibrosis, hepatitis C, respiratory syncytial virus, growth hormone deficiency, anemia, Crohn's disease, neutropenia, pulmonary hypertension, and many others. If you are being treated for any chronic conditions like these, you or your physician should contact CVS Caremark Specialty Connect at (800) 237-2767. Representatives are available to assist you 6:30 a.m. to 8:00 p.m. Central Time Monday through Friday.

**Specialty Guideline Management**

The CVS Caremark Specialty Guideline Management Program supports safe, clinically appropriate and cost-effective use of specialty medications. Participation in the Specialty Guideline Management program begins with a review and approval process overseen by clinical specialists at CVS Caremark. Clinical information obtained by CVS Caremark from your doctor is often necessary as approval decisions are based on drug-specific guidelines. Following approval, you can look forward to immediate access to CVS Caremark Specialty Pharmacy Services.

**Lost or Stolen Medication**

If medication received at a retail pharmacy or through mail-order, is lost/stolen or destroyed, you are responsible for the entire cost of replacement medication.

**Covered Drugs Subject to Dispensing Limitations**

Some drugs covered by the Plan are subject to Maximum Dispensing Limitations at either a retail pharmacy or through the mail order program. The Plan will pay for the specified dispensing quantity within the specified time period. You may contact CVS Caremark Customer Care at (866) 273-8571 if you have questions regarding whether your drug is subject to quantity-dispensing limitations.
When You Must File Your Pharmacy Claims

Employees of CSX can use their CVS Caremark pharmacy card when obtaining prescriptions at network pharmacies. Pharmacists can access eligibility and plan information through the cards.

When employees have prescriptions filled by pharmacies that are not in the CVS Caremark network, they need to submit a claim to CVS Caremark to receive reimbursement.

| All pharmacy expense claims must be postmarked to CVS Caremark no later than June 30 following the end of the calendar year in which you had the expenses; otherwise they will be denied as untimely. It is your responsibility to ensure that your claims are filed before the June 30 deadline. |

CVS Caremark claim forms can be found in the Health & Wellness Center at www.caremark.com. You can also contact CVS Caremark Customer Care at (866) 273-8571 to obtain a form. These should be completed and submitted to CVS Caremark, along with your receipts, for reimbursement.

If You Need Help Filing a Claim

Call CVS Caremark Customer Care at (866) 273-8571 if you have any questions concerning your claim or need help filing your claim.

Claims should be sent to:

  CVS Caremark  
P. O. Box 52136  
Phoenix, AZ  85072-2136
Finding a Participating Dentist
Consult Aetna Dental’s online provider directory, DocFind®, for the most current provider listings at www.aetna.com.

Aetna Member Services: (800) 874-1458

Internet Address: www.aetna.com

CSX offers two dental plans. A separate election and a separate employee contribution is required to enroll in a dental plan.

The Dental Preferred Provider Organization (PPO) is available to all active management employees who otherwise meet the eligibility requirements. The dental PPO plan offers in and out-of-network coverage.

The Dental Maintenance Organization (DMO) is available only to employees who reside in DMO network areas as determined by Aetna. Employees who select the dental DMO must designate a primary care dentist (PCD) who will coordinate dental care with other dental providers contracted with Aetna. There are no out-of-network benefits under the dental DMO. This plan is fully insured through Aetna.

The information in this SPD has been prepared as a general explanation of the benefits available to you under the Dental PPO and DMO Plans. In the event there is any inconsistency between the DMO summary and the controlling DMO Plan Document, the terms of the applicable DMO Plan Document are controlling. Contact Aetna at (800) 874-1458 with questions or to obtain a copy of the Plan Document.

Dental Preferred Provider Organization (PPO)

It is important to understand how the Dental PPO works before you need care. These key terms are the foundation of the Plan:

**Medically Necessary Services and Supplies**

The Dental PPO pays benefits only for medically necessary services and supplies. Refer to the Glossary for a definition of “medically necessary.”

**Negotiated Charge**

Network providers have agreed to charge no more than the negotiated charge for a service or supply this is covered by the Dental PPO. You are not responsible for amounts that exceed the negotiated charge when you obtain care from a network provider.

**Non-Occupational Coverage**

The Dental PPO covers only expenses related to non-occupational injury and non-occupational illness.
**Recognized Charge**

The Plan pays out-of-network benefits under the Dental PPO Plan only for the part of a covered expense that is recognized. You can find a full definition of “recognized charge” in the Glossary.

<table>
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<tr>
<th>Keep in Mind</th>
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<tbody>
<tr>
<td>If your out-of-network provider charges more than the recognized charge, you will be responsible for any expenses incurred that are above the recognized charge.</td>
</tr>
</tbody>
</table>

**Cost Sharing**

You share the cost of dental care with the Plan by paying a deductible and coinsurance.

**Calendar Year Deductible**

You must satisfy the deductible shown in the Summary of Benefits before the Dental PPO begins to pay benefits for certain expenses.

There are two types of calendar year deductibles:

- The *individual deductible* applies separately to you and each covered person in your family. When an individual's deductible expenses reach the deductible, the Dental PPO will pay benefits for that individual at the appropriate coinsurance percentage.

- The *family deductible* applies to you and your family as a group. When the combined deductible expenses incurred by you and your covered family members reach the family deductible, you and your family will be considered to have met your individual deductibles for the rest of that calendar year.

<table>
<thead>
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<th>Keep in Mind</th>
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| ● Only covered dental expenses apply to the deductible.  
● Both network and out-of-network expenses count toward meeting your deductible.  
● Any charge that is over the recognized charge does not count toward your deductible. |

**Coinsurance**

Once you meet the deductible, you pay a portion of the covered expenses you incur (your coinsurance). The Summary of Benefits shows the coinsurance paid by the Dental PPO; you are responsible for the remainder.
Maximums

Calendar Year Maximums

The Dental PPO has a calendar year maximum of $1,500 for each covered person. The maximum applies to diagnostic and preventive care, basic restorative services, and major restorative services.

The following expenses do not apply toward, and are not subject to, the calendar year maximum:

- Orthodontia services;
- Implants; and
- Oral surgery services.

A separate calendar year maximum of $3,000 applies to oral surgery benefits, including implants and crown lengthening.

Orthodontia Lifetime Maximum

A lifetime maximum of $1,000 applies to orthodontia benefits for each covered person.

How the Dental PPO Plan Works

The Dental PPO Plan gives you access to a network of dental care providers who deliver care for negotiated charges. Each provider in the network is called a network provider. Providers who are not included in the network are called out-of-network providers.

You have the freedom to choose network or out-of-network providers when you need dental care. The Plan’s reimbursement level is the same, whether you choose a network provider or an out-of-network provider. However, there are advantages to obtaining care from a network provider:

- You are likely to save money when you use network providers, because they have agreed to provide services for negotiated charges. The Plan pays a percentage of the negotiated charge, and you pay the balance. You are not responsible for amounts that exceed the negotiated charge. When you use out-of-network providers, the Plan pays the same percentage of the recognized charge, and you pay the balance, but you are also responsible for any amount that exceeds the recognized charge.

- When your care is provided by a network provider, you don’t have to file claim forms. When you receive care from an out-of-network provider, you must pay for the services when they’re rendered, then file a claim for reimbursement.

Provider Information

To find a network provider in your area:

- Use DocFind®, Aetna’s online provider directory, at www.aetna.com. Log on to Aetna Navigator and click on Find Health Care in DocFind®. Follow the prompts for
the type of search you want, the area in which you want to search, the type of provider you are seeking, and the number of miles you are willing to travel. When asked to select a plan category, click on Dental PPO/PDN.

- **Call Member Services.** A customer service professional can help you find a network provider in your area. Call (800) 874-1458.

**Advance Claim Review**

The purpose of the advance claim review is to determine – in advance – the benefits the Dental PPO will pay for proposed services. This information can help you and your **dentist** make informed decisions about the care you are considering.

**When to Get an Advance Claim Review**

An advance claim review is recommended whenever a course of dental treatment* is likely to cost more than $350. Ask your dentist to write down a full description of the treatment you need, using the dental claim form. Then, **before treatment begins**, your dentist should send the form to Aetna, along with supporting X-rays and other diagnostic records. Aetna will review the proposed treatment plan and provide you and your dentist with a statement outlining the benefits payable by the Dental PPO. You can then decide how to proceed.

The advance claim review is not required, but it can provide you with important information to consider with your dentist when deciding on a course of treatment. An advance review is not necessary for emergency treatment or routine care.

In determining the amount of benefits payable, Aetna will take into account alternate procedures, services, or courses of treatment for the dental condition concerned in order to accomplish the appropriate result. (See **Alternate Treatment Rule** for more information on alternate dental procedures.)

* A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more dentists to treat a dental condition that was diagnosed by the attending dentist as a result of an oral examination. A course of treatment starts on the date your dentist first renders a service to correct or treat the diagnosed dental condition.

<table>
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<th>Keep in Mind</th>
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<tbody>
<tr>
<td>- The advance claim review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.</td>
</tr>
<tr>
<td>- When you or your dentist contacts Aetna to obtain information about your coverage, the information you receive is not a guarantee of benefits, nor should it be viewed as an estimate of benefits to be paid. Information received verbally should be viewed only as general plan guidelines.</td>
</tr>
</tbody>
</table>
Alternate Treatment Rule

When there are several ways to treat a dental problem, all of which provide acceptable results, the Dental PPO’s coverage is limited to services and supplies that:

- Are considered by the dental profession to be appropriate for treatment; and
- Meet broadly accepted national standards of dental practice, taking into account your current oral condition.

Here are some examples of alternate treatment and the benefit limits that apply:

- **Reconstruction.** The Dental PPO covers only charges for the procedure needed to eliminate oral disease and replace missing teeth. The Dental PPO does not cover appliances or restorations needed to increase vertical dimension or restore occlusion.

- **Partial dentures.** The Dental PPO covers only charges for a cast chrome or acrylic denture if this satisfactorily restores an arch. This limit applies even if you and your dentist choose a more elaborate or precision appliance.

- **Complete dentures.** The Dental PPO covers only charges for a broadly accepted procedure, even if you and your dentist choose personalized or specialized treatment.

- **Replacement of existing dentures.** Replacements are covered only if the existing denture cannot be used or repaired. If it can be used or repaired, the Dental PPO will cover only the charges for services needed to make the denture usable.

Ordered but Undelivered Rule

Your dental coverage may end while you or your covered dependent is in the middle of treatment. In general, the Dental PPO does not cover dental services that are given after your coverage terminates, but there is an exception. The Dental PPO will cover the following services if they were ordered while you or your covered dependent was covered by the Plan, and installed within 30 days after your coverage ends:

- Implants
- Inlays
- Onlays
- Crowns
- Removable bridges
- Cast or processed restorations
- Dentures
- Fixed bridgework
- Root canals

“Ordered” means:

- **For a denture:** the impressions from which the denture will be made were taken.
- **For a root canal:** the pulp chamber was opened.
- **For any other item:** the teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item, and
  - Impressions have been taken from which the item will be prepared.

**Summary of Benefits**

Understanding the terms listed below is key to using your benefits to your best advantage. These terms are defined in the *Glossary* at the back of this booklet.

- The Dental PPO pays benefits only for **medically necessary** care.
- The **deductible** is the part of your covered expenses you pay before the Dental PPO starts to pay benefits each year.
- Your **coinsurance** is the percentage of your covered expenses that you pay after you have satisfied the Dental PPO’s calendar year deductible.

<table>
<thead>
<tr>
<th>Remember!</th>
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<tbody>
<tr>
<td>A written advance claim review is strongly recommended for dental services that will probably cost more than $350. See <em>Advance Claim Review</em> for more information.</td>
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</table>

**Cost Sharing**

<table>
<thead>
<tr>
<th>Dental PPO Feature</th>
<th>Amount</th>
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<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$75</td>
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<tr>
<td>Family</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Maximum Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Calendar year maximum</td>
<td>$1,500</td>
</tr>
<tr>
<td>Oral surgery calendar year maximum</td>
<td>$3,000</td>
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<tr>
<td>Orthodontia lifetime maximum</td>
<td>$1,000</td>
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</table>
**Covered Care**

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>In-Network (Based on negotiated charge)</th>
<th>Out-of-Network (Based on recognized charge)</th>
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<tbody>
<tr>
<td><strong>DIAGNOSTIC AND PREVENTIVE</strong></td>
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<tr>
<td>Includes:</td>
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<td>• oral exams: 2 per calendar year</td>
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<tr>
<td>• cleanings: 2 per calendar year</td>
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<tr>
<td>• diagnostic x-rays, including:</td>
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<tr>
<td>— bitewings - 2 per calendar year</td>
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<tr>
<td>— full mouth or panoramic x-ray</td>
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<tr>
<td>1 per 36-month period</td>
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<tr>
<td>• fluoride applications: 1 per calendar year for children to age 19</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>• sealants: 1 application per calendar year for children up to age 15</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>• space maintainers</td>
<td></td>
<td></td>
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<tr>
<td><strong>BASIC RESTORATIVE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• fillings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• sealants: once per calendar year for dependent children to age 15</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>• periodontal treatment</td>
<td></td>
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<tr>
<td>• root canal therapy</td>
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<tr>
<td><strong>MAJOR RESTORATIVE</strong></td>
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<tr>
<td>Includes:</td>
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<tr>
<td>• inlays and onlays</td>
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<tr>
<td>• gold fillings</td>
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<tr>
<td>• crowns</td>
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<td>• fixed bridgework</td>
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<td>• replacement dentures</td>
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<td>• implants</td>
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<td><strong>ORTHODONTIA</strong></td>
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<tr>
<td>Orthodontia services</td>
<td></td>
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<tr>
<td>Plan Pays</td>
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<td>Plan Pays</td>
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<td>Plan Pays</td>
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<tr>
<td>Plan Pays</td>
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</tbody>
</table>

**What the Dental PPO Plan Covers**

The Dental PPO Plan covers a wide range of dental services and supplies:
• **Diagnostic and preventive care.** These are services and supplies that are focused on keeping your teeth healthy.

• **Basic restorative care.** Dental fillings and periodontic treatment are examples of basic restorative care.

• **Major restorative care.** Major restorative care includes the replacement of natural teeth with bridgework or dentures.

• **Orthodontia.**

**Diagnosis and Preventive Services**

Regular, routine dental care can prevent serious problems. To encourage you to take good care of your teeth, the Dental PPO pays 100% of covered charges for the following diagnostic and preventive services, without a deductible:

- Two routine oral exams per calendar year;
- Two cleanings per calendar year;
- One topical application of sodium or stannous fluoride per calendar year for children to age 19;
- One application of sealants to permanent molars every three years for dependents under age 15;
- Emergency treatment for pain;
- Space maintainers needed to preserve space resulting from premature loss of deciduous (baby) teeth for children to age 19, including all adjustments within six months after installation; and
- Diagnostic x-rays and other x-rays, including:
  - Full mouth series and/or panoramic x-ray (one per 36-month period),
  - Two bitewings per calendar year, and
  - Vertical bitewings.

**Dental Care Rewards**

If you or your dependents enrolled in the Dental PPO receive any of the above preventive care services during a plan year, CSX will decrease your portion of co-insurance and increase your annual benefit maximum in the following year for covered services which apply to Basic or Major Care. The Dental Care Rewards program does not apply to oral surgery charges. The Dental Care Rewards program works as follows:
Your Dental Benefits

Without the Dental Care Reward Program
Member did not receive a preventive service in the prior year

<table>
<thead>
<tr>
<th>Your Portion of Co-insurance</th>
<th>Without the Dental Care Reward Program</th>
<th>With the Dental Care Reward Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Care</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Major Care</td>
<td>50%</td>
<td>40%</td>
</tr>
</tbody>
</table>

Your Annual Benefit Maximum

Without the Dental Care Reward Program: $1,500
With the Dental Care Reward Program: $1,750

Basic Restorative Services

The Dental PPO covers minor restorative care such as fillings and simple extractions. Once you meet your calendar year deductible, the Plan pays 80% of covered expenses for:

- Oral surgery, including (but not limited to):
  - Uncomplicated extractions,
  - Surgical removal of erupted teeth,
  - Removal of impacted teeth,
  - Alveolar or gingival reconstructions, and
  - Osseous surgery.

  Coverage for oral surgery includes local anesthetics and routine post-operative care.

- X-ray and pathology services:
  - Single films (up to 13 films),
  - Intra-oral, occlusal view, maxillary or mandibular,
  - Upper or lower jaw, extra-oral, and
  - Biopsy and histopathologic examination of oral tissue.

- Treatment of periodontal and other diseases of the gums and tissues of the mouth, including:
  - Emergency treatment,
  - Occlusal adjustment (other than with an appliance or by restoration),
  - Subgingival curettage or root planing and scaling, per quadrant,
- Gingivectomy (including post-surgical visits) per quadrant, and
- Osseous surgery.

- Endodontic treatment, including:
  - Pulp capping,
  - Pulpotomy,
  - Apicoectomy, and
  - Root canal therapy.

- Restorative services for the replacement of all or part of a tooth structure, including:
  - Amalgam restorations of primary and permanent teeth,
  - Resin restorations,
  - Sedative fillings,
  - Pins and pin retention, in addition to amalgam or resin restoration,
  - Crowns (when a tooth cannot be restored with a filling material): prefabricated stainless steel and resin crown (excluding temporary crowns),
  - Repairs of crowns and bridges, and
  - Recementation of inlays, crowns and bridges.

Minor restorative care does not include inlays, crowns (except as listed above) or bridges. Multiple restorations in one surface will be considered as a single restoration.

- Initial installation of dentures and partials. Fees for dentures and partial dentures include relines, rebases and adjustments within six months after installation. Fees for relines and rebases include adjustments within six months after installation. Specialized techniques and characterizations are not covered.

- General anesthesia and intravenous sedation when provided in conjunction with a covered surgical procedure.

The Dental PPO does not cover:

- Root canal therapy if the pulp chamber for it was opened before you became covered by the Plan.
**Major Restorative Services**

Major restorative care includes the replacement of natural teeth with bridgework, implants and dentures. Once the deductible is met for the year, the Dental PPO pays 50% of covered charges for:

- Inlays and onlays (metallic, porcelain/ceramic and resin);
- Labial veneers;
- Crowns;
- Post and core;
- Prosthodontics, including:
  - Bridge abutments, and
  - Pontics;
- Replacement dentures and partials. Fees for dentures and partial dentures include relines, rebases and adjustments within six months after installation. Fees for relines and rebases include adjustments within six months after installation. Specialized techniques and characterizations are not covered;
- Full and partial denture repairs;
- Adding teeth to an existing partial denture;
- Implants; and
- Occlusal guard (for bruxism only): limited to one every three years.

The Dental PPO does **not** cover:

- A crown, cast or processed restoration unless:
  - It is treatment for decay or traumatic injury, and the teeth cannot be restored with a filling material, or
  - The tooth is an abutment to a covered partial denture or fixed bridge.
- Initial placement of pontics, crowns, casts, or processed restorations made with high noble metals.
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you became covered by the Dental PPO.
- An appliance, or modification of an appliance, if an impression was made for it before you became covered by the Dental PPO.
• Dentures, crowns, inlays, onlays, bridges, or other appliances or services used to splint, alter vertical dimension to restore occlusion, or correct attrition, abrasion or erosion.

Prosthesis Replacement Rule

Dentures, crowns, restorations, bridges and implants are subject to the Dental PPO’s replacement rule. In order for the Dental PPO to cover certain replacements or additions, you must give Aetna proof that:

• You or your covered dependent had a tooth (or teeth) extracted after the existing denture, bridgework or implant was installed. As a result, you need to have teeth replaced or added to your denture, bridgework or implant.

• The present denture, bridgework, or implant was installed at least 5 years before its replacement and cannot be made serviceable.

• The present denture is an immediate temporary one that replaces a tooth (or teeth) extracted while you were covered by the plan. A permanent denture is needed and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date the immediate temporary one was first installed.

Tooth Missing but Not Replaced Rule

The first installation of dentures, removable bridges, fixed bridges or implants will be covered if:

• The dentures, bridges or implants (see Alternate Treatment Rule) are needed to replace one or more natural teeth that were removed while you were covered by the Dental PPO; and

• The tooth that was removed was not an abutment to a partial denture, removable bridge, or fixed bridge installed during the prior 5 years. The 5-year rule is waived after 24 months of consecutive employment by CSX Corporation.

Orthodontic Treatment

Orthodontia benefits cover the straightening of teeth with braces or other methods. Coverage includes:

• Comprehensive orthodontia treatment;

• Interceptive orthodontia treatment; and

• Limited orthodontia treatment.

Benefits are limited to the lifetime orthodontia maximum shown in the Summary of Benefits chart. The maximum applies to each family member in his or her lifetime.

The Dental PPO does not cover:
• An orthodontic procedure if an active appliance for that procedure was installed before you were covered by the plan; or

• Surgical removal of impacted wisdom teeth when done for orthodontic reasons only.

What the Dental PPO Plan Does Not Cover

The Dental PPO does not cover every dental care service or supply, even if prescribed, recommended, or approved by your physician or dentist. The Dental PPO covers only the services and supplies that are described in What the Dental Plan Covers. The Dental PPO does not cover the following:

• A crown, cast or processed restoration unless:
  – It is treatment for decay or traumatic injury, and the teeth cannot be restored with a filling material, or
  – The tooth is an abutment to a covered partial denture or fixed bridge.

• A crown, bridge, implant, or cast or processed restoration, if a tooth was prepared for it before you became covered by the Dental PPO.

• Acupuncture therapy, except when performed by a physician as a form of anesthesia for surgery covered by the Dental PPO.

• An appliance, or modification of an appliance, if an impression was made for it before you became covered by the Dental PPO.

• An orthodontic procedure if initial bands or an active appliance for that procedure was installed before you were covered by the Dental PPO;

• Care, treatment, services, or supplies not prescribed, recommended, or approved by your physician or dentist.

• Charges in excess of the recognized charge for a dental service given by an out-of-network provider, as determined by Aetna.

• Charges in excess of your network provider’s negotiated charge for a given service or supply. This will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of this Dental PPO are paid.

• Charges you are not legally obligated to pay or made only because you have health coverage.

• Completion of claim forms.

• Cosmetic procedures. Regardless of whether the service is provided for psychological or emotional reasons, the Dental PPO does not cover charges for:
  – Plastic surgery,
Reconstructive surgery,

Cosmetic surgery, or

Other services that improve, alter or enhance appearance, whether or not for psychological or emotional reasons;

... except when needed to repair an injury. Surgery must be performed in the calendar year of the accident that caused the injury, or in the next calendar year.

**Note:** Facings on molar crowns and pontics are considered cosmetic.

- Dentures, crowns, inlays, onlays, bridges, implants, or other appliances or services used to splint, alter vertical dimension to restore occlusion, or correct attrition, abrasion or erosion

- **Experimental or investigational** services or supplies, as determined by Aetna.

- General anesthesia and intravenous sedation, unless done in connection with another **medically necessary** covered service.

- Missed appointments.

- Myofunctional therapy.

- Replacement of teeth removed or lost before you were covered by this Dental PPO.

- Replacement of lost, missing, stolen, or damaged devices or appliances, including the replacement of appliances that have been damaged due to abuse, misuse, or neglect.

- Root canal therapy if the pulp chamber for it was opened before you became covered by the Dental PPO.

- Services and supplies covered, in whole or in part, under any other plan of group benefits provided by CSX Corporation.

- Services and supplies in connection with an injury caused by war, whether declared or undeclared, or by international armed conflict.

- Services and supplies needed solely in connection with a non-covered service.

- Services and supplies provided, paid for, or for which benefits are provided or required because of your past or present service in the armed forces of a government.

- Services and supplies provided, paid for, or for which benefits are provided or required under any governmental law. This exclusion will not apply to “no fault” auto insurance if it is:
  - Required by law,
Provided on an individual basis, and

Considered one of the plans with which this Plan coordinates benefits (see Coordination of Benefits Provision).

This exclusion does not apply to a plan established by government for its own employers or their dependents, or to Medicaid.

- Services and supplies that Aetna determines are not medically necessary for the diagnosis, care or treatment of the disease or injury involved – even if they are prescribed, recommended, or approved by a physician or dentist.

- Services, appliances or supplies to increase vertical dimension.

- Services of a resident physician or intern.

- Surgical removal of impacted wisdom teeth when done for orthodontic reasons only.

- Treatment by a person who is not a dentist. However, the Dental PPO will cover some treatments by a licensed dental hygienist under the supervision of a dentist. These treatments include scaling and cleaning of teeth, and topical application of fluoride.

- Treatment of an occupational injury or disease.

- Treatment of temporomandibular disorder (TMD), including the following conditions affecting the jaw, face, and chewing structures:
  - Muscular disorders,
  - Articular (TMJ) disorders,
  - Mandibular (jaw mobility) disorders, and
  - Maxillomandibular (jaw growth) disorders.

- Veneers or similar properties of crowns and/or artificial teeth that replace or are placed on any teeth except the 10 upper and lower front teeth.

Dental and Medical Coverage – Additional Coverage

The following additional dental expenses will be considered covered expenses for you and your covered dependent if you have medical coverage insured or administered by Aetna and dental coverage under the Dental PPO and have at least one of the following conditions:

- Pregnancy;

- Coronary artery disease/cardiovascular disease;

- Cerebrovascular disease; or
• Diabetes.

Additional Covered Dental Expenses

• One additional cleaning per year;
• Scaling and root planning (4 or more teeth) per quadrant;
• Scaling and root planning (limited to 1-3 teeth) per quadrant;
• Full mouth debridement;
• Periodontal maintenance (one additional treatment per year); and
• Localized delivery of antimicrobial agents (not covered for pregnancy).

The plan coinsurance applied to the additional covered dental expenses above will be 100% for network expenses and out-of-network expenses. These additional expenses will not be subject to any frequency limits except as shown above. Aetna will reimburse the provider directly, or you may pay the provider directly and then submit a claim reimbursement for covered expenses.
Dental Maintenance Organization (DMO)

This plan is available only to employees who reside within an Aetna DMO network area. The DMO gives you and your family access to a network of primary care dentists (PCDs), and other dental specialists, who deliver dental care at contracted rates. Each provider in the network is called a network provider. The DMO Plan covers care only when the care is provided by your PCD or when your PCD refers you to a participating network dental specialist and the care is approved by Aetna.

How the DMO Plan Works

Your PCD

When you enroll in the DMO Plan, you must choose a PCD for yourself and each covered family member. You and each member of your family can select a different participating PCD who is the key to your dental care.

Your PCD will provide your primary care and, when medically necessary, your PCD will refer you to participating dental specialists for treatment under the terms of the plan. The referral is important because it is how your PCD arranges for you to receive necessary, appropriate care and follow-up treatment. You must have a referral from your PCD to receive coverage for all services from any other network providers.

The DMO Plan covers services as follows when provided by your PCD or when provided by a network provider through a referral from your PCD:

<table>
<thead>
<tr>
<th>DMO Plan Features</th>
<th>Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Annual Maximums</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Preventive &amp; Emergency Services</strong></td>
<td>100% of negotiated fees</td>
</tr>
<tr>
<td>Oral Exams – four per calendar year (two routine and two problem focused)</td>
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<tr>
<td>Cleanings – twice per calendar year</td>
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<tr>
<td>X-rays (bitewing) – one set per calendar year</td>
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<tr>
<td>Fluoride applications – two per calendar year, up to age 16</td>
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<tr>
<td>Space maintainers</td>
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<tr>
<td>Palliative Treatment</td>
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<tr>
<td>Full mouth x-rays – 1 every 3 rolling years</td>
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</tbody>
</table>

**Sealants**
(Dependents up to age 16)
1 treatment every 3 rolling years on permanent molars only for children under age 16
<table>
<thead>
<tr>
<th>DMO Plan Features</th>
<th>Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternate Treatment Provision</td>
<td>Covered dental charges will be limited to, when available, alternate services/supplies customarily used to treat dental disease or injury.</td>
</tr>
<tr>
<td><strong>Basic Restorative Services</strong></td>
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<tr>
<td>Periodontics</td>
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<tr>
<td>Simple Extractions</td>
<td></td>
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<tr>
<td>Amalgam (silver) fillings</td>
<td></td>
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<tr>
<td>Composite fillings (anterior teeth only)</td>
<td></td>
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<tr>
<td>Root canal therapy, bicuspid and anterior</td>
<td></td>
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<tr>
<td>Stainless steel crowns</td>
<td></td>
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<tr>
<td>100% of negotiated fees</td>
<td></td>
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<tr>
<td><strong>Major Restorative Services</strong></td>
<td></td>
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<tr>
<td>Full or partial dentures, fixed bridgework</td>
<td></td>
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<tr>
<td>Additions of teeth to existing dentures</td>
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<tr>
<td>Inlays, onlays, gold fillings, crowns</td>
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<tr>
<td>Denture, bridgework repair</td>
<td></td>
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<tr>
<td>Implants</td>
<td></td>
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<tr>
<td>General anesthesia</td>
<td></td>
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<td>Extractions- Impacted</td>
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<tr>
<td>Root Canal therapy, Molar</td>
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<tr>
<td>60% of negotiated fees</td>
<td></td>
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<tr>
<td><strong>Oral Surgery</strong></td>
<td></td>
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<tr>
<td>60% - 100% of negotiated fees (varies per procedure)</td>
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<tr>
<td><strong>Orthodontic Services</strong></td>
<td></td>
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<tr>
<td>(Employees and dependents)</td>
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<tr>
<td>60% of negotiated fees limited to 24 months of comprehensive orthodontic treatment plus 24 months of retention. No deductible</td>
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<tr>
<td>DMO Plan Features</td>
<td>Network Benefits</td>
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<tr>
<td>Coordination of Benefits</td>
<td>Benefits will not exceed the normal benefit available under the plan. The amount paid by the primary carrier is subtracted from Aetna's normal benefit. If the other carrier's benefit is greater than or equal to Aetna's normal benefit, no payment is made.</td>
</tr>
</tbody>
</table>
Special Programs

If you enroll in one of the options administered by Aetna, you and your covered family members can take advantage of special programs offered by Aetna or sponsored by CSX. The services described in this section are easy-to-use, value-added programs that complement your medical coverage.

Aetna Natural Products and ServicesSM Program

The Aetna Natural Products and ServicesSM program gives you access to complementary health care services and natural products at a reduced rate. The program provides:

- **Access to professional services.** You can receive reduced rates (at least a 25% discount off services) from natural therapy professionals, including acupuncturists, chiropractors, massage therapists, and dietetic counselors. Access is easy:
  - Use Aetna’s online provider directory, DocFind, at www.aetna.com. Click on Medical Providers, then Natural Therapy Professionals to find a directory of natural therapy professionals in your state.
  - Schedule an appointment with the professional you’ve chosen from the directory. Show your Aetna ID card and pay the reduced rate at the time of your visit.

- **Access to products.** You are eligible for discounts on over 2,400 health-related products, including over-the-counter (OTC) vitamins, herbal and nutritional supplements, and natural products. Members will receive at least a 15% discount off the manufacturer’s suggested retail price (MSRP) on all products offered through ChooseHealthy.com™, a product of American Specialty Health® (ASH) Networks and Healthyroads, Inc. Make your purchase online or by phone, mail order, or fax.

To order online, go to www.aetna.com, log in to Aetna Navigator, then click on Benefits / Health Programs / Natural Products and Services Discounts to access the online order link. You can also call ASH Networks directly at (877) 335-2746.

<table>
<thead>
<tr>
<th>How Can I Learn More?</th>
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<tbody>
<tr>
<td>To find out more, call Member Services or visit Aetna Navigator at <a href="http://www.aetna.com">www.aetna.com</a>. There you can find a listing of participating providers, vendors, and the latest additions to the product list.</td>
</tr>
</tbody>
</table>

Aetna VisionSM Discounts

Aetna Vision Discounts helps you and your family save on eye care services and products, including eye exams, eyeglasses, contact lenses and solutions, non-prescription sunglasses, and other eye care accessories. The program also offers you a discount on LASIK (laser correction) surgery, even though it is not otherwise covered by the Plan.

To use this program, visit www.aetna.com, log in to Aetna Navigator, click on Find Health Care in DocFind®, and select Pharmacy/Vision/Hearing, then Vision Locations. When you need products
or supplies, you can choose from a wide selection of optical centers nationwide, such as Pearle Vision®, Lenscrafters®, JC Penney®, Optical, Target Optical®, and participating Sears Optical® locations, plus thousands of independent eye care providers nationwide. Just show your Aetna ID card and the discount will be applied to your charges.

**Aetna Weight Management℠ Discount Program**

The Aetna Weight Management℠ discount program offers you discounts on Jenny Craig® weight loss programs and products. Depending on the program you choose, you can receive discounts on:

- Membership fees at Jenny Craig centers or with the Jenny Craig at-home program;
- One-on-one weekly consultations;
- Motivational tools; and
- Menu planning services.

You can get started by registering through Aetna Navigator and printing out your personalized registration coupon. Call 1-800-JENNY to find a center close to you, then bring your registration coupon and Aetna ID card to receive your free consultation.

Offers are good only at participating centers and through Jenny Direct at-home. There is an additional cost for food purchases and shipping.

**Aetna Fitness Program/Global Fit**

The Aetna Fitness℠ discount program offers you access to discounted services provided by GlobalFit™, a provider of fitness clubs and programs supporting members’ healthy lifestyles, including:

- Preferred membership rates* at nearly 10,000 fitness clubs in GlobalFit’s national network;
- Free guest passes to allow you to sample a club before joining;**
- Flexible membership options to help you meet your fitness goals, including:
  - Commit: a 48-week membership program; and
  - Non-commit: a month-to-month membership option;***
- Guest privileges at network clubs for Commit members who travel;**
- At-home weight-loss programs;
- Savings on exercise videos and home exercise equipment such as elliptical trainers and treadmills; and
• One-on-one health coaching services to help you quit smoking, reduce stress, lose weight, or meet any other health goal.****

To view a list of participating clubs, visit the GlobalFit website at [www.globalfit.com/fitness](http://www.globalfit.com/fitness). If you would like to speak with a GlobalFit representative, you can call the GlobalFit Help Line at (800) 298-7800.

*At some clubs, participation in this program may only be available to new members.

**Not available at all clubs.

***A one-time activation fee will apply to both options.

****Offered by WellCall, Inc. through GlobalFit.

**Aetna National Medical Excellence® Program**

Aetna’s National Medical Excellence Program® helps you access covered treatment for solid organ transplants, bone marrow transplants, and certain other rare or complicated conditions at participating facilities experienced in performing these services.

The program has three components:

• National Transplantation Program designed to help arrange care for solid organ and bone marrow transplants.

• National Special Case Program developed to coordinate arrangements for treatment of complex conditions at tertiary care facilities across the country when care is not available within 100 miles of your home.

• Out of Country Program designed for those who need emergency inpatient medical care while temporarily traveling outside the United States.

If you need a transplant or other specialized care, the NME Program will coordinate covered services and will provide the following lodging and travel expenses if you must travel more than 100 miles:

• Transportation expenses you and a companion (if applicable) incur while traveling between your home and the program facility. Travel expenses incurred by more than one companion are not covered.

• As an NME patient, your lodging expenses incurred while traveling between your home and the National Medical Excellence facility to receive covered services.

• The lodging expenses you incur for lodging away from home to receive covered outpatient services from an NME program provider.

• The lodging expenses incurred by a companion traveling with you from your home to a National Medical Excellence provider so you can receive covered services.
• Your companion’s lodging expenses when his or her presence is required to enable you to receive inpatient or outpatient care from a NME program provider. Only the lodging expenses incurred by one companion are covered per night.

The Plan will pay for travel and lodging expenses on the day you become a participant in the National Medical Excellence Program. Coverage ends either:

• One year after the day a covered procedure was performed; or

• On the date you cease to receive any services from the program provider in connection with the covered procedure; or

• On the date your coverage terminates under the Plan.

The Plan only covers those services, supplies, and treatments considered medically necessary for your medical condition. The Plan does not cover treatment considered experimental or investigational (as determined by Aetna).

<table>
<thead>
<tr>
<th>Keep in Mind</th>
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<tbody>
<tr>
<td>• Benefits for travel and lodging expenses are subject to a maximum of $10,000. Lodging expenses are subject to a $50 per night maximum for each person.</td>
</tr>
<tr>
<td>• Travel and lodging expenses must be approved in advance by Aetna. The Plan does not cover expenses that are not approved.</td>
</tr>
<tr>
<td>• Travel and lodging expenses do not include expenses that are covered under any other part of the Plan.</td>
</tr>
<tr>
<td>• Inpatient and partial-hospitalization care need to be precertified by Aetna. Refer to Overview of Your Medical Benefits.</td>
</tr>
</tbody>
</table>

Aetna Health Connections℠ Disease Management Program

Aetna Health Connections Disease Management program is designed to help you achieve your optimal health by providing information, support, and tools to help you make smarter health decisions. The program combines education, counseling, self-care, physician support, and state-of-the-art technology to help you manage chronic medical conditions, including asthma, diabetes, certain cancers, arthritis, Crohn’s disease, cystic fibrosis, and HIV. The program emphasizes lifestyle changes to help you avoid complications and improve the quality of your life.

Aetna Health Connections℠ can help you:

• Get the most appropriate treatment and preventive care for your individual needs;

• Understand how to follow your doctor’s treatment plan and understand your treatment options;

• Take charge of your own health and manage your chronic conditions well;

• Make changes to reach your personal health goals; and
• Identify and manage your risks for other conditions.

If you have one of 30 chronic conditions, the program offers you support using educational materials and online resources. It also offers nurse case management for those at high risk.

Participation is voluntary. If you have a chronic disease supported by the program or if you are at risk of developing a chronic condition, you can call Member Services or submit a request to participate through Aetna Navigator® at www.aetna.com. In addition, your physician may refer you to the program or Aetna may identify you as a potential participant based on your medical and prescription drug claim activity.

If you decide to take advantage of the program’s services, a nurse will work with you, and your care will be monitored for potential problem areas or concerns.

ConsumerMedical

ConsumerMedical provides you with access to objective and independent expert clinical support enabling you and your participating dependents to make informed health decisions. You may call ConsumerMedical at (888) 361-3944 or submit an online intake questionnaire when logged in to the ConsumerMedical secure web portal available at https://www.cmr-medicaldecisionsupport.com/Login. Based on your topic of interest and specific support needs, the ConsumerMedical team will assess your interest or needs with respect to each of these five questions:

• **What do I have?** Help confirming the diagnosis that you’ve been given is correct through the identification of expert physicians to obtain a second or third opinion.

• **What do I need?** Help understanding your treatment options and confirming that the recommended treatment is the best one for you.

• **Where do I go?** Help getting to the leading doctors and hospitals for your care.

• **What does it cost?** Help learning how to shop for your care so you get the best quality and price.

• **How do I connect?** Help building a strong support network with your family, friends, and other patients through local and online communities.

More information about ConsumerMedical and its offerings is available at [http://consumermedical.com/](http://consumermedical.com/). If your physician has recommended one of the following surgeries, you will receive a $400 gift card if you engage with ConsumerMedical about the surgery: knee replacement, bariatric surgery, hip replacement, low back surgery, and hysterectomy.
When Coverage Ends

For Employees

Your coverage under the Plan will end on the last day of the month in which any of the following events occur:

- You are no longer eligible for coverage, including a personal leave of absence;
- You do not make the required contributions;
- Your employment stops;
- You voluntarily stop your coverage;
- You become covered under another health plan offered by CSX or one of its subsidiaries; or
- The Plan is discontinued.

For Dependents and Surviving Spouses

Coverage for your dependents will end on the last day of the month in which any of the following events occur:

- Your own coverage ends for any of the reasons listed above;
- You are no longer eligible for dependents’ coverage;
- You do not make the required contribution toward the cost of dependents’ coverage; or
- Your dependent is no longer eligible for coverage.

For Disabled Employee

If you become disabled, you are no longer eligible for coverage as an active employee. You may be eligible for coverage as a disabled employee.

You are an eligible Disabled Employee if:

- You were regularly assigned to a position classified by CSX as a full-time, salaried position;
- You were occupying that position immediately prior to the onset of disability; and
- You are approved for long-term disability benefits under the CSX Corporation Long Term Disability Plan.
For employees who became disabled on or after January 1, 2010, coverage ends on the first of the month following 24 months of disability coverage beginning from the original medical leave commencement date under the CSX Corporation Short-Term Disability Plan. If you are disabled and you or your dependent becomes eligible for Medicare due to age or disability, you may be eligible for health care coverage under CSX’s retiree and disabled employee health insurance plan currently arranged through OneExchange.

**Medicare Eligibility**

It is your responsibility to notify the plan administrator when you are Medicare eligible. If claims are paid by Aetna as primary when Medicare should have been primary, Aetna will attempt to collect these overpayments from your providers. Refer to the section of this SPD titled *When You Retire* if you are disabled and eligible for Medicare.
Continuation of Coverage

You may be able to continue coverage for a period of time after your participation in the Plan ends, as described in this section.

Family Medical Leave Act

If CSX Corporation grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue coverage for yourself and your eligible dependents during your approved leave. You must agree to make any required contributions.

The continued coverage will cease when:

- You fail to make any required contribution;
- Your approved leave is determined by CSX Corporation to be terminated; or
- The Plan is discontinued.

In addition, any coverage for a dependent will not be continued beyond the date it would otherwise terminate.

If you do not return to work at the end of the approved leave, CSX Corporation may recover from you your share of the cost of maintaining your benefits coverage during the entire period of the leave, unless the failure to return to work was for reasons beyond your control.

If coverage under the Plan terminates because your approved FMLA leave is deemed terminated, you may, on the date of termination, be eligible to continue coverage under COBRA on the same terms as though your employment terminated on that date.

Uniformed Services Employment and Re-Employment Rights Act

For military service of less than 31 days, health care coverage is continued as if you had remained employed. If CSX Corporation grants you an approved military leave of absence of more than 30 days in accordance with, and ordered or authorized by, the proper military authority, you may continue health coverage for yourself and your eligible dependents for up to sixty months of your approved military leave of absence. You must agree to make any required contributions during any portion (paid or unpaid) military leave of absence.

If your military leave extends beyond sixty months or you do not return to active employment following the end of your leave, your coverage under the Plan will terminate and you may be eligible to continue coverage under COBRA.

Continuation of Coverage for Surviving Dependents

Coverage for your surviving spouse and dependent children may be continued if you die while employed by CSX or one of its participating affiliates and you were covered by the Plan at the time of your death. Your dependents may continue coverage as follows:
● If you had less than 10 years of service at the time of your death, or you were hired or promoted from a contract position after December 31, 2002: Surviving spouses and children up to age 26 receive twenty four months of medical, dental and vision coverage at the active group rate regardless of Medicare status. At the end of twenty four months, COBRA will be offered. Coverage will end on the date the surviving spouse remarries if prior to the date coverage would otherwise end.

● If you had 10 or more years of service at the time of your death, and you were hired or promoted from a contract position prior to January 1, 2003: Surviving spouses and children up to age 26 receive twenty four months of medical, dental and vision coverage at the active group rate regardless of Medicare status. At the end of the twenty four months, non-Medicare spouses and children up to age 26 will be charged the retiree premiums for medical and dental PPO, if elected. They are no longer eligible for DMO, but coverage may be continued through COBRA. Medicare eligible spouses and Medicare eligible children transition to OneExchange. Coverage will end on the date the surviving spouse remarries if prior to the date coverage would otherwise end.

**COBRA Continuation Coverage**

You and your dependents have the right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to continue medical coverage under certain circumstances (called “qualifying events”) when you would otherwise lose coverage. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children may become qualified beneficiaries if coverage is lost because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay premiums.

**Election Continuation**

You will be given detailed information about how to continue coverage under the COBRA requirements. You are responsible for informing the CSX Compensation & Benefits Department about a qualifying event that is not related to your employment or Medicare eligibility, such as a change in your marital status or a change in your dependent’s eligibility for coverage under the Plan.

Each qualified beneficiary may elect coverage independently. To elect coverage, the qualified beneficiary must:

- Provide application for continued health coverage – an election notice to continue coverage will be mailed to your home address.
- Submit the application to the COBRA Administrator within 60 days after the qualifying event, or within 60 days after the date that CSX notifies you of your COBRA continuation right, if later.
- Agree to pay the required premiums.
An employee may elect coverage on behalf of his or her spouse, and parents may elect coverage on behalf of dependent children.

COBRA Administrator:
AETNA US Healthcare
COBRA Unit -MB1K
151 Farmington Avenue
Hartford, CT 06156
(800) 429-9526

Conditions and Continuation Periods

You must make your COBRA continuation election within 60 days after the qualifying event or you will lose COBRA continuation rights.

The following chart shows the qualifying events and summarizes the maximum coverage periods that comply with COBRA requirements.

<table>
<thead>
<tr>
<th>Qualifying Event Causing Loss of Health Coverage</th>
<th>Covered Persons Eligible to Elect Continuation</th>
<th>Maximum Continuation Periods*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your active employment terminates for reasons other than gross misconduct</td>
<td>You, your spouse and your dependent children</td>
<td>18 months*</td>
</tr>
<tr>
<td>Your working hours are reduced</td>
<td>You, your spouse and your dependent children</td>
<td>18 months*</td>
</tr>
<tr>
<td>You become enrolled in Medicare</td>
<td>Your spouse and dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>You and your spouse divorce or legally separate, and you are no longer responsible for dependent coverage</td>
<td>Your spouse and dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>Your covered dependent child no longer qualifies as a dependent under the Plan</td>
<td>Your dependent child</td>
<td>36 months</td>
</tr>
<tr>
<td>You die</td>
<td>Your spouse and dependent children</td>
<td>36 months</td>
</tr>
</tbody>
</table>

* 36 months for your spouse and children, beginning on the date you became enrolled in Medicare, if you enrolled in Medicare within 18 months before the qualifying event.
Disability May Increase Maximum Continuation to 29 Months

If you or a family member qualify for disability status under Railroad Retirement or Title II or XVI of the Social Security Act during the 18 month continuation period, that family member:

- Has the right to elect to extend continuation beyond the initial 18 month maximum continuation period.
- Qualifies for an additional 11-month period, subject to the overall COBRA conditions.
- Must notify the COBRA Administrator within 60 days after the disability determination status, and before the 18-month continuation period is exhausted.
- Must notify the COBRA Administrator within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Is responsible for the associated premium after the 18th through the 29th month.

Multiple Qualifying Events May Also Increase a Continuation Period

It is possible that a family member could qualify for an extension of the 18- or 29-month continuation period by meeting the requirements of another qualifying event; e.g., divorce or death. The total period of continuation will never be more than 36 months.

Premium Costs Are Regulated by Law

- Premiums for the 18- or 36-month periods may be 102% of the total plan costs.
- Premiums for coverage during an extended disability period, after the 18th month period through the 29th month, may be up to 150% of the total plan costs.

Acquiring Dependents During a Continuation Period

If you acquire new dependents during a period of continuation, through birth, adoption, or marriage, they can be added to the health plan for the remainder of the continuation period if:

- They meet the definition of an eligible dependent,
- Notice is made to the COBRA Administrator within 31 days after eligibility as a dependent, and
- Additional premiums for continuation are paid on a timely basis.

When COBRA Continuation Coverage Ends

Coverage ends on the earliest date that one of these events occurs:

- The qualified beneficiary reaches the maximum COBRA continuation period – the end of the 18, 29, or 36 months. (A newly acquired dependent added for the balance of a
continuation period would terminate coincident with the end of your continuation period, if not disabled and not eligible for an extended maximum.)

- The qualified beneficiary fails to pay required premiums.

- The qualified beneficiary becomes covered under another group plan that does not restrict coverage for pre-existing conditions. If a new plan limits pre-existing condition coverage, the continuation coverage under this Plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this Plan.

- The date CSX Corporation no longer offers a group health plan.

- The date the qualified beneficiary becomes eligible for Medicare. This will not apply if contrary to the provisions of the Medicare Secondary Payer Rules or other federal law.

- The qualified beneficiary dies.
When You Retire

CSX allows employees to continue medical and dental coverage for themselves and their dependents after retirement. The eligibility rules for retiree coverage are described in Who Is Eligible.

**Medical Plan Options**

Your retirement medical benefits are based on your eligibility for Medicare:

- Retirees who are not eligible for Medicare may:
  - Enroll in Low Premium Plan;
  - Enroll in Consumer Driven Health Plan (CDHP); or
  - Waive Coverage.

Retirees may elect to waive medical and prescription drug coverage. By doing so, they may not reenroll until the next open enrollment unless they experience a qualified change in family status.

- Retirees and dependents of retirees who qualify for Medicare because of age or disability are no longer eligible for the “Medical Plan Options” stated above or dental coverage, and instead are eligible for health care coverage pursuant to CSX’s retiree plan. This coverage is obtained through OneExchange, which assists retirees in finding and choosing supplemental coverage with a secondary provider (Medicare serves as the primary coverage).

**Dental Coverage for Non-Medicare Retirees**

If you were enrolled in the Dental Plan at the time of your retirement, you may continue your Dental Plan coverage. You may not later re-enroll in the Plan if you refuse dental coverage at any time during retirement.

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<th>Keep in Mind</th>
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<tr>
<td>Employees who were not enrolled in the Dental Plan on the day prior to their retirement are not eligible for dental coverage during retirement. If enrolled in the Dental DMO at time of retirement you may elect to enroll in the Dental PPO Plan at the time of your retirement.</td>
</tr>
</tbody>
</table>

For additional information, see the Summary Plan description for the CSX Corporation Retired or Disabled Employee Medical, Dental and Prescription Drug Plan.
Coordination With Other Plans

If you have coverage under other group plans or receive payments for an illness or injury caused by another person, the benefits you receive from the Plan may be adjusted. This may mean a reduction in benefits under the Plan.

Coordination of Benefits Provision

Benefits available through other group plans and/or no-fault automobile coverage will be coordinated with the Plan. “Other group plans” include any other plan of dental or medical coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, whether or not the plan is insured; and
- “No-fault” and traditional “fault” auto insurance, including medical payments coverage provided on other than a group basis, to the extent allowed by law.

To find out if benefits under this Plan will be reduced, the Claims Administrator must first determine which plan pays benefits first. The determination of which plan pays first is made as follows:

<table>
<thead>
<tr>
<th>If:</th>
<th>Then:</th>
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<tbody>
<tr>
<td>a) one plan has a coordination of benefits (COB) provision, and the other plan does not,</td>
<td>… the plan without a COB provision determines its benefits before the plan that has a COB provision.</td>
</tr>
<tr>
<td>b) one plan covers the person as a dependent, and the other plan covers the person as an employee,</td>
<td>… the plan that covers a person as an employee determines its benefits before the plan that covers the person as a dependent.</td>
</tr>
<tr>
<td>c) the person is eligible for Medicare,</td>
<td>… the Medicare Secondary Payer rules will apply. Under the Medicare Secondary Payer rules, the order of benefits will be determined as follows:</td>
</tr>
</tbody>
</table>

- The plan that covers the person based on current employment status (of themselves or a family member);
- Medicare will pay second; and
- The plan that covers the person based on former employment status will pay third.
<table>
<thead>
<tr>
<th>If:</th>
<th>Then:</th>
</tr>
</thead>
<tbody>
<tr>
<td>d) a child’s parents are not divorced or separated,</td>
<td>… the plan of the parent whose birthday occurs earlier in the calendar year pays the child’s expenses first. When both parents’ birthdays occur on the same day, the plan that has covered the parent the longest pays first. If the other plan doesn’t have the parent birthday rule, the other plan’s COB rule applies.</td>
</tr>
</tbody>
</table>
| e) a child’s parents are separated or divorced, | - If there is a court decree that states that the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the parent birthday rule (see “d” above) applies.  
- If a court decree gives financial responsibility for the child’s medical, dental, or other health care expenses to one of the parents, the plan covering the child as that parent’s dependent determines its benefits before any other plan that covers the child as a dependent.  
- If there is no such court decree, the order of benefits will be determined as follows:  
  - the plan of the natural parent with whom the child resides,  
  - the plan of the stepparent with whom the child resides,  
  - the plan of the natural parent with whom the child does not reside, or  
  - the plan of the stepparent with whom the child does not reside. |
<p>| f) a person has coverage as an active employee or as the dependent of an active employee, and also has coverage as a retired or laid-off employee, | … the plan that covers the person as an active employee or as the dependent of an active employee is primary. |</p>
<table>
<thead>
<tr>
<th>If:</th>
<th>Then:</th>
</tr>
</thead>
<tbody>
<tr>
<td>g) a person is covered under a federal or state right of continuation law (such as COBRA),</td>
<td>… the benefits of a plan that covers a person under a right of continuation under federal or state laws will be determined after the benefits of any other plan that is not a mandated continuation plan.</td>
</tr>
<tr>
<td>h) the above rules do not establish an order of payment,</td>
<td>… the plan that has covered the person for the longest time will pay benefits first.</td>
</tr>
</tbody>
</table>

If the other plan pays first, the benefits paid under this Plan will be reduced. The Claims Administrator will calculate the reduced amount as follows:

- The amount this Plan would pay in the absence of other coverage, minus
- Benefits payable from your other plan(s).

If your other plan(s) provides benefits in the form of services rather than cash payments, the cash value of the services will be used in the calculation.

**Motor Vehicle Accident**

This Plan always pays secondary to:

- Any medical payment, personal injury protection, or no-fault coverage under any automobile policy available to you; or
- Any plan or program which is required by law.

All covered persons should review their automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

**Subrogation, Right of Reimbursement, and Right of Recovery**

This section summarizes your responsibilities and the Plan’s rights if you receive benefits from the Plan due to an illness or Injury allegedly caused by a third party (or for which a third party is allegedly legally responsible) or if you receive benefits that the Plan paid in error. By accepting these benefits from the Plan, you agree to these provisions and to repay the Plan for benefits you receive under these circumstances.

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The Plan’s right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. “You” or “your” includes anyone on whose behalf the Plan pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.
The Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source may be made until the Plan’s subrogation and reimbursement interest are fully satisfied.

The Plan does not cover any expenses for which a third party is responsible as a result of having caused or contributed to a sickness or injury. However, the Plan will pay the benefits that would otherwise be payable to a covered person under the Plan and will recover its payments from the funds that a covered person receives through any award from or settlement with the responsible party, the responsible party’s insurer or any other source as the result of an illness or injury caused by another party. The Plan has the right to be reimbursed for benefits from any settlement or payment you receive from the person(s) who caused the illness or injury.

Definitions

“Covered person” means, for the purposes of this provision, anyone on whose behalf the Plan pays or provides any benefit, including (but not limited to) the minor child or dependent of any Plan participant or person entitled to receive any benefits from the Plan.

“Insurance coverage” means any coverage providing medical expense or liability coverage, including (but not limited to):

- Uninsured motorist coverage,
- Underinsured motorist coverage,
- Personal umbrella coverage,
- Medical-payment coverage,
- Workers’ compensation coverage,
- No-fault automobile insurance coverage, or
- Any first-party insurance coverage.

“Responsible party” means:

a) any party actually, allegedly, or potentially responsible for making any payment to a covered person due to that covered person’s injuries, illness, or condition;

b) the insurer, guarantor, or any other indemnifier of anyone described in a);

c) anyone who may be obligated to provide benefits or payments to a covered person through any form of insurance coverage; and

d) anyone who may be liable to a covered person under any equitable or legal liability theory.
How Subrogation Works

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to (or stand in the place of) all rights of recovery a covered person has against any responsible party with respect to any claim or potential claim against any party due to the person’s injuries, illness, or condition, to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

How Right of Reimbursement Works

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

The Plan has an automatic lien, to the extent of benefits advanced for the treatment of the injury, illness, or condition for which the responsible party is liable. The lien will be imposed upon any recovery that a covered person receives from any responsible party or insurance coverage as a result of an injury, illness, or condition, whether by settlement, judgment, or otherwise.

The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan, including (but not limited to):

- The covered person;
- The covered person’s representative or agent;
- The responsible party;
- The responsible party’s insurer, representative, or agent; and/or
- Any other source possessing funds representing the amount of benefits paid by the Plan.

How Right of Recovery Works

If the Plan makes overpayments or payments in error, the Plan Administrator, in its sole discretion, has the right to recover the payment or overpayments from anyone who received or benefited from them. If the Plan made payments based on fraudulent information you provided, the Plan will exercise all available legal rights, including its right to withhold payment on future benefits until the overpayment is recovered.

Your Obligations under this Section

By accepting benefits from the Plan (whether the payment of the benefits is made to the covered person or made on behalf of the covered person to any provider), the covered person agrees that:
• If he or she receives any payment from any responsible party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the covered person’s fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan’s subrogation and reimbursement interest are fully satisfied.

• In order to secure the Plan’s recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan’s subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

• This Plan’s recovery rights are a first priority claim against all responsible parties and are to be paid to the Plan before any other claim for damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any responsible party’s payments, even if such payment to the Plan will result in a recovery to the covered person which is insufficient to make him or her whole or to compensate him or her in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the covered person to pursue his or her damage claim.

• Any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. The covered person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile. By accepting such benefits, the covered person also agrees to pay all attorney’s fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

The covered person shall do nothing to prejudice the Plan’s subrogation or reimbursement rights, or to prejudice the Plan’s ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

It is the duty of the covered person to:

• Fully cooperate with the Plan’s efforts to recover benefits it paid.

• Notify the Plan or the Claims Administrator within 30 days after the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the covered person.

• Provide the Plan or its representatives notice of any recovery prior to receipt of such recovery funds or within 5 days of receipt if no notice was given prior to receipt, and provide notice prior to any disbursement of settlement or any other recovery funds obtained.
• Provide all information requested by the Plan, the Claims Administrator, or its representative, including (but not limited to) completing and submitting any applications, forms, or statements requested by the Plan.

Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights, or failure to reimburse the Plan from any settlement or recovery received may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits, or the institution of court proceedings against you to enforce these rights.

The Plan’s Rights under this Section

The Plan will not pay and is not responsible for your attorneys’ fees, court costs, experts’ fees, filing fees, or any other costs or expenses of litigation. You will not deduct any of these expenses from the amount reimbursed to the Plan; any so-called “Fund Doctrine,” “Common Fund Doctrine,” or “Attorney’s Fee Doctrine” does not override this right.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.
You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act (“HIPAA”), 42 U.S.C. Section 1301 et seq., to share your personal health information in exercising its subrogation and reimbursement rights.

Application of this Section

The terms of this entire subrogation, right of reimbursement, and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any responsible party and regardless of whether the settlement or judgment received by the covered person identifies the medical benefits the Plan provided or purports to allocate any portion of the settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only. The Plan’s claim will not be reduced due to your own negligence.

In the event any claim is made that any part of this subrogation, right of reimbursement, and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan or the Claims Administrator shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Coordination With Medicare

When you or any of your covered family members become eligible for Medicare, you are still covered by this Plan as long as you are an active employee; however, the Plan’s Coordination of Benefits (COB) provision coordinates your medical benefits with any other group health coverage you may have – including Medicare. This may mean your benefits under this Plan will be reduced by any Medicare benefits for which you are eligible. Your benefits may be calculated differently. The information below will help you understand how Medicare works and how it affects your benefits under this Plan.
**Active Employees: How Medicare Affects Your Plan Benefits**

While you are an active employee, this Plan is the primary plan that will pay benefits first. Medicare is secondary and will consider your expenses after this Plan has paid its benefits.
Claims and Appeals: Medical and Dental

All claims must be submitted in writing. This should be done as promptly as possible. Your claim must give proof of the nature and extent of the loss. You can request the appropriate claim forms from Aetna. You can also download copies on Aetna Navigator: go to www.aetna.com, log into Aetna Navigator, then click on Members and Consumers / Requests & Changes / Forms.

The deadline for filing a claim for benefits is two years after the date you incur the expense.

<table>
<thead>
<tr>
<th>Keep in Mind</th>
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<tbody>
<tr>
<td>Your network provider will file claims for you. If you use an out-of-network provider, you are responsible for filing your own claims.</td>
</tr>
</tbody>
</table>

How to File an out-of-network Medical or Dental Claim

When you incur a covered expense, you must submit a claim to request payment from the Plan for covered expenses. Follow the steps below to file a claim.

First: Complete a Benefits Request Form

To request reimbursement, complete and return a Benefits Request Form within two years after the expense is incurred.

The Medical Benefits Request and Dental Benefits Request forms are available from the Employee Gateway under Health, Pay & Benefits > Forms > Benefits Forms. You can also download a copy by logging into Aetna Navigator™ at www.aetna.com and using the forms library located at Members and Consumers / Health Coverage Information / Forms.

Follow the instructions printed on the form. Be sure to answer all questions. If you leave out information, your claim may be delayed. If you are submitting multiple claims, you must submit a separate form for each covered family member.

Second: Attach Itemized Bills to the Completed Form

You’ll need to enclose an original itemized bill from your doctor or other health care provider with your completed Benefits Request Form. Make sure your Participant ID number (found on your Plan ID Card) or your Social Security Number is on all bills, in case they get separated from the claim form. Keep a copy of the bill for your own records. An itemized bill should show:

- The patient’s name.
- The health care provider’s name and tax identification number (TIN).
- The patient’s relationship to you (self, spouse, child). If this is not shown on the bill, write it on the Benefits Request Form.
- The patient’s date of birth. Write it on the Benefits Request Form if it doesn’t appear on the bill.
• The date of purchase of the service or supply.
• The condition being treated.
• The amount charged for each service or supply.

Cancelled checks or credit card receipts are not acceptable in lieu of an itemized bill. If an itemized bill is not available, ask your health care provider to complete the Provider’s Statement on the back of the claim form.

The completion of paperwork in support of a physician’s charges is the responsibility of the physician’s office staff. Aetna will not reimburse you or the physician’s office for the cost of administrative services.

Third: Mail the Completed Form and Itemized Bills

Once you’ve completed your Benefits Request Form and attached the appropriate itemized bills, mail them directly to the appropriate address shown on your medical ID card or below:

Medical:  
Aetna  
P.O. Box 14079  
Lexington, KY  40512-4079

Dental:  
Aetna Member Services  
P.O. Box 14094  
Lexington, KY  40512

Time Frames for Medical and Dental Claim Processing

Aetna will make a decision on your claim whether it is filed by you or your provider.

An “Adverse Benefit Determination” is a decision made by Aetna that results in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse Benefit Determinations can be made for one or more of the following reasons:

• The individual is not eligible to participate in the Plan; or

• Aetna determines that a benefit or service is not covered by the Plan because:
  – It is not included in the list of covered benefits,
  – It is specifically excluded,
  – A Plan limitation has been reached, or
  – It is not medically necessary.

Aetna will provide you with a written notice of an Adverse Benefit Determination. The notice will contain:
● Sufficient information to help you determine the identity of the claim (e.g., date of service, name of health care provider, specific benefit denial code and its corresponding meaning, and specific treatment code);

● The specific reasons for the denial, with references to the specific Plan provisions on which the denial is based;

● A description of any additional material or information needed to perfect the claim, with an explanation of why the additional information is necessary;

● An explanation of any rule, guideline, or protocol that was relied upon in making the adverse determination (or a statement that you may receive it free of charge upon request);

● An explanation of the scientific or clinical judgment on which the determination is based if the denial is based on medical necessity, experimental status, or a similar limitation (or a statement that you may receive such explanation free of charge upon request); and

● A description of the Plan’s internal and applicable external appeals process, including information about how to initiate an appeal, and a statement of your right to file suit under Section 502(a) of ERISA following exhaustion of the appeals process.

Also, in connection with any appeal, you (or your authorized representative) will have the right to examine your claim file and to present evidence as part of the review process, to the extent required under the federal law. You will receive, free of charge, any new or additional evidence considered, relied upon or generated by the Plan in connection with its review of an appeal of an Adverse Benefit Determination, and any new or additional rationale the Plan intends to rely upon in deciding the internal appeal, sufficiently in advance of the final decision on the internal appeal to allow you (or your authorized representative) a chance to respond before the decision. The Plan will continue to provide coverage pending the outcome of the appeal, to the extent required under the federal law. Benefits for an ongoing course of treatment will not be reduced or terminated without providing advance notice and an opportunity for advance review.

The following chart outlines the timing and notification process that applies to Adverse Benefit Determinations for various types of claims. Aetna will provide written notices of Adverse Benefit Determinations within the time frames shown. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will help you make an appeal of the Adverse Benefit Determination, if you wish to do so. Please see Aetna Claims Appeal Process for more information about appeals.
<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Who Is Notified</th>
<th>When Notification is Made</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Claim</td>
<td>If claim is approved, physician is notified.</td>
<td>As soon as possible, but not more than 72 hours.</td>
</tr>
<tr>
<td></td>
<td>If claim is denied, the patient and physician are</td>
<td></td>
</tr>
<tr>
<td></td>
<td>notified.</td>
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<td></td>
<td>A claim resulting from a situation in which delaying</td>
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<td>treatment or care could:</td>
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<td></td>
<td>- Endanger the patient’s life or health;</td>
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<td></td>
<td>- Affect the patient’s ability to regain maximum</td>
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<td></td>
<td>function; or</td>
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<td>- Cause the patient to suffer severe pain that</td>
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<td></td>
<td>cannot be adequately managed without the</td>
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<td></td>
<td>requested care or treatment.</td>
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<td></td>
<td>- In the case of a pregnant woman, cause serious</td>
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<td>jeopardy to the health of the fetus.</td>
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<tr>
<td>Pre-Service Claim</td>
<td>If claim is approved, physician is notified.</td>
<td>15 calendar days</td>
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<tr>
<td></td>
<td>If claim is denied, the patient and physician are</td>
<td></td>
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<tr>
<td></td>
<td>notified.</td>
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<td></td>
<td>A claim for a benefit that requires approval before</td>
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<td>medical care is received.</td>
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<td>The patient must call the Claims Administrator to</td>
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<td>start the approval process. (See Precertification</td>
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<td>for more information about the approval process.)</td>
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<tr>
<td>Concurrent Care Claim Extension</td>
<td>If claim is approved, physician is notified.</td>
<td>If an urgent care claim, as soon as possible but</td>
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<tr>
<td></td>
<td>If claim is denied, the patient and physician are</td>
<td>not more than 24 hours, provided the request</td>
</tr>
<tr>
<td></td>
<td>notified.</td>
<td>was made at least 24 hours prior to the</td>
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<td>expiration of the previously approved course</td>
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<td>of treatment.</td>
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<td></td>
<td>Otherwise, 15 calendar days</td>
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<tr>
<td>Concurrent Care Claim Reduction or</td>
<td>The physician and the patient.</td>
<td>Notification to reduce or end a previously</td>
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<tr>
<td>Termination</td>
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<td>approved course of treatment will provide</td>
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<td>enough advance notice to allow the patient to</td>
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<td>appeal before coverage terminates.</td>
</tr>
</tbody>
</table>
### Type of Claim | Who Is Notified | When Notification is Made
--- | --- | ---
Post-Service Claim | If claim is approved, physician is notified. If claim is denied, the patient and physician are notified. | 30 calendar days

### Extensions of Time Frames

The time periods described in the chart may be extended as follows:

- **For urgent care claims:** If Aetna does not have sufficient information to decide the claim, you and your provider will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after the additional information is provided. If you fail to provide the information, your claim will be denied.

- **For non-urgent pre-service and post-service claims:** The time frames may be extended for up to 15 additional days for reasons beyond the Plan’s control. In this case, Aetna will notify you of the extension before the original notification time period has ended. If you fail to provide the information, your claim will be denied.

For example, if Aetna needs more information to process your post-service claim, Aetna will notify you of the extension before the original notification time period has ended. Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier).

### Payment of Medical and Dental Benefits

Benefits are payable to you; however, the Plan has the right to pay any health benefits to the service provider. This will be done unless you (or your health care provider) direct otherwise at the time the claim is filed.

### The Explanation of Benefits (EOB) Statement

When Aetna processes a claim for you or a covered dependent, you'll receive an Explanation of Benefits (EOB) Statement that will clearly explain how your benefit or payment was determined.

### Recovery of Overpayment

If a benefit payment is made to you or to a health care provider, and the payment is greater than the benefit amount you are entitled to under the Plan, the Plan has the right to:

- Request the return of the overpayment; or
- Offset the amount of overpayment against future benefit payments to be made to or on behalf of the claimant or another person in his or her family.
This right does not affect any other right of recovery the Plan may have with respect to overpayment.

If you receive benefits as the result of erroneous overpayments, misleading representations, false information, or other fraudulent representations to the Plan, you will be liable to repay all resulting amounts the Plan pays. Also, you will be liable for all costs of collection, including interest, attorneys’ fees, and court costs. The Plan may apply subsequent benefits that would otherwise be payable to recoup any overpayments.

**Aetna Claims Appeal Process**

In the event your claim is denied in whole or in part, you have the right to appeal the Adverse Benefit Determination. As discussed below, the standard process is a mandatory, two-level process. Also discussed is a voluntary External Review Process that may be utilized at your discretion.

**Health Claims – Standard Appeals**

As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An “Adverse Benefit Determination” is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is experimental or investigational; or
- A decision that the service or supply is not medically necessary.

A “Final Internal Adverse Benefit Determination” is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.
Exhaustion of Internal Appeals Process
Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan’s appeal requirements (“Deemed Exhaustion”) and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to External Review if:

- A rule violation was minor and is not likely to influence a decision or harm you; and
- It was for a good cause or was beyond Aetna’s or the Plan’s or its designee’s control; and
- It was part of an ongoing good faith exchange between you and Aetna or the Plan.

This exception is not available if the rule violation is part of a pattern or practice of violations by Aetna or the Plan.

You may request a written explanation of the violation from the Plan or Aetna, and the Plan or Aetna must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an External Reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the External Reviewer or court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

Full and Fair Review of Claim Determinations and Appeals
Aetna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call Aetna’s Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-
service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna’s Member Services. Aetna’s Member Services telephone number is on your ID Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Aetna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

**Health Claims – Voluntary Appeals External Review**

“External Review” is a review of an eligible Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A “Final External Review Decision” is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the **Request for External Review Form**.
You must submit the Request for External Review Form to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

**Request for External Review**
The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the claim decision involves medical judgment and the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations); or
- The standard levels of appeal have been exhausted; or
- The appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

**Preliminary Review**
Within 5 business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review and you are eligible for external review.
Within one business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48 hour period following the receipt of the notification, whichever is later.

**Referral to ERO**

Aetna will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request’s eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

(i) Your medical records;
(ii) The attending health care professional’s recommendation;
(iii) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
(iv) The terms of your Plan to ensure that the ERO’s decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
(vi) Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
(vii) The opinion of the ERO’s clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.
Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

**Expedited External Review**

The Plan must allow you to request an expedited External Review at the time you receive:

a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

b) A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard External Review. Aetna must immediately send you a notice of its eligibility determination.

**Referral of Expedited Review to ERO**

Upon a determination that a request is eligible for External Review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

<table>
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<tr>
<th>Keep in Mind</th>
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<tbody>
<tr>
<td>If you file a request for External Review, any applicable statute of limitations will be suspended while the appeal is pending.</td>
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<tr>
<td>Since this level of appeal is voluntary, you are not required to pursue it before initiating legal action.</td>
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<tr>
<td>The filing of a request for External Review will have no effect on your rights to any other benefits under the Plan.</td>
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**Claim Fiduciary for the Aetna Medical and Dental Program**

Aetna is the Claim Fiduciary, through delegation from the Plan Administrator, under the Aetna Medical and Dental Program and its decisions are made in accordance with the provisions of the Plan. The Claim Fiduciary has complete authority to review denied claims for benefits under the Plan. This includes, but is not limited to, determining whether treatment is, or is not, medically
necessary. In exercising its fiduciary responsibility, the Claim Fiduciary has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

The Claim Fiduciary has the right to adopt reasonable policies, procedures, rules, and interpretations of the Plan to promote orderly and efficient administration. The Claim Fiduciary may not act arbitrarily and capriciously, which would be an abuse of its discretionary authority.

Legal Action

If you do not agree with the final determination on review, you have the right to bring a legal action in federal court under Section 502(a) of ERISA. You must, however, exhaust the applicable Level One and Level Two Appeals procedure before you initiate any legal action regarding denial of a claim.

No legal action can be brought to recover a benefit after three years from the deadline for filing claims.
CVS Caremark Claims Appeal Process

Prescription drug claims may be denied at the pharmacy. In that case, you have the right to appeal any such adverse benefit determination. CVS Caremark is the named fiduciary for this purpose and decides all claims and appeals for prescription benefits. CVS Caremark will process prescription appeals in accordance with federal regulations under ERISA and in accordance with applicable Program provisions. CVS Caremark has full discretionary authority to interpret the terms of the Program for these purposes. However, if your claim is denied on the grounds that you are not covered under the Program or are not eligible for coverage, you should contact the Aetna Member Services at (800) 874-1458.

How to File an Appeal

If your claim for pharmacy benefits is denied, either in whole or in part, you may appeal the denial by requesting a review of your claim by CVS Caremark. Your written request for an appeal must be received by CVS Caremark within 180 days after the date you received your notice that CVS Caremark denied your claim. Your request for an appeal should be mailed to:

CVS Caremark
Prescription Claim Appeals
MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: (866) 443-1172

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim for benefits. You may also request reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You will not be charged for this information. CVS Caremark’s review of the initial adverse determination will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in the initial determination of your claim. You will also be provided a review that does not afford deference to the initial adverse determination to be conducted by someone who is neither the individual who made the initial determination nor the subordinate of such individual.

If your appeal involves a determination based in whole or part 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), CVS Caremark will consult with a healthcare professional with the appropriate training and experience in the field of medicine at issue in your appeal. The healthcare professional consulted will be an individual who is neither an individual who was consulted in connection with the initial determination that is the subject of the appeal nor the subordinate of any such individual. CVS Caremark will provide you with the name of any medical or vocational experts whose advice was sought in connection with your appeal.
If, after reviewing your appeal and any further information that you have submitted, CVS Caremark denies your claim, either in whole or in part, a written notification will be provided to you within a reasonable period of time, but not later than 30 days (72 hours for urgent care claims) from the day your request for a review was received by Caremark.

If, after reviewing your appeal and any further information that you have submitted, CVS Caremark denies your appeal, either in whole or in part, you must appeal CVS Caremark’s denial by requesting a review of your claim. Your written request for an appeal must be received by CVS Caremark within 90 days after the date you received your notice that CVS Caremark denied your claim.

The remainder of your second level appeal will be handled as discussed above. Your request for a second level appeal should be mailed to:

    CVS Caremark
    Prescription Claim Appeals
    MC 109
    P.O. Box 52084
    Phoenix, AZ 85072-2084
    Fax: (866) 443-1172

If, after reviewing your appeal and any further information that you have submitted, CVS Caremark denies your second level appeal, either in whole or in part, a notice (which will be provided to you in writing by mail or hand delivery, or through e-mail) will be provided to you within a reasonable period of time, but not later than 30 days (72 hours for urgent care claims) from the day your request for a review was received by CVS Caremark.

The notice describing CVS Caremark’s decision will describe (i) the specific reason or reasons for its decision, including any adverse determinations, (ii) references to the specific plan provisions on which the decision was based, (iii) your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, (iv) a description of any voluntary appeals procedures, if any, and your right to obtain information about such procedures, and (v) your right to bring a cause of action for benefits under section 502(a) of ERISA. If you do not agree with any of the Claim Administrator’s decisions you must exhaust all levels of appeals provided by the Plan before you can proceed to court.

Your notice will also describe, if applicable, any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or the availability of such internal rule, guideline, protocol or other similar criterion free of charge upon request). Also, if your appeal involved a question of medical necessity or the experimental nature of a treatment, or a similar exclusion or limit, the explanation of the scientific or clinical judgment for the determination (or the availability of such an explanation) will be provided to you.
Legal Action

If your appeal is denied at the Second Level, you will have the right to bring an action in federal court under Section 502(a) of ERISA. You must, however, exhaust the Second Level appeal procedure before you initiate any legal action regarding denial of a claim.

No legal action can be brought to recover a benefit after three years from the deadline for filing claims.
Your ERISA Rights

The Employee Retirement Income Security Act of 1974, known as ERISA, guarantees your rights as a participant in the Plan. ERISA provides that you are entitled to:

**Receive Information About Your Plan and Benefits**

You have the right to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is 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 all documents governing the operation of the Plan, including insurance contracts and the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a recognized charge for the copies.

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

- Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

**Continue Group Health Plan Coverage**

You have the right to continue health care coverage for yourself, spouse, and/or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and 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.

**Prudent Action by Plan Fiduciaries**

In addition to creating rights for Plan Participants, ERISA 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 other Plan participants and beneficiaries.

No one, including your employer or any 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 ERISA.
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 your rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that 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 domestic relations order or a medical child support order, you may file suit in a 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.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance with obtaining documents, you should contact:

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- 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.
**General Information About the Plan**

**Employer/Plan Sponsor**  
CSX Corporation  
500 Water Street, C-905  
Jacksonville, FL 32202  
(800) 368-5279

**Employer Identification Number**  
62:1051971

**Plan Name**  
CSX Corporation Medical, Dental and Prescription Drug Plan

**Plan Number**  
504

**Plan Type**  
Welfare

**Plan Year**  
The Plan Year runs from January 1 to December 31.

**Plan Administrator**  
Plan Administrator  
c/o Vice President – Compensation & Benefits  
CSX Compensation & Benefits Department  
CSX Corporation  
500 Water Street, C-905  
Jacksonville, FL 32202  
Phone (904) 359-2345

**Type of Claims Administration**  
**Medical and Dental**  
The Plan is administered under an administrative-services-only agreement with Aetna Life Insurance Company.

**Prescription Drug**  
The prescription drug program for all Medical Plan options is administered under an administrative agreement with CVS Caremark.
Addresses for Claims Processing

Aetna - Medical Claims:
Aetna Member Services
PO Box 31450
Tampa, FL  33631-3450

Aetna – Medical Appeals
Attn: National Account CRT
P.O. Box 14463
Lexington, KY 40512

CVS Caremark:
CVS Caremark Claims
P. O. Box 52136
Phoenix, AZ  85072-2136

CVS Caremark Prescription Claim Appeals
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

Aetna - Dental PPO Claims:
Aetna Member Services
PO Box 14094
Lexington, KY  40512

Aetna - Dental DMO Claims:
Aetna Member Services
PO Box 14094
Lexington, KY  40512

Source of Contributions to the Plan
Employer and Employee

Agent for Service of Legal Process
CSX Corporation
Corporate Secretary’s Office
500 Water Street
Jacksonville, FL  32202

Amendment or Termination of the Plan

CSX reserves the right to terminate the Plan at any time. Any covered claims or expenses that were incurred prior to the termination of the Plan shall be covered to the extent provided in the Plan. Any claims or expenses incurred after the Plan is terminated will not be covered.

CSX also reserves the right to suspend, withdraw, amend, or change the Plan, in whole or in part, at any time. For example, this means that copayments, deductibles, and limits may change; or the services or procedures covered or excluded may change. You are not vested in any benefits provided under the Plan. Any covered claims or expenses that were incurred prior to such suspension, withdrawal, amendment, or change (or if your employer ceases participation in the Plan) shall be covered to the extent provided in the Plan. Any claims or expenses that were
incurred after such suspension, withdrawal, amendment, or change (or if your employer ceases participation in the Plan), and are not covered by the Plan as modified, shall not be covered.

CSX may, in its sole discretion, delegate the authority to amend or terminate the Plan to any individuals or other body. The decision to amend or terminate the Plan, or withdraw from participation in the Plan, is in the sole discretion of CSX (or its delegate), and shall be made unilaterally without prior consultation with any participant or beneficiary.

No one has been authorized to give any information or to make any representations, other than as contained herein and, if given and made, such information or representations must not be relied upon as having been authorized by CSX.

Plan Interpretation

The Plan shall be interpreted by the Plan Administrator (or its delegate) in accordance with the terms of the Plan and its intended meaning. However, the Plan Administrator (or its delegate) shall have the discretion to make any findings of fact needed in the administration of the Plan, and shall have the discretion to interpret or construe ambiguous, unclear, or implied (but omitted) terms in any fashion they deem to be appropriate in their sole judgment.

To the extent the Plan Administrator (or its delegate) has been granted discretionary authority under the Plan, the Plan Administrator’s (or its delegate’s) prior exercise of such authority shall not obligate it to exercise its authority in a like fashion thereafter.

If any Plan provision does not accurately reflect its intended meaning, as demonstrated by consistent interpretations or other evidence of intent, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator (or its delegate) in a fashion consistent with its intent. All actions taken and determinations made by the Plan Administrator (or its delegate) shall be final and binding upon all persons claiming any interest in or under the Plan.

Duties of the Plan Administrator

The Plan Administrator (or its delegate) shall be responsible for the general administration and management of the Plan. The Plan Administrator (or its delegate) shall have all the powers and duties necessary to fulfill its responsibilities including, but not limited to, the following powers and duties:

- To construe and interpret the Plan as it, in its sole discretion, deems to be appropriate; and
- To determine all questions relating to the eligibility of persons to participate or receive benefits as it, in its sole discretion, deems to be appropriate.

The Plan Administrator may delegate its duties, either internally or externally to a third party, as it deems appropriate in its sole discretion.

Claim Fiduciary

Aetna is the Claim Fiduciary for the Medical and Dental Plans and CVS Caremark is the Claim Fiduciary for the Prescription Drug Plan, through delegation from the Plan Administrator.
Decisions of the Claim Fiduciaries are made in accordance with provisions of the Plan. The Claim Fiduciary has complete authority to review denied claims for benefits under the Plan. This includes, but is not limited to, determining whether treatment is, or is not, medically necessary. In exercising its fiduciary responsibility, the Claim Fiduciary has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

The Claim Fiduciary has the right to adopt reasonable policies, procedures, rules, and interpretations of the Plan to promote orderly and efficient administration. The Claim Fiduciary may not act arbitrarily and capriciously, which would be an abuse of its discretionary authority.

**Plan Document**

The benefits described in this booklet are part of the CSX Corporation Health and Welfare Plan. This booklet constitutes the Summary Plan Description (SPD) required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The SPD and the CSX Corporation Health and Welfare Plan document together constitute the Plan. In the event of any conflict between this booklet and the Plan Document, the terms of this booklet control.
Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

Financial Sanctions Exclusions

If any benefit provided by this Plan violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Assignments

Coverage and your rights under this Plan may not be assigned. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding.

Rescission of Coverage

The Plan may rescind your coverage if you, or the person seeking coverage on your behalf:

- Performs an act, practice or omission that constitutes fraud; or
- Makes an intentional misrepresentation of material fact.

You will be given 30 days advance written notice of any rescission of coverage.

As to medical and prescription drug coverage only, you have the right to an internal Appeal with Aetna and/or the right to a third party review conducted by an independent External Review Organization if your coverage under this booklet is rescinded retroactive to its Effective Date.

Non-Discrimination

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

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna 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: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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, 800-537-7697 (TDD)


**Additional Provisions**

The following additional provisions apply to your coverage:

- This booklet applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- In the event of a misstatement of any fact affecting your coverage under the Plan, the true facts will be used to determine the coverage in force.
Federal Notices

The Newborns’ and Mothers’ Health Protection Act

Federal law generally prohibits restricting benefits for hospital lengths of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery and less than 96 hours following a caesarean section. However, the Plan may pay for a shorter stay if the attending provider (physician, nurse midwife, or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

Also, federal law states that plan benefits may not, for the purpose of benefits or out-of-pocket costs, treat the later portion of such a hospital stay in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

The Women’s Health and Cancer Rights Act

In accordance with the Women’s Health and Cancer Rights Act, this Plan covers the following procedures for a person receiving benefits for a medically necessary mastectomy:

- All stages of reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy.

For answers to questions about the plan’s coverage of mastectomies and reconstructive surgery, call Aetna Member Services at the number shown on your ID card.
CHIP Notice

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
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<tr>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
<td>Website: <a href="http://flmedicaidtplrecovery.com/hipp/">http://flmedicaidtplrecovery.com/hipp/</a></td>
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<tr>
<td>Phone: 1-855-692-5447</td>
<td>Phone: 1-877-357-3268</td>
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<tr>
<th>ALASKA – Medicaid</th>
<th>GEORGIA – Medicaid</th>
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<tr>
<td>The AK Health Insurance Premium Payment Program</td>
<td>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a></td>
</tr>
<tr>
<td>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td>- Click on Health Insurance Premium Payment (HIPP)</td>
</tr>
<tr>
<td>Phone: 1-866-251-4861</td>
<td>Phone: 404-656-4507</td>
</tr>
<tr>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
<td>Medicaid Eligibility:</td>
</tr>
<tr>
<td>Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
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<tr>
<th>ARKANSAS – Medicaid</th>
<th>INDIANA – Medicaid</th>
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<tr>
<td>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a></td>
<td>Healthy Indiana Plan for low-income adults 19-64</td>
</tr>
<tr>
<td>Phone: 1-855-MyARHIPP (855-692-7447)</td>
<td>Website: <a href="http://www.hip.in.gov">http://www.hip.in.gov</a></td>
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<td></td>
<td>Phone: 1-877-438-4479</td>
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<td></td>
<td>All other Medicaid</td>
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<tr>
<td></td>
<td>Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a></td>
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<td>Phone 1-800-403-0864</td>
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<tr>
<th>COLORADO – Medicaid</th>
<th>IOWA – Medicaid</th>
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<tr>
<td>Medicaid Website: <a href="http://www.colorado.gov/hcpf">http://www.colorado.gov/hcpf</a></td>
<td>Website: <a href="http://www.dhs.state.ia.us/hipp/">http://www.dhs.state.ia.us/hipp/</a></td>
</tr>
<tr>
<td>Medicaid Customer Contact Center: 1-800-221-3943</td>
<td>Phone: 1-888-346-9562</td>
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<tr>
<th>KANSAS – Medicaid</th>
<th>NEW HAMPSHIRE – Medicaid</th>
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CSX Medical, Dental & Prescription Drug SPD  
Active Management Employees  
January 1, 2017
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<tr>
<th>State</th>
<th>Medicaid and CHIP Website</th>
<th>Medicaid and CHIP Phone</th>
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<tr>
<td>KENTUCKY – Medicaid</td>
<td><a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
<td>1-800-635-2570</td>
</tr>
<tr>
<td>LOUISIANA – Medicaid</td>
<td><a href="http://dbh.louisiana.gov/index.cfm/subhome/s/n/331">http://dbh.louisiana.gov/index.cfm/subhome/s/n/331</a></td>
<td>1-888-695-2447</td>
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<tr>
<td>MASSACHUSETTS – Medicaid and CHIP</td>
<td><a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a></td>
<td>1-800-462-1120</td>
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<tr>
<td>MINNESOTA – Medicaid</td>
<td><a href="http://www.dhs.ma/">http://www.dhs.ma/</a></td>
<td>1-800-657-3739</td>
</tr>
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<td>MISSOURI – Medicaid</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.html">http://www.dss.mo.gov/mhd/participants/pages/hipp.html</a></td>
<td>573-751-2005</td>
</tr>
<tr>
<td>MONTANA – Medicaid</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIP</a></td>
<td>1-800-694-3084</td>
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<tr>
<td>NEBRASKA – Medicaid</td>
<td><a href="http://dhss.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">http://dhss.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx</a></td>
<td>1-855-632-7633</td>
</tr>
<tr>
<td>NEVADA – Medicaid</td>
<td><a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a></td>
<td>1-800-992-0900</td>
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<td>SOUTH DAKOTA - Medicaid</td>
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<td>SOUTH DAKOTA – Medicaid</td>
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<td>WEST VIRGINIA – Medicaid</td>
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<td>WISCONSIN – Medicaid</td>
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<td>WASHINGTON – Medicaid</td>
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<td>WASHINGTON – Medicaid</td>
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<td>State</td>
<td>Program</td>
<td>Website</td>
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<tr>
<td>TEXAS</td>
<td>Medicaid</td>
<td>Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a></td>
</tr>
<tr>
<td>WEST VIRGINIA</td>
<td>Medicaid</td>
<td>Website: <a href="http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx">http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx</a></td>
</tr>
<tr>
<td>WISCONSIN</td>
<td>Medicaid and CHIP</td>
<td>Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a></td>
</tr>
<tr>
<td>VERMONT</td>
<td>Medicaid</td>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
</tr>
<tr>
<td>WYOMING</td>
<td>Medicaid</td>
<td>Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a></td>
</tr>
<tr>
<td>VIRGINIA</td>
<td>Medicaid and CHIP</td>
<td>Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
</tr>
</tbody>
</table>

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

- U.S. Department of Labor Employee Benefits Security Administration<br>www.dol.gov/ebsa<br>(866) 444-EBSA (3272)
- U.S. Department of Health & Human Services Centers for Medicare & Medicaid Services<br>www.cms.hhs.gov<br>(877) 267-2323, Menu Option 4, Ext. 61565

**Notice of Special Enrollment Rights**

If you decline enrollment in medical coverage for you or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in your company’s medical plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage) as long as you request enrollment no more than 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in your company’s medical plan as long as you request enrollment by contacting the CSX Compensation & Benefits department no more than 31 days after the marriage, birth, adoption or placement for adoption.
If you and your eligible dependents are not already enrolled in your company’s medical plan, you may be able to enroll yourself and your eligible dependents if (1) you or your dependents lose coverage under a state Medicaid or children’s health insurance program (CHIP), or (2) you or your dependents become eligible for premium assistance under state Medicaid or CHIP, as long as you request enrollment no more than 60 days from the date of the Medicaid/CHIP event.

For more information, contact the CSX Compensation & Benefits department at (800) 368-5279.

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act of 2008 (“GINA”) generally restricts the Plan’s ability to use genetic information concerning you and your family members. Genetic information includes information regarding genetic tests for you and your family members, information regarding the manifestation of a disease or disorder in you or your family members, and any request for (or receipt of) genetic services, including participation in clinical research trials that involve genetic services. The Plan will comply with the rules and regulations of GINA.
Disclosure of Protected Health Information

Health plans are subject to federal privacy and security regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"). The regulations are the “Privacy Rules” and “Security Rules”. The Privacy Rules describe certain limitations on the disclosure of protected health information by the Plan, as well as the measures that the Plan must take to safeguard this information. The Security Rules describe the restrictions that apply to any protected health information collected, stored, processed, or transmitted in electronic form and the measures that the Plan must take to safeguard this electronic information.

“Protected health information” or “PHI” is information about you, including demographic information collected from you, which:

- Can reasonably be used to identify you; and
- Relates to your past, present, or future physical or mental health condition.

Protected health information is also information about the provision of health care or the payment for that care.

The Plan considers personal information to be confidential. We protect the privacy of that information in accordance with federal and state privacy laws, as well as our own company privacy policies. We will use or disclose your protected health information for the purpose of carrying out Plan administrative functions in a manner that is consistent with the Privacy Rules.

How the Plan Uses and Discloses Protected Health Information (PHI)

Permitted Uses and Disclosures

The Plan may use and disclose PHI related to a person covered by the Plan, as follows:

- PHI about a person may be disclosed to that person.
- PHI about a person (excluding any PHI that is genetic information) may be used or disclosed, without the consent of the person, for the purpose of carrying out certain Plan payment and health care operations functions, including:
  - Obtaining premiums or contributions for the coverage,
  - Determining or fulfilling the Plan’s responsibility to provide benefits,
  - Obtaining or providing reimbursement for the provision of health care under the Plan, and
  - Conducting or arranging for medical review, legal services, and auditing functions.
- PHI may be disclosed or used to comply with a valid authorization under the Privacy Rules.
• Any other disclosure or use of PHI is permitted if contemplated in the Privacy Rules.

**Required Uses and Disclosures**

The Privacy Rules require the Plan to disclose PHI about a person to that person when:

• Access is requested; or
• An accounting of disclosed information is requested; and
• When required by the Secretary of the Department of Health and Human Services.

**Genetic Information for Underwriting Purposes**

Although the Plan may use and disclose PHI for health care operations, the Plan may not use or disclose PHI that is genetic information for underwriting purposes (generally, eligibility determinations, premium computations, application of pre-existing condition exclusions, and any other activities related to the creation, renewal, or replacement of health benefits). Genetic information includes information regarding genetic tests for a covered individual or a covered individual’s family members, information regarding the manifestation of a disease or disorder in a covered individual or a covered individual’s family members, and any request for (or receipt of) genetic services, including participation in clinical research trials that involve genetic services.

**Certification Requirements**

The Plan may disclose PHI about a covered person to CSX Corporation only if CSX Corporation certifies to the Plan that CSX Corporation will:

• Not use or further disclose the information other than as described in this booklet, or as required by law.
• Ensure that any agents (including a subcontractor) to whom CSX Corporation provides protected health information received from the Plan agree to the same restrictions and conditions that apply to CSX Corporation with respect to such information.
• Not use or disclose the protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plans, unless authorized by the Plan participant.
• Report to the Plan’s privacy officer (or his or her delegate) any use or disclosure of the protected health information that is inconsistent with the uses or disclosures described above (including any breach within the meaning of 45 C.F.R. § 164.402) of which CSX Corporation becomes aware.
• As required by federal privacy regulations, (45 C.F.R. §§164.524, .526 and .528):
  • Make protected health information available to individuals, including for purposes of amendment,
  • Incorporate any such amendments, and
Make available the information required to provide individuals with an accounting of certain of CSX Corporation’s disclosures of their protected health information.

- Make internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human services for purposes of determining compliance by the Plan with the Privacy Rules.

- If feasible, return or destroy all protected health information received from the Plan that CSX Corporation still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible.

- Ensure that it provides for adequate separation between the Plan and CSX Corporation, as required under the HIPAA privacy standards.

**Appropriate Safeguards for Electronic Protected Health Information**

The Plan is required under the HIPAA Security Standards to ensure that Electronic PHI (as defined in the HIPAA Privacy Standards) created, received, maintained or transmitted to or by CSX Corporation on behalf of the Plan will be reasonably and appropriately safeguarded. In connection with this regulatory requirement, if CSX Corporation has such Electronic PHI, it will:

- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any Electronic PHI that CSX Corporation creates, receives, maintains or transmits on behalf of the Plan.

- ensure that any agent, including a subcontractor, to whom it provides Electronic PHI that CSX Corporation creates, maintains or transmits on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect such information.

The safeguards described above are not intended in any way to limit the disclosure or use of Electronic PHI in accordance with the provisions of the above section entitled “Required Uses and Disclosures.”

**Access to Protected Health Information**

Individuals employed by CSX Corporation in the CSX Benefits Department have access to protected health information for limited purposes if:

- Their primary functions include activities relating to the administration of the Plan; and

- They routinely have access to protected health information in connection with the payment and health care operation functions of the Plan.

Failure to comply with the Privacy Rules will be reviewed by the Plan’s privacy officer and may result in disciplinary action.
**Reporting of Security Incidents**

CSX Corporation will report the occurrence of any Security Incident (as defined in the HIPAA Security Standards) of which it becomes aware to the Plan's security officer (or his or her delegate).

**Breaches of Unsecured Protected Health Information**

The Plan (or its delegate) will comply with the applicable notice requirements for any unauthorized acquisition, access, use, or disclosure (a “breach”) of Unsecured Protected Health Information (as defined in HIPAA) within the required timeframe(s) for such a breach.
In this section, you’ll find definitions for the words and phrases that appear in bold type throughout the text of this booklet.

**Adverse Benefit Determination**

A decision that results in denial, reduction, or termination of a benefit or the amount paid for a benefit. An *Adverse Benefit Determination* also includes a decision not to provide a benefit or service.

**Aetna**

Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with Aetna.

**Ambulance**

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

**Autism Spectrum Disorder**

As defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

**Body Mass Index**

A practical marker used to assess the degree of obesity that is calculated by dividing the weight in kilograms by the height in meters squared.

**Brand-Name Drug**

A prescription drug that is protected by trademark registration and is not a generic drug.

**Coinsurance**

Coinsurance is both the percentage of covered expenses that the Plan pays (the Plan’s coinsurance) and the percentage of covered expenses that you pay (your coinsurance). Please refer to the *Summary of Benefits* for specific information on coinsurance amounts.

**Companion**

A person who needs to be with an Institute of Excellence (IOE) patient to enable him or her:

- To receive services in connection with an IOE procedure or treatment on an inpatient or outpatient basis; or
- To travel to and from the facility where treatment is given.
Copay, Copayment

This is a fee, usually charged at the time you receive a service or supply, which represents a portion of the applicable expense. Copay amounts are specified in the Summary of Benefits.

Custodial Care

Services and supplies that are primarily intended to help a person meet their personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators, or catheters. Examples of custodial care include:

- Routine patient care such as changing dressings, periodic turning, and positioning in bed, tracheostomy care and feeding (intermittent and continuous);
- Watching or protecting you;
- Respite care;
- Institutional care, including room and board for rest cures, adult day care, and convalescent care;
- Helping you with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

Deductible

A deductible is the part of your covered expenses you pay before the Plan starts to pay benefits. Additional information about deductible amounts can be found in the Summary of Benefits.

Dentist

A legally qualified dentist, or a physician licensed to do the dental work he or she performs.

Detoxification

The process whereby an alcohol- or drug-intoxicated or alcohol- or drug-dependent person is assisted, in a facility meeting any applicable licensing standards established by the jurisdiction in which it is located, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a physician, while keeping the physiological risk to the patient at a minimum.
Durable Medical Equipment

Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an illness or injury;
- Suited for use in the home;
- Not normally of use to people who do not have an illness or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, communication aids, vision aids, and telephone alert systems.

Effective Treatment of Substance Abuse

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

- Has a follow-up therapy program directed by a physician on at least a monthly basis; or
- Includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

Detoxification and maintenance care are not effective treatment.

Emergency Admission

One where the physician admits you to the hospital or treatment facility right after the sudden and, at that time, unexpected onset of an emergency medical condition which requires confinement right away as a full-time inpatient.

Emergency Medical Condition

This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
• In the case of a pregnant woman, serious jeopardy to the health of the fetus.

**Experimental or Investigational**

A drug, device, treatment, or procedure is *experimental or investigational* if:

• There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the *illness* or *injury* involved; or

• Approval required by the FDA has not been granted for marketing; or

• A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or

• It is a type of drug, device, or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial. A phase is defined in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or

• The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental or investigational, or for research purposes.

**Final Internal Adverse Benefit Determination**

The final benefit determination on a Level Two Appeal.

**Generic Drug**

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

**Home Health Care Agency**

An agency that meets *all* of the following requirements.

• Mainly provides skilled nursing and other therapeutic services;

• Is associated with a professional group (of at least one *physician* and one *R.N.*) which makes policy;

• Has full-time supervision by a physician or an R.N.;

• Keeps complete medical records on each person;

• Has an administrator; and

• Meets licensing standards.
Hospice Care

This is care given to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

Hospice Care Agency

This is an agency or organization that:

- Has **hospice care** available 24 hours a day;
- Meets any licensing or certification standards established by the jurisdiction where it is located;
- Provides:
  - Skilled nursing services,
  - Medical social services, and
  - Psychological and dietary counseling;
- Provides, or arranges for, other services that include:
  - Physician services,
  - Physical and occupational therapy,
  - Part-time home health aide services which mainly consist of caring for terminally ill people, and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management;
- Has at least the following personnel:
  - One physician,
  - One R.N., and
  - One licensed or certified social worker employed by the agency;
- Establishes policies about how hospice care is provided;
- Assesses the patient’s medical and social needs;
- Develops a hospice care program to meet those needs;
- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the agency;
● Permits all area medical personnel to utilize its services for their patients;
● Keeps a medical record on each patient;
● Uses volunteers trained in providing services for non-medical needs; and
● Has a full-time administrator.

Hospital

This is:

● An institution that:
  − Operates in accordance with the laws of the jurisdiction in which it is located;
  − Is primarily engaged in providing on its premises, inpatient medical, surgical, and diagnostic services, under the supervision of a staff of physicians,
  − Provides 24-hour-a-day R.N. service, and
  − Charges patients for its services; or
● An institution that does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does hospital include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital, or facility primarily for rehabilitative or custodial services.

Infertile

This means:

● For a female who is under age 35, the inability to conceive after one year or more without contraception or 12 cycles of artificial insemination.

● For a female who is age 35 or older, the inability to conceive after six months without contraception or six cycles of artificial insemination.

Injury

An accidental bodily injury that results solely and directly from an unexpected or unforeseen occurrence or event, or the unforeseeable consequences of a voluntary act by the person. The act or event must be definite as to time and place.
Institute of Excellence (IOE)

A hospital that has contracted with Aetna to furnish services or supplies to an IOE patient in connection with specific transplants at a negotiated charge.

L.P.N.

A licensed practical or vocational nurse.

Late Enrollee

An eligible Employee who requests enrollment under this Plan after the Initial Enrollment Period. In addition, this is an eligible dependent for whom the employee did not elect coverage within the Initial Enrollment Period, but for whom coverage is elected at a later time. However, an eligible employee or dependent may not be considered a Late Enrollee under certain circumstances discussed in the Special Enrollment Period section above.

Mail Order Pharmacy

An establishment where prescription drugs are legally dispensed by mail or other carrier.

Maintenance Care

This is care made up of services and supplies that:

- Are furnished mainly to maintain, rather than to improve, a level of physical, or mental function;
- Provide a surrounding free from exposures that can worsen the person’s physical or mental condition.

Medically Necessary

These are health care or dental services, and supplies or prescription drugs that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating an illness, an injury, a disease; or its symptoms.

The provision of the service, supply or prescription drug must be:

- In accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not mostly for the convenience of the patient, physician, other health care or dental provider; and
Do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with physician or dental specialty society recommendations. They must be consistent with the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

**Mental Illness**

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

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive mental developmental disorder (autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

**Morbid Obesity**

The condition of having a Body Mass Index that is greater than 40 kilograms per meter squared, or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

**Negotiated charge**

This is the maximum charge a network provider has agreed to make for any service or supply for the purpose of benefits under this Plan.

**Network Provider**

A group of private-practice physicians, hospitals, and other health care providers who have agreed to deliver care for a negotiated charge.
**Non-occupational Illness**

A **non-occupational illness** means an illness that does not:

- Arise out of (or in the course of) any activity in connection with employment or self-employment, whether or not on a full time basis; or
- Result in any way from an illness which does.

An illness will be considered non-occupational, regardless of its cause, if you provide proof to Aetna that you are:

- Covered by any type of workers' compensation law; and
- Not covered for that illness under such law.

**Non-Occupational Injury**

An accidental **injury** that does not:

- Arise out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Result in any way from an injury which does.

**Orthodontic Treatment**

This is any medical or dental service or supply furnished to prevent, diagnose, or treat a misalignment of:

- The teeth;
- The bite; or
- The jaws or jaw joint relationship,
  … whether or not for the purpose of relieving pain.

**Out-of-Network Provider**

This is a health care provider who does not belong to Aetna’s network and has not contracted with the Claims Administrator to furnish services or supplies at a **negotiated charge**.

**Pharmacy**

An establishment where **prescription drugs** are legally dispensed.

**Physician**

A duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual...
practices, and who provides medical services which are within the scope of the individual’s license or certificate.

This also includes a health professional who is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices, who provides medical services which are within the scope of the individual’s license or certificate, and who, under applicable insurance law, is considered a “physician” for purposes of this coverage.

Precertification

A process in which the Claims Administrator is contacted before inpatient hospital services are provided, to determine whether the services being recommended are considered covered expenses under the Plan. It is not a guarantee that benefits will be payable.

Prescription

An order for the dispensing of a prescription drug by a physician, acting within the scope of his or her license, who has the legal authority to write an order for a prescription drug. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drugs

A drug, biological, or compounded prescription which, by federal law, may be dispensed only by prescription and which is required to be labeled “Caution: Federal Law prohibits dispensing without prescription.”

Primary Care Physician (PCP)

A network physician who:

- Supervises, coordinates, and provides initial care and basic medical services to Plan participants as a general or family care practitioner or, in some cases, as an internist or a pediatrician;
- Initiates referrals for specialist care; and
- Maintains continuity of patient care.

Primary Care Dentist (PCD)

A network dentist who:

- Supervises, coordinates, and provides care and basic dental services to Plan participants;
- Initiates referrals for specialist care; and
- Maintains continuity of patient care.
Recognized Charge

The amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider’s full charge.

Your Plan’s recognized charge applies to all out-of-network covered expenses except out of network emergency services. It applies even to charges from an out-of-network provider in a hospital that is a network provider. It also applies when your PCP or other network provider refers you to an out-of-network provider. Except for Aetna facility fee schedule, the recognized charge is determined based on the Geographic area where you receive the service or supply.

A service or supply provided by a provider is treated as covered expenses under the other health care coverage category when:
- You get services or supplies from an out-of-network provider. This includes when you get care from out-of-network providers during your stay in a network hospital.
- You could not reasonably get the services and supplies needed from a network provider.

The other health care coverage does not apply to services or supplies you receive in an out-of-network emergency room.

When the other health care coverage applies, you will pay the other health care cost share.

Except as otherwise specified below, the recognized charge for each service or supply is the lesser of what the provider bills and:
- For professional services and for other services or supplies not mentioned below:
  - The reasonable amount rate
- For services of hospitals and other facilities:
  - The reasonable amount rate
The **recognized charge** is the **negotiated charge** for **providers** with whom we have a direct contract but are not **network providers** or, if there is no direct contract, with whom we have a contract through any third party that is not an affiliate of **Aetna**.

If your ID card displays the National Advantage Program (NAP) logo, the **recognized charge** is the rate we have negotiated with your NAP provider. Your out-of-network cost sharing applies when you get care from NAP **providers**, except for **emergency services**. A NAP **provider** is a **provider** with whom we have a contract through any third party that is not an affiliate of **Aetna** or through the Coventry National or First Health Networks. However, a NAP **provider** listed in the NAP directory is not a **network provider**.

We have the right to apply **Aetna** reimbursement policies. Those policies may further reduce the **recognized charge**. These policies take into account factors such as:

- The duration and complexity of a service,
- When multiple procedures are billed at the same time, whether additional overhead is required,
- Whether an assistant surgeon is necessary for the service,
- If follow up care is included,
- Whether other characteristics modify or make a particular service unique,
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided, and
- The educational level, licensure or length of training of the **provider**.

**Aetna** reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate,
- Generally accepted standards of medical and dental practice, and
- The views of **physicians** and dentists practicing in the relevant clinical areas.

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special terms used in this definition of Recognized Charge are: **Aetna** facility fee schedule, FCR Rate, Geographic area, and Reasonable amount rate are defined as follows:

**Aetna facility fee schedule**
The schedule of rates we developed using our data or experience for out-of-network facility services and supplies. We adjust the schedule from time to time at our discretion.
FCR Rate
The Facility Charge Review (FCR) Rate is an amount that we determine is enough to cover the provider's estimated costs for the service and leave the provider with a reasonable profit. For hospitals and other facilities which report costs (or cost-to-charge ratios) to CMS, the FCR Rate is based on what the facilities report to CMS; the FCR Rate is based on statewide averages of the facilities that do report to CMS. We may adjust the formulas as needed to maintain the reasonableness of the recognized charge. For example, we may make an adjustment if we determine that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.

Geographic area
The Geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider Geographic area such as an entire state.

Reasonable amount rate
There is not a single “reasonable” amount. Your plan establishes the “reasonable” amounts as follows:

- For professional services:
  - The 80th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we reserve the right to substitute an alternative. If the alternative data source does not contain a value for a particular service or supply, we will base the recognized charge on the Medicare allowable rate.

- For inpatient and outpatient charges of hospitals:
  - The FCR rate.

- For inpatient and outpatient charges of facilities other than hospitals
  - The FCR rate

Additional information:
Get the most value out of your benefits. Use the “Estimate the Cost of Care” tool on Aetna Navigator® to help decide whether to get care in network or out-of-network. Aetna’s secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the “Estimate the Cost of Care” feature. Within this feature, view our “Cost of Care” and “Member Payment Estimator” tools.

Rehabilitative Services
The combined and coordinated use of medical, social, educational, and vocational measures for training or retraining if you are disabled by illness or injury.
Residential Treatment Facility

This is an institution that meets all of the following requirements:

- Has, on site, licensed behavioral health, medical, or substance abuse professionals 24 hours per day;
- Provides a comprehensive patient assessment;
- Has the ability to assess and recognize withdrawal complications that threaten life or bodily functions, and to obtain needed services either on-site or externally;
- Has 24-hour supervision with evidence of close and frequent observation;
- Has medical treatment available, actively supervised by an attending physician;
- Provides living arrangements that foster community living and peer interaction and are consistent with developmental needs;
- Offers group therapy sessions;
- Has the ability to involve family and other support systems in therapy;
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy;
- Has peer-oriented activities;
- Is managed by a licensed behavioral health professional who functions under the direction and supervision of a licensed psychiatrist;
- Has individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Provides a level of skilled intervention consistent with patient risk;
- Provides active discharge planning initiated upon admission to the program;
- Can make referrals to, or has a connection with, appropriate substance abuse programs during residential treatment, and following discharge;
- Meets any applicable licensing standards established by the jurisdiction in which it is located; and
- Charges patients for its services.
**R.N.**

A registered nurse.

**Room and Board**

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

**Semi-Private Room Rate**

The **room and board** charge that an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, Aetna will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

**Skilled Nursing Facility**

This is an institution that meets **all** of the following requirements.

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
  - Professional nursing care by an R.N., or by an L.P.N. directed by a full-time R.N., and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities;
- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time R.N.;
- Is supervised full-time by a **physician** or R.N.;
- Keeps a complete medical record on each patient;
- Has a utilization review plan;
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders; and
- Charges patients for its services.

**Skilled Nursing Services**

Services that meet all of the following requirements:

- The services require medical or paramedical training;
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license; and
- The services are not **custodial**.
Stay
A full-time inpatient confinement for which a room and board charge is made.

Surgery Center
A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped, and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - Physicians who practice surgery in an area hospital, and
  - Dentists who perform oral surgery.
- Have at least two operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic X-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N.
- Is equipped and has trained staff to handle emergency medical conditions.
- Must have all of the following:
  - A physician trained in cardiopulmonary resuscitation, and
  - A defibrillator, and
  - A tracheotomy set, and
  - A blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
● Keeps a medical record on each patient.

**Terminally Ill**

A medical prognosis of six months or less to live.

**Urgent Condition**

This means a sudden illness, injury, or condition that:

● Is severe enough to require prompt medical attention to avoid serious deterioration of the your health;

● Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;

● Does not require the level of care provided in the emergency room of a hospital; and

● Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.