



**HEALTH CARE PREPAYMENT PLAN
&
MEDICARE SECONDARY PLAN
BENEFIT GUIDE 2009**

**Your Medicare Health Benefits and Services
as a Member of UPREHS**

January 1 – December 31, 2009

This booklet gives the details about your Medicare health coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

UPREHS CUSTOMER SERVICES

For help or information, please call Customer Services Monday through Friday from 7:30 AM to 3:30 PM Mountain Time. Calls to this number are free:

1- 800-547-0421

TTY/TDD Call the national number 711

Website: WWW.UPHEALTH.COM

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Section 1 Numbers and Other Reference Information

How to contact Union Pacific Railroad Employees Health Systems (UPREHS) Customer Services

If you have any questions or concerns, please call or write to UPREHS Customer Services. We will be happy to help you. Our business hours are 7:30 AM to 3:30 PM, Mountain Time, Monday through Friday.

CALL: 1-800-547-0421 Calls to this number are free. TTY/TDD calls use the national access number, 711.

FAX: 1-801-595-4399

EMAIL: www.uphealth.com

WRITE: UPREHS, PO Box 161020, Salt Lake City, Utah 84116-1020
UPREHS Depot Drug Mail Order Pharmacy, PO Box 165090,
Salt Lake City, Utah 84116-5090

OR VISIT: UPREHS, 1040 North 2200 West Suite 200, Salt Lake City, UT 84116

How to contact the Medicare Program 1-800-633-4227 (TTY 1-877-486-2048) help line

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). Centers for Medicare and Medicaid Services (CMS) are the Federal agency in charge of the Medicare program. CMS contracts with and regulates Medicare managed care organizations (including the UPREHS HCPP) and Medicare private fee-for-service organizations.

Here are ways to get help and information about Medicare from CMS

Call Medicare at **1-800-633-4227** to ask questions or to request free information booklets from Medicare. You can call the national Medicare help line 24 hours a day, 7 days a week. The TTY number is 1-877-486-2048 (special telephone equipment required). Calls to these numbers are free.

Use a computer to look at www.medicare.gov, the official **government Website for Medicare information**. This Website gives you a lot of up-to-date information about Medicare and nursing homes. It includes booklets you can print directly from your computer. It has a tool to help you compare Medicare managed care plans in your area. You can also search the “Helpful Contacts” section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this Website using their computers.

How to contact the Railroad Retirement Board

Most UPREHS Medicare members receive their Medicare benefits through the Railroad Retirement Board under Railroad Medicare. You can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). The TTY number is 312-751-4701 (special telephone equipment required). You can also visit their Website at www.rrb.gov.

How to contact Palmetto Government Benefits Administrator

Palmetto GBA may process your Medicare Part B claims that are not sent to UPREHS HCPP. Palmetto GBA is the Railroad Medicare Part B carrier. Palmetto GBA would process all of your Medicare claims from providers not participating in the UPREHS network. Whether or not the provider is participating with UPREHS, Palmetto GBA is still able to process your claims. You can call Palmetto GBA at 1-800-833-4455 (calls to this number are free) or write to Palmetto GBA, PO Box 10066, Augusta, GA 30999-0001.

State Health Insurance Assistance Program (SHIP)

State Health Insurance Assistance Program (SHIP) is an organization in your state that provides free Medicare help and information. SHIPs are state organizations paid by the Federal government to give free health insurance information and help to people with Medicare. SHIPs have different names depending on which state they are in. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare managed care plans and about Medigap (Medicare supplement insurance) policies. This includes information about special Medigap rights for people who have tried a Medicare managed care plan for the first time. You can find the SHIP in your state by calling the national **1-800-MEDICARE (1-800-633-4227)** telephone number. You can also find the Website for your local SHIP at www.medicare.gov.

Quality Improvement Organization (QIO)

Quality Improvement Organization (QIO) is a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare. A QIO (formerly called Peer Review Organizations or PROs) is paid by the Federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. See Section 10 for more information about complaints. You can find the QIO in your state by calling the national **1-800-MEDICARE (1-800-633-4227)** telephone number.

Medicaid Agency

A Medicaid Agency is a state government agency that handles health care programs for people with low incomes. **Medicaid** is a joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact your state Medicaid Agency.

Social Security Administration

The **Social Security Administration** provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. You can call the Social Security Administration at 1-800-772-1213. The TTY number is 1-800-325-0778 (you need special telephone equipment to use this number). Calls to these numbers are free. You can also visit their Website at www.ssa.gov.

Section 3 Getting Care if You Have a Medical Emergency or an Urgent Need for Care

What is a medical emergency?

A medical emergency is when **you reasonably believe that your health is in serious danger** — when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a medical emergency?

If you have a medical emergency get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. You do not need to get permission first from a UPREHS participating provider. You are expected to get care immediately regardless of the providers' participation status.

What is covered if you have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in America.
- Ambulance services are covered in situations where other means of transportation would endanger your health.

UPREHS Medicare Secondary Plan payment for medical emergency care

You are **not** required to go to UPREHS participating providers when you have a medical emergency to receive Original Medicare benefits.

UPREHS MSP does not reduce benefit payment for covered benefits for medical emergency care from nonparticipating providers for the first 24 (twenty-four) hours. After 24 hours, UPREHS MSP is reduced to 40% of the Medicare coinsurance or annual deductible.

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care thinking that your health is in serious danger, and the doctor may say that it was not a medical emergency after all. If this happens to you, you are still covered for the care you received to determine what was wrong, as long as you thought your health was in serious danger as explained above in *What is a medical emergency?*

- If you get any additional care after the doctor says it was **not** a medical emergency, UPREHS MSP will not reduce your secondary payment **if you get the care from a UPREHS participating provider.**
- If you get any additional care from a nonparticipating provider after the doctor says it was not a medical emergency, or after the first 24 hours, your UPREHS MSP payment will be reduced to 40% of the coinsurance or deductible amount.

What is urgently needed care?

Urgently needed care (different from a medical emergency) is when you need medical attention right away for an unforeseen illness or injury and it is not reasonable given the situation for you to get medical care from a UPREHS participating provider. In these cases, your health is not in serious danger. As we explain below, maximum UPREHS MSP payment for urgently needed care depends on whether or not a UPREHS participating provider was available to you at the time.

If you have a sudden illness or injury that is not a medical emergency, and you have UPREHS participating providers available to you, we expect you to get this care from participating providers. In most cases, UPREHS MSP reduces payment to 40% for urgently needed care that you get from a nonparticipating provider when a participating provider was available to you.

UPREHS MSP payment is reduced to 40% of the Medicare coinsurance for covered benefits for urgent care from out-of-network providers when suitable in-network providers were available.

What is the difference between a medical emergency and urgently needed care?

The main difference between a medical emergency and an urgent need for care is in the danger to your health.

- It is urgently needed care if you need medical help immediately, but your health is not in serious danger.
- It is a medical emergency if you believe that your health is in serious danger.

Section 4 Benefits Chart – A List of Covered Services

What are covered services?

Covered services means the medical care, services, supplies, and equipment that are covered by Original Medicare and/or your UPREHS MSP. This section has a Benefits Chart that gives a list of your covered services, explains some limitations on those benefits, and tells what you must pay for each covered service. The section that follows (Section 5) tells about services that are not covered (also called exclusions). Generally, covered services for Original Medicare and UPREHS MSP can only change at the beginning of each contract year.

If you have problems with getting Medicare services that you believe are covered, please see Sections 10 and 11.

There are some conditions that apply in order to get covered services and some general requirements apply to all covered services. The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to Original Medicare coverage guidelines established by the Medicare program and to UPREHS guidelines for MSP coverage.
- The listed medical care, services, supplies, and equipment as covered services must be medically necessary. Certain preventive care and screening tests are also covered. (See Section 14 for a definition of *medically necessary*.)
- With few exceptions, covered services must be provided by UPREHS participating providers to receive maximum MSP benefits. The exceptions are care for a medical emergency and urgently needed care. Original Medicare benefits are not changed when you obtain services from providers who do not participate with UPREHS.
- The Benefits Chart provides a summary of benefits under Original Medicare Part A and B and the UPREHS Medicare Secondary Plan. This chart does not describe all covered benefits or exclusions under Original Medicare or the UPREHS Medicare Secondary Plan. This chart does not take the place of laws, rules, or regulations under either program.
- When you obtain services out-of-network, the UPREHS Medicare Secondary Plan reduces benefit payment. You pay the remaining approved amounts or more up to the Medicare limiting amount, which is 115% of the Medicare approved amount if the provider does not accept Medicare assignment.

UPREHS MEDICARE PLAN BENEFITS CHART

| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
|--|--|--|---|
| PHYSICIAN SERVICES | | | |
| <ul style="list-style-type: none"> • Office visits including medical and surgical care in a physician’s office, certified ambulatory surgical center, or hospital. • Consultation, diagnosis and treatment by a specialist. • Second opinion by another participating medical provider prior to surgery. • Outpatient hospital medical and surgical services. • Comprehensive outpatient rehabilitation facility services. • Telehealth office visits including consultation, diagnosis and treatment by a specialist. • Hearing & balance exams ordered by your doctor to see if you need medical treatment. • Inpatient medical and surgical services. | <p>You pay the Part B annual deductible plus 20% of the approved amount not paid by Medicare.</p> <p><i>*UPREHS HCPP processes Original Medicare Part B claims for participating physician office visits and office services, consultations, hospital visits, and surgical procedures.</i></p> | <p>UPREHS pays the Part B annual deductible and/or the approved amount not paid by Medicare. You pay \$0.</p> <p><i>*UPREHS HCPP processes Original Medicare Part B claims for participating physician office visits and office services, consultations, hospital visits, and surgical procedures.</i></p> | <p>UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amount not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment.</p> |
| AMBULANCE SERVICES | | | |
| <p>Includes ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health. Medicare benefits cover only transport to the nearest facility equipped to handle the medical problem. Includes fixed wing, rotary wing and ground ambulance transport.</p> | <p>You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay for all amounts above Medicare approved amounts if the provider does not accept assignment. You pay all amounts for services that are not allowed by Medicare.</p> | <p>UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay all amounts for services that are not allowed by Medicare.</p> | <p>UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay all amounts for services that are not allowed by Medicare.</p> |

(Benefits chart continued on next page)

UPREHS MEDICARE PLAN BENEFITS CHART

| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
|--|---|---|--|
| HOSPITAL INPATIENT CARE | | | |
| <p>A benefit period begins on the first day you go to a Medicare-covered inpatient hospital and ends when you have not received any hospital care for 60 consecutive days. If you go to the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. Medicare Part A includes an extra 60 lifetime reserve days for hospital stays longer than 90 days. Benefit periods renew, but lifetime reserve days do not. (For more information see Section 7.)</p> <ul style="list-style-type: none">• Semiprivate room (private if medically necessary).• Meals including special diets.• Regular nursing services.• Cost of special care units, such as intensive care or coronary care units.• Drugs and medications.• Lab tests.• X-rays and other radiology services.• Necessary surgical and medical supplies.• Use of appliances, such as wheelchairs.• Operating and recovery room costs.• Physician Services• Rehabilitation services, such as physical therapy, occupational therapy, and speech language therapy services.• Transplants: kidney, pancreas, heart, liver, lung, corneal, heart/lung, bone marrow, stem cell, intestinal and multivisceral transplants under certain conditions. See Section 7 for more information.• * Blood including storage and administration. Coverage of whole blood and packed red cells begin with the fourth pint of blood that you need and storage begins with the first pint of blood that you need. | <p>You pay \$1,068 for days 1-60 in the benefit period. You pay \$267 per day for days 61-90. You pay \$534 per day for days 91-150 (lifetime reserve days). You pay all hospital costs for each day beyond 150 days.</p> <p>*You pay for the first 3 pints of unreplaced blood then 20% of the Medicare approved amount.</p> | <p>UPREHS pays the approved amount not paid by Medicare for each benefit period and/or daily coinsurance. You pay \$0. You pay all hospital costs for each day beyond 150 days.</p> <p>*UPREHS pays all approved amounts for blood not paid by Medicare. You pay \$0.</p> | <p>UPREHS pays 40% of the approved amount not paid by Medicare for each benefit period and/or daily coinsurance. You pay the remaining approved amount or more if the provider does not accept assignment. You pay all hospital costs for each day beyond 150 days.</p> <p>*UPREHS pays 40% of approved amounts for blood not paid by Medicare. You pay the remaining amounts.</p> |

UPREHS MEDICARE PLAN BENEFITS CHART

| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
|--|--|--|--|
| EMERGENCY SERVICES | | | |
| Emergency Services are covered inpatient or outpatient services provided in the United States that are 1) given by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. (For more information see Section 3.) | You pay 20% of the approved amount not paid by Medicare for each emergency room visit. You do not pay this amount if you are admitted to the hospital for the same condition within 1-3 days of the emergency room visit. You also pay 20% of the approved doctor amount not paid by Medicare. | UPREHS pays the approved amount not paid by Medicare. You pay \$0. | UPREHS pays the approved amount not paid by Medicare for the first 24 hours. After 24 hours, UPREHS pays 40% of the approved amount not paid by Medicare and you pay the remaining approved amount or more if the provider does not accept assignment. |
| URGENTLY NEEDED SERVICES | | | |
| Covered services obtained in the United States when a UPREHS participating provider is temporarily unavailable or inaccessible. Services must be medically necessary and immediately required 1) as a result of an unforeseen illness, injury, or condition; and 2) it is not reasonable given the circumstances to obtain the services through a UPREHS participating provider. | You pay 20% of the approved amounts not paid by Medicare. Not covered outside the United States except under limited circumstances. | UPREHS pays the approved amount not paid by Medicare. You pay \$0. | UPREHS pays the approved amount not paid by Medicare for the first 24 hours. After 24 hours, UPREHS pays 40% of the approved amount not paid by Medicare and you pay the remaining approved amount or more if the provider does not accept assignment. |

UPREHS MEDICARE PLAN BENEFITS CHART

| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
|---|---|---|---|
| SKILLED NURSING FACILITY CARE (SEE SECTION 7 FOR MORE INFORMATION.) | | | |
| <ul style="list-style-type: none">• Semi-private room (private if medically necessary).• Meals including special diets.• Physician and regular nursing services.• Physical, occupational, and speech therapy.• Drugs and blood clotting factors.• Blood including storage and administration begins with the first pint used. You pay for the first 3 pints of unreplaced blood. Coverage of whole blood and packed red cells begins with the 4th pint used.• Lab tests, x-rays, and other radiology services, etc.• Drugs (this includes substances that are naturally present in the body, such as blood clotting factors).• Medical and surgical supplies provided by SNF's.• Use of appliances such as wheelchairs. | You pay \$0 for up to 20 days per benefit period following a medically necessary 3-day hospital stay. For days 21-100 you pay up to \$135.50 a day. You pay all amounts beyond the 100th day in the benefit period and all non-approved days. | UPREHS pays the approved amount not paid by Medicare. You pay \$0. You pay all amounts beyond the 100th day in the benefit period and all non-approved days. | UPREHS pays 40% of the approved amount not paid by Medicare. You pay the remaining amounts or more if the provider does not accept assignment. You pay all amounts beyond the 100th day in the benefit period and all non-approved days |
| HOME HEALTH CARE (SEE SECTION 7 FOR MORE INFORMATION.) | | | |
| <ul style="list-style-type: none">• Part-time or intermittent skilled nursing and home health aids. Covered under home health care benefit. Must total less than 8 hours per day and 35 or fewer hours per week.• Physical, occupational, and speech therapy.• Medical social services.• Medical equipment (DME) and medical supplies. | Medicare pays all approved amounts for approved visits. You pay all amounts for non-approved visits. For medical equipment used during home health, you pay the Part B annual deductible plus 20% of approved amounts. | Medicare pays all approved amounts. You pay \$0 for approved visits. You pay all amounts for non-approved visits. DME is a limited UPREHS covered benefit. Refer to the DME topic. You may pay the remaining amounts not paid by Medicare. | Medicare pays all approved amounts for approved visits. You pay \$0 for approved visits. You pay all amounts for non-approved visits. DME is a limited UPREHS covered benefit. Refer to the DME topic. You may pay the remaining amounts not paid by Medicare. |

UPREHS MEDICARE PLAN BENEFITS CHART

| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
|---|---|--|--|
| HOSPICE CARE (SEE SECTION 7 FOR MORE INFORMATION.) | | | |
| Support services for the terminally ill. <ul style="list-style-type: none"> • Home care and short-term respite care and other services not otherwise covered by Medicare. • Drugs for symptom control and pain relief. • A variety of other services not otherwise covered by Medicare. • Hospice consultation services (one time only) if terminally ill and not yet elected hospice benefits. | You pay part of the cost for inpatient respite care. You must receive care from any Medicare-certified hospice. | UPREHS pays the approved amount not paid by Medicare when the referring or attending physician is a UPREHS participating provider. You pay \$0. | UPREHS pays 40% of the approved amount not paid by Medicare. You pay the remaining approved amounts. |
| MEDICAL SUPPLIES | | | |
| Includes dressing, splints, casts, hemophilia clotting factors, antigens, and surgical supplies such as dressings. | You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay all amounts for non-covered items. | UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay \$0. You pay all amounts for non-covered items. | UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. You pay all amounts for non-covered items. |
| PREVENTIVE SERVICES | | | |
| <i>Initial Preventive Physical Examination and Abdominal Aortic Aneurysm Screening:</i> | | | |
| A one-time physical exam within the first 6 months that you have Medicare Part B. If you are at risk for abdominal aortic aneurysms, you may get a referral for a one-time screening ultrasound at your Initial Exam. A one-time screening ultrasound for Abdominal Aortic Aneurysm for people at risk. Only covered by Medicare and UPREHS with a referral as a result of your Initial Physical Exam. | You pay the Part B annual deductible plus 20% of the approved amounts not paid by Medicare. | UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay \$0. | UPREHS pays 40% of the approved amount not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. |
| <i>Mammography Screening:</i> | | | |
| One baseline exam between ages 35 and 39, then once every year age 40 and over. | The Part B annual deductible does not apply. You pay 20% of the approved amounts not paid by Medicare. | UPREHS pays the approved amounts not paid by Medicare. You pay \$0. | UPREHS pays 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. |

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| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
|---|---|---|--|
| PREVENTIVE SERVICES, CONTINUED | | | |
| <i>Pap Test, Pelvic Exam and Clinical Breast Exam:</i> | | | |
| Once every 24 months. Once every 12 months if you are at high risk of cervical or vaginal cancer, or have had an abnormal pap smear in the past 36 months and are of childbearing age. | UPREHS pays 40% of any Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. The Part B annual deductible does not apply. Medicare pays the lab analysis. You pay 20% of approved amounts not paid by Medicare for pelvic exam. | UPREHS pays the approved amounts not paid by Medicare. You pay \$0. | UPREHS pays 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. |
| <i>Bone Mass Measurements:</i> | | | |
| For people who are at risk of osteoporosis or of losing bone mass. Medicare covers procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results every 2 years or more when medically necessary. | You pay the Part B annual deductible plus 20% of the approved amounts not paid by Medicare. | UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay \$0. | UPREHS pays 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. |
| <i>Prostate Cancer Screening:</i> | | | |
| All men with Medicare age 50 and older once every 12 months. <ul style="list-style-type: none"> • Digital rectal examination. • Prostate Specific Antigen (PSA) test. | You pay \$0 for approved lab services. Medicare pays all approved amounts. You pay the Part B annual deductible and 20% of the remaining approved amounts for digital rectal services. | UPREHS pays the approved amounts for digital rectal services not paid by Medicare. You pay \$0. | UPREHS pays 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. |

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| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
|--|---|---|---|
| PREVENTIVE SERVICES, CONTINUED | | | |
| <i>Colorectal Cancer Screening:</i> | | | |
| <p>Testing for early detection of colorectal cancer. All people with Medicare age 50 and older.</p> <ul style="list-style-type: none"> • Fecal Occult Blood test – every 12 months. • Flexible Sigmoidoscopy – every 48 months, or 10 years after a screening colonoscopy. • Colonoscopy – no minimum age, once every 24 months to 10 years depending on your cancer risk. • Barium Enema – no minimum age, every 24 months if you are at high risk, otherwise, every 48 months. | <p>You pay \$0 for Fecal Occult Blood tests. Medicare waives the Part B annual deductible. You pay 20% of the approved amounts not paid by Medicare for all other tests.</p> | <p>Medicare pays all approved amounts for Fecal Occult Blood tests. UPREHS pays the approved amounts not paid by Medicare for all other tests. You pay \$0.</p> | <p>UPREHS pays 40% of the approved amounts not paid by Medicare for tests. You pay the remaining approved amounts or more if the provider does not accept assignment.</p> |
| <i>Diabetes Screenings:</i> | | | |
| <p>Must have 2 or more of the following: Age 65 or older, overweight, family history of diabetes, a history of gestational diabetes, or delivery of a baby weighing more than 9 pounds. OR: If you have high blood pressure, dyslipidemia, obesity, or history of high blood sugar.</p> <p>You may receive a test for elevated blood glucose.</p> | <p>Medicare pays all approved amounts. You pay \$0.</p> | <p>Medicare pays all approved amounts. You pay \$0.</p> | <p>Medicare pays all approved amounts. You pay \$0.</p> |
| <i>Immunizations & Vaccinations:</i> | | | |
| <ul style="list-style-type: none"> • Flu shot – one every year or more if medically necessary. • Pneumonia shot – once per lifetime. • Hepatitis B vaccine – if you are at high or intermediate risk. • Other vaccines if you are at risk. | <p>You pay \$0 for, flu and pneumonia shots, Medicare pays all approved amounts. For Hepatitis B you pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare.</p> | <p>Medicare pays all approved amounts for flu and pneumonia shots. For Hepatitis B, UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay \$0.</p> | <p>Medicare pays all approved amounts for flu and pneumonia shots. For Hepatitis B, UPREHS pays 40% the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment.</p> |
| <i>Cardiovascular Disease Screening:</i> | | | |
| <p>Blood lipid tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of cardiovascular disease every 5 years.</p> | <p>Medicare pays all approved amounts. You pay \$0.</p> | <p>Medicare pays all approved amounts. You pay \$0.</p> | <p>Medicare pays all approved amounts. You pay \$0.</p> |

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UPREHS MEDICARE PLAN BENEFITS CHART

| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
|--|---|---|--|
| Glaucoma Tests: | | | |
| Once a year if you have diabetes, family history of glaucoma, are African American age 50 or over, or Hispanic American age 65 and over. | You pay the Part B annual deductible plus 20% of approved amounts not paid by Medicare. | UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay \$0. | UPREHS pays 40% the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. |
| DURABLE MEDICAL EQUIPMENT (DME) | | | |
| Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. DME can be used in the home such as wheelchairs, crutches, hospital beds IV infusion pump, CPAP & BIPAP units and supplies, oxygen equipment, nebulizers, walkers, etc. UPREHS makes secondary payment of up to \$400 a year for Medicare approved wheelchair rental, purchase, maintenance or accessories. | You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay for all amounts above Medicare approved amounts if the provider does not accept assignment. You pay the remaining amounts for non-covered items. | UPREHS benefits for DME are limited to CPAP & BIPAP units and supplies, walkers, crutches, limited wheelchair benefits, braces, canes, nebulizers, and TENS. UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare when covered. You pay the remaining amounts for non-covered items. | When a covered benefit, UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. You pay the remaining amounts for non-covered items. |
| PROSTHETIC DEVICES AND RELATED SUPPLIES (OTHER THAN DENTAL) | | | |
| Items that replace a body part or function (other than dental). The following are some examples: <ul style="list-style-type: none">• Colostomy bags and supplies directly related to colostomy care.• One pair of corrective lenses (eye glasses or contact lenses) after a cataract operation. (See Vision Care.)• Artificial arms and limbs, braces, and certain supplies related to prosthetic devices and repair and/or replacement of prosthetic devices.• Breast prostheses and a surgical brassiere after a mastectomy.• Pacemakers.• One pair per calendar year of therapeutic shoes for those with diabetic foot disease. (Not covered by UPREHS.) | You pay the part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay for all amounts above Medicare approved amounts if the provider does not accept assignment. You pay the remaining amounts for non-covered items. | When a covered benefit, UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay the remaining amounts for non-covered items. Therapeutic shoes are not a UPREHS covered benefit. | When a covered benefit, UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts for noncovered items and/or more if the provider does not accept assignment. Therapeutic shoes are not a UPREHS covered benefit. |

UPREHS MEDICARE PLAN BENEFITS CHART

| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
|--|---|--|--|
| MEDICAL NUTRITION THERAPY | | | |
| For people with diabetes, renal (kidney) disease who are not on dialysis, and after a transplant when referred by a doctor. | You pay the Part B annual deductible plus 20% of approved amounts not paid by Medicare. | UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay \$0. | UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. |
| DIABETES SELF-MONITORING, TRAINING & SUPPLIES | | | |
| For all people who have diabetes whether an insulin or non-insulin user. Includes: <ul style="list-style-type: none">• Blood glucose monitors, test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors.• Self-management training under certain conditions.• Fasting plasma glucose tests for persons at risk of diabetes.• One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts. Not a UPREHS covered benefit. | You pay the Part B annual deductible plus 20% of approved amounts not paid by Medicare. Medicare pays for blood tests and you pay \$0. | You must use the UPREHS Depot Drug Mail Order Pharmacy for glucose monitors, lancets and test strips and you will pay \$0. UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare for self-management training and you pay \$0. Therapeutic shoes are not a UPREHS covered benefit. | You pay all amounts not paid by Medicare for glucose monitors, lancets and test strips when not obtained from UPREHS Depot Drug Mail Order Pharmacy. For self-management training, UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. Therapeutic shoes are not a UPREHS covered benefit. |
| OUTPATIENT REHABILITATION SERVICES | | | |
| <ul style="list-style-type: none">• Includes physical & occupational therapy, speech & language therapy, cardiac rehabilitation:• Includes Comprehensive Outpatient Rehabilitation Facility Services.• Includes Cardiac Rehabilitation Therapy for those who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris. | Medicare limits apply. You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay all services not approved by Medicare. | Medicare limits apply. UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay \$0. You pay all services not approved by Medicare. | UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. You pay all services not approved by Medicare. |

UPREHS MEDICARE PLAN BENEFITS CHART

| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
|--|--|---|---|
| HEARING SERVICES | | | |
| Routine hearing examinations are not a covered benefit by Medicare or UPREHS. | Not a Medicare covered benefit. You pay all amounts. | Not a UPREHS covered benefit. You pay all amounts. | Not a UPREHS covered benefit. You pay all amounts. |
| Diagnostic medical need hearing examination. | You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. | UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay \$0. | UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. |
| PODIATRY SERVICES | | | |
| <ul style="list-style-type: none">• Treatment of injuries and diseases of the feet such as hammertoe or heel spurs.• Routine foot care for certain medical conditions affecting the lower limbs. | You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay all amounts for routine foot care not approved by Medicare. | UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay \$0. You pay all amounts for routine foot care not approved by Medicare. | UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. You pay all amounts for routine foot care not approved by Medicare. |
| CHIROPRACTIC SERVICES | | | |
| <ul style="list-style-type: none">• Medicare covered benefits are limited to manual manipulation of the spine to correct subluxation.• Routine chiropractic services are not a Medicare or UPREHS benefit. | You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay all amounts for routine chiropractic services. | UPREHS pays 80% of the Part B annual deductible and/or 80% of the approved amounts not paid by Medicare up to the UPREHS chiropractic annual limit of \$600. You pay the remaining approved amounts. You pay all approved amounts not paid by Medicare that exceed the UPREHS limit. You pay all amounts for routine chiropractic services. | UPREHS pays 80% of the Part B annual deductible and/or 80% of the approved amounts not paid by Medicare up to the UPREHS chiropractic annual limit of \$600. You pay the remaining approved amounts. You pay all approved amounts not paid by Medicare that exceed the UPREHS limit. You pay all amounts for routine chiropractic services. |

(Benefits chart continued from previous page)

UPREHS MEDICARE PLAN BENEFITS CHART

| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
|---|---|---|---|
| LABORATORY SERVICES | | | |
| Medically necessary clinical laboratory tests. | You pay \$0. Medicare pays all approved amounts. | Medicare pays all approved amounts. You pay \$0. | Medicare pays all approved amounts. You pay \$0. |
| VISION CARE | | | |
| Routine Eye Exams, Refractive Services, Eye Glasses are not a Medicare or UPREHS covered benefit. | | | |
| <ul style="list-style-type: none"> • Outpatient physician services for eye care. • High-risk glaucoma patients such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older receive glaucoma screening once per year. | You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. | UPREHS pays the Part B annual deductible and the approved amounts not paid by Medicare. You pay for the refractive service if you have more than one annually. | UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay for the refractive service if you have more than one annually. |
| UPREHS Refractive Surgery Benefit | | | |
| Not a covered benefit under Medicare. See chart for UPREHS benefits. | Not a Medicare covered benefit. You pay all amounts. | UPREHS pays \$760 per eye lifetime limit for refractive surgery. Payment for all related services is included in the limit (pre- and post-operative exams, surgeon fee, facility fee, etc.). You pay the remaining amounts. | UPREHS pays \$760 per eye lifetime limit for refractive surgery. Payment for all related services is included in the limit (pre- and post-operative exams, surgeon fee, facility fee, etc.). You pay the remaining amounts. |
| Frames & Lenses After Cataract Surgery | | | |
| Medicare benefits include one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (IOL). Corrective lenses/frames and replacements after cataract removal without an IOL. | You pay the Part B annual deductible plus 20% of the approved amounts not paid by Medicare. | UPREHS pays the approved amounts not paid by Medicare for one eyeglass lens after each cataract surgery. | UPREHS pays the approved amounts not paid by Medicare for one eyeglass lens after each cataract surgery. |
| INPATIENT MENTAL HEALTH CARE | | | |
| Medicare benefits are the same as hospital inpatient care, except there is a 190-day lifetime limit in a freestanding psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. | You pay all approved amounts not paid by Medicare. | Not a UPREHS covered benefit. You pay all approved amounts not paid by Medicare. | Not a UPREHS covered benefit. You pay all approved amounts not paid by Medicare. |

(Benefits chart continued on next page)

(Benefits chart continued from previous page)

| UPREHS MEDICARE PLAN BENEFITS CHART | | | |
|--|--|---|---|
| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
| OUTPATIENT MENTAL HEALTH CARE, PARTIAL HOSPITALIZATION, & SUBSTANCE ABUSE CARE | | | |
| Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable State laws. Partial hospitalization is a structured program of active treatment that is more intense than the care received in a doctor or therapist's office and is an alternative to inpatient hospitalization. | You pay the Part B annual deductible and 50% of the approved amounts not paid by Medicare except for the following services for which you pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. | Not a UPREHS covered benefit. You pay all approved amounts not paid by Medicare. | Not a UPREHS covered benefit. You pay all approved amounts not paid by Medicare. |
| OUTPATIENT DIAGNOSTIC TESTS & THERAPEUTIC SERVICES AND SUPPLIES | | | |
| <ul style="list-style-type: none"> • Includes X-rays and outpatient radiation therapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Other outpatient diagnostic tests. | You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. | UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay \$0. | UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. |
| OUTPATIENT SURGERY | | | |
| Includes outpatient hospital surgery and surgeries performed at Medicare approved Ambulatory Surgical Centers (ASC's). | You pay the Part B annual deductible plus 20% of the approved amounts not paid by Medicare. | UPREHS pays the Part B annual deductible and the approved amounts not paid by Medicare. You pay \$0. | UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. |
| HEALTH & WELLNESS EDUCATION & PROMOTION | | | |
| Programs focused on clinical health conditions such as hypertension, cholesterol, asthma, and special diets, weight management fitness, etc. | Not a Medicare covered benefit. You pay all amounts. | Not a UPREHS covered benefit. You pay all amounts. | Not a UPREHS covered benefit. You pay all amounts. |

(Benefits chart continued on next page)

UPREHS MEDICARE PLAN BENEFITS CHART

| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
|---|--|--|--|
| DIALYSIS (KIDNEY) | | | |
| <ul style="list-style-type: none"> • Renal dialysis services including outpatient and inpatient dialysis treatments. • Self-dialysis training for you and someone helping you with home dialysis, and home equipment and supplies. • Home dialysis equipment and supplies. • Certain home support services such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply. | You pay the Part B annual deductible plus 20% of the approved amounts not paid by Medicare. | UPREHS pays the Part B annual deductible and the approved amounts not paid by Medicare. You pay \$0. | UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. |
| DENTAL SERVICES | | | |
| <i>Medical Need</i> | | | |
| Medicare benefits are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of the teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. Routine dental services are not a covered benefit. | You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. Routine dental services are not a covered benefit. | UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay \$0. Routine dental services are not a covered benefit. | UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts or more if the provider does not accept assignment. Routine dental services are not a covered benefit. |
| DRUGS COVERED BY MEDICARE PART A AND MEDICARE PART B | | | |
| Medicare Part A doesn't generally pay for outpatient prescription drugs. Part A payment for drugs made to the hospital or skilled nursing facility (SNF) covers all drugs provided during a covered stay. Medicare Part B covers only a limited number of drugs. Drugs covered under Medicare Part B as a medical benefit include substances that are naturally present in the body and that are not self-administered. Drugs are usually limited to those that are given as part of a doctor's service, or to drugs given by infusion or injection. If the injection is usually self-administered or isn't given as part of a doctor's service, Part B may not cover it, but it could be covered under Part D. | You pay the applicable inpatient deductible and copayments for Medicare Part A. You pay the applicable deductible and copayments for Medicare Part B not paid by Medicare. | When supplied by a hospital, SNF, or physician, UPREHS pays the approved amounts not paid by Medicare. You pay \$0. | UPREHS pays 40% of the annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts. |

(Benefits chart continued from previous page)

UPREHS MEDICARE PLAN BENEFITS CHART

| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
|---|---|--|---|
| Medicare Part B Drugs Usually Supplied by a Physician in the Office: | | | |
| <p>Vaccinations such as:</p> <ul style="list-style-type: none"> • Flu Shot – 1 flu shot per flu season in the fall or winter, sometimes two flu shots in the same calendar year. • Pneumococcal Shot – to prevent certain types of pneumonia. A doctor must order the shot. Most people need only one in a lifetime. • Hepatitis B Shot - (3 shots) only if you have high or medium risk for Hepatitis B. Your risk increases if you have hemophilia, End-Stage Renal Disease, or conditions that lower resistance to infection and some other factors. • Other Shots - some other vaccines such as a tetanus shot when related to treatment of an injury or illness. | <p>You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare.</p> | <p>UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. When supplied by a participating physician. You pay \$0. Not a Part B benefit if supplied by a pharmacy.</p> | <p>UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts. Not a Part B benefit if supplied by a pharmacy.</p> |

(Benefits chart continued on next page)

UPREHS MEDICARE PLAN BENEFITS CHART

| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
|---|--|--|---|
| DRUGS COVERED BY MEDICARE PART A AND MEDICARE PART B, CONTINUED | | | |
| <i>Other Drugs That are Covered Under Part B</i> | | | |
| <ul style="list-style-type: none">• Durable Medical Equipment (DME) Supply Drugs – some drugs used in infusion pumps and nebulizers when medically necessary.• The UPREHS Depot Drug Mail Order Pharmacy continues to supply most nebulizer solutions for payment under Part B.• Osteoporosis Drugs – an injectable drug for women with osteoporosis meeting Medicare criteria.• Some Antigens – must meet Medicare criteria.• Erythropoiesis-simulating Agents (such as Epogen, Epoetin alfa, or Aranesp, Darbepoetin alfa) – by injection for anemia if you have ESRD and for some cancer patients under special conditions.• Blood Clotting Factors - you give yourself by injection if you have hemophilia.• Immunosuppressive Drugs – for Medicare approved transplants.• Oral Cancer Drugs – if the same drug is available in injectable form. Part B may cover new cancer drugs when they become available so make certain to verify.• Oral Anti-Nausea Drugs – used as part of an anti-cancer chemotherapeutic regimen. Must be administered within 48 hours of the chemotherapy drug and must fully replace intravenous anti-nausea drugs.• Parenteral & Enteral Nutrition (Intravenous & Tube Feeding) - for people who can't absorb nutrition through their intestinal tracts.• Intravenous Immune Globulin (IVIG) - in the home for people with primary immune deficiency disease and a doctor certifies that home administration is appropriate. Medicare does not pay for other items and services related to getting IVIG at home. | <p>You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay for items or services related to the administration of the drug, which are not covered by Medicare.</p> <p>Medicare does not pay for other items and services related to getting IVIG at home.</p> | <p>UPREHS pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay \$0 for the drug. You pay for items or services not approved by Medicare.</p> <p>UPREHS does not pay for other items and services related to getting IVIG at home.</p> | <p>UPREHS pays 40% of the Part B annual deductible and/or 40% of the approved amounts not paid by Medicare. You pay the remaining approved amounts and any other amounts not approved by Medicare.</p> <p>You pay for other items and services related to getting IVIG at home.</p> |

| UPREHS MEDICARE PLAN BENEFITS CHART | | | |
|---|---|---|---|
| BENEFITS | ORIGINAL MEDICARE PART A AND B BENEFITS | IN-NETWORK SECONDARY PLAN BENEFITS | OUT-OF-NETWORK SECONDARY PLAN BENEFITS |
| DRUGS COVERED BY MEDICARE PART D | | | |
| <i>Refer to your UPREHS Prime Medicare Plan Benefit Guide and Section 6 for more complete information</i> | | | |
| Please refer to your 2009 UPREHS Prime Medicare Plan Benefit Guide. UPREHS offers you comprehensive prescription drug coverage. Under Medicare, a Part D-covered drug must meet all of these conditions: <ul style="list-style-type: none">• The drug is available only by prescription.• The Food & Drug Administration (FDA) approves the drug.• The drug is used and sold in the United States.• The drug is used for a medically accepted indication, as defined under the Social Security Act.• Vaccinations that are medically necessary and not covered under Medicare Part B. | See your UPREHS Prime Medicare Plan Benefit Guide for Medicare Part D benefits. | See your UPREHS Prime Medicare Plan Benefit Guide for Medicare Part D benefits. | See your UPREHS Prime Medicare Plan Benefit Guide for Medicare Part D benefits. |

Section 5 Medical Care and Services That are Not Covered (List of Exclusions and Limitations)

The purpose of this section is to tell you about medical care and services that are not covered (excluded) or are limited by Original Medicare and/or your UPREHS Medicare Secondary Plan. The list below tells about these exclusions and limitations. The list describes services that are not covered under *any* conditions, and some services that are covered only under specific conditions. The *UPREHS Medicare Plan Benefits Chart* in Section 4 also explains about some restrictions or limitations that apply to certain services.

If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare unless they are found upon appeal to be services that Original Medicare should have paid or covered. For more information on appeals, see Sections 10 and 11.

Benefit exclusions

If you obtain services, items and/or drugs that are not covered, you must pay for them yourself. This information provides a summary of benefit exclusions under Medicare Parts A and B, the UPREHS HCPP, and the UPREHS Medicare Secondary Plan. This summary does not describe all benefits or exclusions under Original Medicare, or the UPREHS Medicare Secondary Plan. This summary does not take the place of laws, rules, or regulations under any of these programs.

There are some benefits that are not covered by Original Medicare Part A and B that **are covered** benefits through the UPREHS Medicare Secondary Plan. There are also some benefits that are covered by Original Medicare Part A and B that are **not covered** benefits by the UPREHS Medicare Secondary Plan (such as mental health services and most DME, etc.).

Original Medicare excluded benefits

The following are excluded benefits under your Original Medicare Part A and B and the UPREHS HCPP. Your UPREHS Medicare Secondary Plan excludes benefit coverage for any condition, item, or service excluded by Original Medicare and/or the UPREHS HCPP (with some exceptions). Exceptions to the UPREHS Medicare Secondary Plan exclusion coverage are noted. If you obtain services, items and/or drugs that are not covered, you must pay for them yourself. Neither Original Medicare nor UPREHS MSP will pay for the exclusions that are listed in this Section (or elsewhere in this book). The following services and supplies are not covered under Original Medicare:

1. The UPREHS Prime Medicare Plan covers outpatient prescription drugs under Medicare Part D. See the UPREHS Prime Medicare Plan Benefit Guide for coverage rules.
2. Services that are not covered under Original Medicare, unless such services are specifically listed as covered in *UPREHS Medicare Plan Benefits Chart* in Section 4.

3. Services that are not part of the UPREHS Medicare-approved benefit package. If you obtain services from a provider who contracts with UPREHS, the service will be treated as an in-network covered service unless the provider advises you otherwise and/or it is not a Medicare covered benefit. However, if you obtain a service from an out-of-network provider, you may want to confirm in advance with UPREHS that the service you obtain is medically necessary and a Medicare covered service.
4. Even though you are not required to get prior authorization for services from out-of-network providers, you can ask us about them to make sure that we agree that the services are covered and medically necessary. You may also find out what your cost sharing increases would be if you choose to obtain services from out-of-network providers.
5. Those services not reasonable and necessary under Original Medicare program standards unless otherwise listed as a covered service. As noted throughout this Benefit Guide, services that are not covered by Original Medicare are not usually covered by UPREHS. As noted before, we provide all covered services according to Medicare guidelines.
6. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary.
7. Emergency facility services for routine conditions that do not appear to a reasonable person to be based on a medical emergency. (See Section 3 for more information on emergency services.)
8. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by Original Medicare not to be generally accepted by the medical community. Even if newly authorized by Medicare, they will not necessarily automatically be covered under the UPREHS Medicare Secondary Plan.
9. Acupuncture.
10. Cosmetic surgery or procedures, unless it is needed because of accidental injury or to improve the function of a malformed part of the body. Medicare covers breast surgery and all stages of reconstruction and symmetrical appearance surgery for the breast on which a mastectomy was performed. Medicare also covers surgery and reconstruction of the unaffected breast.
11. Custodial care is not covered unless it is provided in conjunction with Medicare-covered skilled nursing care and/or skilled rehabilitation services. Custodial care includes care that assists members in the activities of daily living, like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication that is usually self-administered is not covered.
12. Homemaker services.
13. Meals delivered to your home.

14. Naturopaths' services.
15. Nursing care on a full-time basis in your home.
16. Orthopedic shoes and supportive devices for the feet unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease. Coverage for shoes, supportive devices for the feet, or footwear is excluded under the UPREHS Medicare Secondary Plan. (See *UPREHS Medicare Plan Benefits Chart* in Section 4.)
17. Personal convenience or comfort items, such as a telephone or television in your room at a hospital or skilled nursing facility.
18. Private duty nurses.
19. Private room in a hospital, unless medically necessary.
20. Charges imposed by immediate relatives or members of your household.
21. Reversal of sterilization procedures; sex change operations; conception by artificial means, such as in vitro fertilization, and non-prescription contraceptive supplies and devices. However, medically necessary services for infertility are covered by Original Medicare, but excluded by the UPREHS Medicare Secondary Plan.
22. Surgical treatment of morbid obesity unless medically necessary and covered under Original Medicare.
23. Routine eye examinations and eyeglasses (except after cataract surgery), radial keratotomy, LASIK surgery, vision therapy and other and low vision aids and services. The UPREHS Medicare Secondary Plan provides limited coverage for refractive surgery and routine eye exams (see *UPREHS Medicare Plan Benefits Chart* in Section 4).
24. Routine dental care (such as cleanings, fillings, or dentures) or other dental services including dental splints, dental prosthesis, any dental treatment for the teeth, gums, jaw; or dental treatment related to temporomandibular joint syndrome (TMJ). Certain dental services that you get when you are in the hospital will be covered when covered by Original Medicare.
25. Original Medicare and your UPREHS MSP covers chiropractic care ONLY for manual manipulation of the spine. Chiropractic care is limited according to Medicare guidelines and your UPREHS MSP chiropractic annual benefit limit of \$600. (See *UPREHS Medicare Plan Benefits Chart* in Section 4.)
26. Routine foot care is generally not covered and is limited according to Original Medicare guidelines. (See the *UPREHS Medicare Plan Benefits Chart* in Section 4.)
27. Hearing aids and routine hearing examinations.
28. Services provided to veterans in Veteran's Affairs (VA) facilities.

29. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hypogasmia.

UPREHS Medicare Secondary Plan excluded benefits

Even though some of these items, services, or circumstances could be a covered benefit under your Original Medicare benefits, they are excluded benefits under your UPREHS Medicare Secondary Plan. If you obtain services, items and/or drugs that are not covered, you must pay for them yourself. We won't pay for the exclusions that are listed in this Section (or elsewhere in this book).

The UPREHS Medicare Secondary Plan excludes the following in addition to Medicare excluded benefits:

1. Members who abuse the benefits, or rules and regulations of UPREHS may be excluded from further benefits even though Original Medicare may continue coverage.
2. Pensioned members who are eligible for Medicare are not permitted to duplicate benefits under Medicare with benefits under any other UPREHS plan.
3. Payment for services provided in a United States Government hospital or through the provisions of State Medicaid including MediCal programs will not be duplicated by any other UPREHS plans.
4. Payment for DME such as hospital beds, physical therapy equipment, hearing aids, eye glasses, contact lenses, footwear, bed pans, urinals, hot water bottles, thermometers, syringes (except for insulin syringes when obtained through the UPREHS Depot Drug Mail Order Pharmacy), and similar articles, etc., even though Original Medicare may cover some of these items.
5. Payment for any treatment of an injury sustained which is the result of the commission of and/or participation in a felonious or illegal act even though Original Medicare makes payment. The exception would be injuries sustained as a result of domestic violence or as the result of a medical condition.
6. Payment for on-duty injuries sustained while in the employment of some person, firm, company, self-employment, or organization other than the UPRR and/or subsidiaries and affiliated companies.
7. Payment for treatment of mental disorders including, but not limited to services of psychiatrists and psychologists.
8. Payment for treatment of conditions or injuries resulting from self-inflicted injuries even though Original Medicare may cover these services, unless the infliction of such injury is the result of a medical condition.
9. Payment for treatment or medication for alcohol or substance abuse detoxification or rehabilitation even though Original Medicare may cover these services. These medications may now be covered under your UPREHS Medicare Part D benefit. Please check that current formulary book for more information.
10. Hospice services when you are enrolled in a Medicare-participating and certified hospice are paid by Original Medicare. The UPREHS Medicare Secondary Plan covers your copayments

(Benefits chart continued from previous page)

for Hospice outpatient drugs (when not covered under Medicare Part D) and inpatient respite care as a medical benefit under Hospice services. Your UPREHS participating provider will refer you to a Medicare-participating hospice if you wish to elect such coverage. You may remain enrolled in the UPREHS HCPP and the UPREHS Medicare Secondary Plan even though you have elected hospice coverage. You may continue to obtain your care unrelated to the terminal condition from UPREHS participating providers and you may also use a UPREHS participating provider as your hospice-attending physician.



Section 6 Prescription Drugs, Diabetic Supplies & Insulin

UPREHS Prime Medicare Plan Part D Pharmacy Program

UPREHS is contracted with the Centers for Medicare & Medicaid Services (CMS) as an Employer Group direct contract Medicare Part D Prescription Drug Plan. As a current UPREHS Medicare member, we have automatically enrolled you in this plan so that we can continue to provide your prescription drug benefits. You have been sent a UPREHS Prime Medicare Plan Benefit Guide. Please refer to that book for all Pharmacy Plan information.

Your enrollment in the UPREHS Prime Medicare Plan Pharmacy Program does not affect Original Medicare coverage for drugs covered under Medicare Part A or Part B. If you meet Original Medicare's coverage requirements, your drugs will still be covered under Medicare Part A or Part B even though you are enrolled in our prescription drug plan. Some drugs may be covered under Medicare Part B in some cases and through your prescription drug plan in other cases, but never both at the same time. Usually, your pharmacist or provider will determine whether to bill Medicare Part B or Part D for the drug in question.

Diabetic supplies, insulin and syringes

Your Original Medicare benefits include medical coverage of a Blood Glucose Monitor, diabetic test strips and lancets. Medicare considers these items to be medical benefits and not pharmacy benefits even though they are usually obtained from pharmacies. When you obtain the Blood Glucose Monitor, diabetic test strips and lancets from the UPREHS Depot Drug Mail Order Pharmacy, you have no coinsurance and the items are **not** applied to your pharmacy benefit. If you obtain these items from any other source, your UPREHS MSP does **not** cover any deductible or coinsurance amount not paid by Medicare.

Your UPREHS Prime Medicare Plan pharmacy program includes coverage of diabetic insulin and syringes as a Medicare Part D benefit. See your Pharmacy Benefit Guide for more information.

If you obtain a Medicare covered Blood Glucose Monitor, diabetic test strips, and/or lancets from other pharmacies instead of the UPREHS Depot Drug Mail Order Pharmacy, you are responsible for payment not made by Original Medicare.

UPREHS will supply one Blood Glucose Monitor per member when medically necessary at no charge to you.

UPREHS supplies Johnson & Johnson Life Scan One Touch "Ultra II" or "One Touch Mini" model glucometers and test strips. If these brands do not meet your medical needs, you must obtain your supplies elsewhere and you will be financially responsible for any applicable Medicare coinsurance and/or deductible amounts.

Section 7 Hospital Care, Skilled Nursing Facility Care, and Other Services

This Section gives additional Information about some of the covered services listed in the *UPREHS Medicare Plan Benefits Chart* in Section 4.

What is meant by hospital care?

We use hospital to mean a facility that is certified by the Medicare program and licensed by the State to provide inpatient, outpatient, diagnostic, and therapeutic services. The term hospital does not include facilities that mainly provide custodial care, such as convalescent nursing homes or rest homes. By custodial care, we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

Your UPREHS MSP pays for your hospital coinsurance in each Medicare-approved benefit period and you pay nothing when the services are from a UPREHS participating network hospital. When services are from a nonparticipating hospital, your UPREHS MSP payment is reduced to 40% and you must pay the remainder of the bill not paid by Medicare. Coinsurance is the amount for your hospital care left over after Medicare has paid their portion. If Medicare does not approve payment for hospital care or an item, then your UPREHS MSP plan makes no payment. You are financially responsible for the payment to the hospital if not approved by Medicare.

What is a benefit period for hospital care?

Original Medicare uses benefit periods to determine your coverage for inpatient services during a hospital stay. Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF) and ends when you have not received any hospital or SNF care for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. For more information, see *What is a Skilled Nursing Facility (SNF)* later in this section.

Please note that after your hospital day limits are used up, Original Medicare and UPREHS MSP will still pay for covered physician and other medical services. These services include diagnostic tests such as x-ray or lab tests.

What happens if you drop out of the UPREHS Medicare Plans during a hospital stay?

If you leave the UPREHS Medicare Plans during an inpatient hospital stay, special rules apply to your coverage for the stay and to the coinsurance you owe for this stay. If this situation applies to you, please call UPREHS Customer Services at 1-800-547-0421. They can explain how your services are covered for this stay and what coinsurance you owe, if any, for the periods of your stay when you were and were not a UPREHS Medicare member.

What is a skilled nursing facility (SNF)?

A **skilled nursing facility** is a place that provides skilled nursing or skilled rehabilitation services. It can be a separate facility, or part of a hospital or other health care facility. A skilled nursing facility is called a SNF for short. The term **skilled nursing facility** does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. By **custodial care**, we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

What is skilled nursing facility care?

Skilled nursing facility care means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities such as eating and dressing by yourself.

To be covered, the care you get in a SNF must meet certain requirements

To be covered by Original Medicare, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care need to be made. Note that Medicare will still cover medical services and other skilled care when you start needing less than daily skilled care in the SNF.

Your UPREHS MSP pays for your SNF coinsurance in each Medicare-approved benefit period and you pay nothing when the services are from a UPREHS participating network SNF. When services are from a nonparticipating SNF, the UPREHS MSP payment is reduced to 40% and you must pay the remainder of the bill not paid by Medicare.

Stays that provide custodial care only are not covered

Custodial care is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Neither Original Medicare nor your UPREHS MSP covers custodial care.

There are benefit period limitations on coverage of skilled nursing facility care

Inpatient skilled nursing facility coverage is limited to one hundred (100) days each benefit period. A **benefit period** begins on the first day you go to a Medicare-covered inpatient hospital or a SNF and ends when you have not received any hospital or SNF care for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Please note that after your hospital or SNF day limits are used up, Original Medicare and your

(Benefits chart continued from previous page)

UPREHS MSP still cover physician services and other medical services. These services are listed in the *UPREHS Medicare Plan Benefits Chart* in Section 4.

What happens if you drop out of UPREHS during a SNF stay?

If you leave UPREHS during a SNF stay, please call Customer Services at 1-800-547-0421. Customer Services can explain how your services are covered for this stay, and what you owe for the periods of your stay when you were and were not a member.

What is home health care?

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the *UPREHS Medicare Plan Benefits Chart* in Section 4. If you need home health care services, your doctor will arrange these services for you if the requirements described below are met.

What are the requirements for getting home health care services?

To get home health care Original Medicare benefits, you must meet these conditions:

1. You must be **homebound**. This means that you are normally unable to leave your home and that going outside your home is a major effort. When you leave home, it must be to get medical treatment, or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a State or accredited to furnish adult day care services in a State.

Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive would not mean that you are not homebound if the absences are on infrequent or are relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. **Supportive devices** include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.

2. Your doctor must decide that you need medical care in your home, and must review and approve a plan for your care at home. Your **plan of care** that is prepared by your doctor describes the services you need, how often you need them, and what type of health care worker should give you these services.
3. The Medicare program must approve the home health agency caring for you.



4. You must need **at least one** of the following types of skilled care:
- Skilled nursing care on an intermittent (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
 - Physical therapy, which includes exercise to improve the movement and strength of an area of the body and training on how to use special equipment such as how to use a walker or get in and out of a wheel chair or bathtub.
 - Speech therapy, which includes exercise to regain and strengthen speech skills or treat a swallowing problem.
 - Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

Home health care can include services from a home health aide, as long as you are also getting skilled care

As long as some qualifying skilled services are **also** included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are **also** getting a covered skilled service. Home health care services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

What are part-time and intermittent home health care services?

If you meet the requirements given above for getting covered home health care services, you may be eligible for **part-time** or **intermittent** skilled nursing services and home health aide services.

- **Part-time or Intermittent** means that your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

Hospice care for people who are terminally ill

Hospice is a special way of caring for people who are terminally ill and counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

Under Original Medicare, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call Medicare at 1-800-MEDICARE (1-800-633-4227) to get a list of the Medicare-certified hospice providers or the Regional Home Health Intermediary in your area. (If you are enrolled in Medicare Part B only and not entitled to Part A, you should call Medicare to get information on your hospice

(Benefits chart continued from previous page)

coverage.)

If you enroll in a Medicare-certified hospice, Original Medicare pays for most of the hospice services you receive. Your UPREHS MSP pays for any approved services not paid by Medicare. Your hospice doctor can be UPREHS participating or nonparticipating. If you choose to enroll in a Medicare-certified hospice, you are still a UPREHS member and continue to get the rest of your care unrelated to your terminal condition through UPREHS.

The Medicare program has written a booklet about *Medicare Hospice Benefits*. To get a free copy call Medicare at **1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048)**, which is the national Medicare help line, or visit the Medicare Website at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the Website.

Organ transplants

If you need an organ transplant, your doctor or hospital must have your case reviewed by one of the transplant centers that is approved by Medicare. Not all hospitals that perform transplants are approved by Medicare. The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas, liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

UPREHS MSP benefits for organ and tissue transplants

Your UPREHS MSP organ and tissue transplant benefit is always secondary to the Original Medicare payment. UPREHS MSP payment depends on the following limitations:

- UPREHS pays a one-time lifetime limit of up to \$150,000 that includes all types of organ and tissue transplants. This amount is cumulative across all plans during your UPREHS membership lifetime. The amount of this benefit available to you once you are a Medicare member depends on how much was used during your UPREHS active and/or other retiree plan membership. Any remaining amount of this benefit, if it was not used during your earlier plan membership, is available to supplement your Original Medicare payments.
- UPREHS supplementary payments for covered expenses directly related to the organ or tissue transplant(s) (pre-transplant evaluation and testing to determine candidacy for transplant and outpatient post-transplant follow-up physician visits and testing, etc.) are not applied toward your lifetime limit.
- Organ and tissue transplant(s) must be a Medicare-covered benefit and performed in a Medicare-approved transplant facility to receive your Original Medicare benefit. UPREHS MSP payments for out-of-network transplants are reduced even if performed in a Medicare-approved facility. This reduction can leave you with a large financial burden that may be avoided if a UPREHS Care Coordinator helps you obtain your services in-network. Call 1-800-547-0421 if you need an organ or tissue transplant.



Participating in a clinical trial

A clinical trial is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe. There are certain requirements for Medicare coverage of clinical trials.

Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not UPREHS) pays the clinical trial doctors and other providers for the covered services you receive that are related to the clinical trial. When you are in a clinical trial, you may continue your UPREHS membership and continue to get the rest of your care that is unrelated to the clinical trial through UPREHS participating providers. Your UPREHS MSP pays the coinsurances that apply to Medicare approved clinical trial services. UPREHS MSP out-of-network payment reductions apply if the providers are not participating with UPREHS.

The Medicare program has written a booklet about *Medicare and Clinical Trials*. To get a free copy, call **1-800-MEDICARE (1-800-633-4227)** or visit their Website at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about Medicare's Website.

Care in Religious Non-Medical Health Care Institutions (RNHCI)

Original Medicare covers care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) under certain conditions. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of **nonexcepted** medical treatment. **Excepted** medical treatment is medical care or treatment that you receive involuntarily or that is required under Federal, State or local law. **Nonexcepted** medical treatment is any other medical care or treatment.

Medicare also allows coverage for RNHCI services when furnished in the home, but only with respect to items and services ordinarily furnished by home health agencies that are not RNHCI's.

Your UPREHS MSP payment is limited to those services allowed for payment by Original Medicare. Since there are no participating RNHCI's in the UPREHS network, out-of-network payment reductions apply.

Section 13 Legal Notices

Notice about governing law

Many different laws apply to this booklet. Some additional provisions may apply to your situation because law requires them. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the State(s) in which you reside may apply.

Notice about non-discrimination

When we make decisions about the provision or payment of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Health Care Prepayment Plans, like UPREHS, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Information required by the Employee Retirement Income Security Act of 1974 (ERISA)

As a Member in the Union Pacific Railroad Employees Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations all Plan documents, including copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge of the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duty 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a healthcare benefit or exercising your rights under ERISA. If your claim for a healthcare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty days, you may file suit in a Federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you

(Benefits chart continued from previous page)

receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a State or 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 US 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. 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, you should contact the nearest office of the Pension and Welfare Benefits Administration, US Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, US. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210.

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|---|---|
| Name of Plan | Union Pacific Railroad Employees Health Systems (the "Plan") |
| Plan Sponsor | Union Pacific Railroad Company |
| Plan Identification Numbers | Employee Identification Number (EIN): 87-0427760 CMS HCPP Plan Number (PN): H4652; CMS PDP Plan Number E7316 |
| Plan Administrator | Union Pacific Railroad Employees Health Systems P.O. Box 161020 Salt Lake City, UT 84116-1020 Telephone: (801) 595-4300 Fax: (801) 595-4399 |
| Type of Plan | Health Care Benefit Plan; Medicare HCPP; Medicare Prescription Drug Plan |
| Trustee | Zions First National Bank 102 S Main Street Salt Lake City, UT 84101 |
| Current Board of Trustees of Plan | M.A. Young, Chairman T. Graumann B. Palmer D. Jacobsen R. Orosco D. Hazlett A. Nowlin H. Doucett M. H. Williams D. Smith R. Brown |
| Operating Trustees | M.A. Young, Chairman D.T. Butterfield, Chief Executive Officer K.J. Potts, Vice President |
| Agent for Service of Legal Process | Service of Legal Process may be made upon the Plan Administrator or any Trustee listed above. |
| Type of Administration of Health Care Benefits Provided by the Plan & Plan Year | Trustees and Self-Administered. The Plan is administered directly by the Plan Administrator. The Plan's healthcare benefits are funded directly by the Plan and are not insured by an outside entity. Each Plan Year ends each year on December 31. |



Section 14 Definitions of Terms

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term.

APPEAL — An appeal is a special type of complaint you make if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you ask for an appeal if we don't pay for an item/service you think you should be able to receive. Sections 10 and 11 explain about appeals, including the process involved in making an appeal.

BENEFIT GUIDE OR EVIDENCE OF COVERAGE — This document explains your covered services, defines our obligations, and explains your rights and responsibilities as a member of the UPREHS Medicare Plans.

BENEFIT PERIOD — For both UPREHS and the Original Medicare Plan, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period *begins* on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period *ends* when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays, but not for hospital stays.

You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (For more information on skilled care, see Section 7.)

Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital. (The type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital.)

BOARD OF TRUSTEES — Means the governing Board of Trustees of Union Pacific Railroad Employes Health Systems.

CARE COORDINATOR — A licensed Registered Nurse employed by UPREHS to help members of all plans coordinate medical care in complicated treatment situations.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) — The Federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

COST-SHARING — Cost-sharing refers to amounts that a member has to pay when services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; UPREHS pays your deductible amounts (2) any fixed “co-payment” amounts that a plan may require be paid when specific services are received; or (3) any “coinsurance” amount that must be paid as a percentage of the total amount paid

(Benefits chart continued from previous page)

for a service.

COVERED SERVICES — The general term we use in this booklet to mean all of the health care services and supplies that are covered by Original Medicare and/or UPREHS.

CUSTOMER SERVICES — A department within UPREHS responsible for answering your questions about your membership, benefits, grievances, and appeals. See the cover of this book and Section 1 for information about how to contact Customer Services.

CUSTODIAL CARE — Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare and UPREHS do not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

DEDUCTIBLE — The amount under Original Medicare that you must pay for the health care services you receive. UPREHS pays your Original Medicare Part A and Part B annual deductible amounts.

DISENROLL OR DISENROLLMENT — The process of ending your membership in the UPREHS Medicare Plans. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 13 tells about disenrollment.

DURABLE MEDICAL EQUIPMENT (DME) — Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs or hospital beds.

ELIGIBILITY FOR UPREHS MEDICARE PLANS — The UPREHS Board of Trustees maintains the right to declare eligibility for membership in UPREHS. Generally, former employees and retirees of the Union Pacific Railroad (UPRR) or its subsidiaries are considered to be eligible for the UPREHS Medicare Plans when they have 60 months or more of membership in UPREHS prior to the time of applying for a railroad annuity. In addition, a former employee must also have 60 months or more of compensated service during the last period of service with the UPRR, UPREHS, or a labor organization representing employees of the UPRR. Time off on authorized leave of absence, during furlough when seniority and rights to return to work are retained, or when discharged and the employee is reinstated will not constitute a break in the 60 continuous months requirement. The former employee must be receiving an annuity under the Railroad Retirement or Social Security Act at the time of applying for annuity and was:

- In the service of the UPRR, UPREHS or such labor organization, on furlough with seniority and rights to recall, retained, or carried on a craft seniority roster designated as physically disqualified: and
- On the last day of service with UPRR, UPREHS or such labor organization was a member of UPREHS, and if on authorized leave of absence, furlough or physical disqualification, continued membership in UPREHS by payment of premiums during the applicable period.

EMERGENCY SERVICES — Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 tells about emergency services.

EVIDENCE OF COVERAGE (EOC) AND DISCLOSURE INFORMATION — This document, along



(Benefits chart continued from previous page)

with your enrollment form (and any other attachments or riders), which explains your coverage, what we must do, your rights, and what you have to do as a member of the UPREHS Medicare Plans.

HEALTH CARE PREPAYMENT PLAN (HCPP) — A health care plan authorized through a Federal contract to perform certain Medicare Part B official functions on behalf of members. UPREHS is contracted with CMS as an HCPP. This contract authorizes UPREHS to pay Original Medicare Part B claims to participating physicians for office visits and related office services, consultations, hospital visits and surgical procedures.

GRIEVANCE — A type of complaint you make about us or one of our network providers, including a complaint concerning the quality of your care. This type of complaint does not involve payment or coverage disputes. See Section 10 for more information about grievances.

HOME HEALTH AIDE — A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

HOME HEALTH CARE — Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 4 under the heading *Home Health Care*. If you need home health care services, Original Medicare will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

HOSPICE CARE — A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit www.medicare.gov and under Search Tools, choose Find a Medicare Publication to view or download the publication *Medicare Hospice Benefits*. Or, call 1-800-MEDICARE (1-800-633-4227. TTY users should call 1-877-486-2048).

INPATIENT CARE — Health care that you get when you are admitted to a hospital as an inpatient.

MEDICALLY NECESSARY — Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

MEDICARE — The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).



(Benefits chart continued from previous page)

MEDICARE ADVANTAGE PLANS — Sometimes called Medicare Part C. A public or private organization licensed by the state as a risk-bearing entity that is under contract with the Centers for Medicare and Medicaid Services (CMS) to provide covered services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans.

MEDICARE ADVANTAGE PLAN — A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area.

MEDICARE PRESCRIPTION DRUG COVERAGE — Medicare Part D. Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B.

MEDICARE SPOUSE — A Medicare spouse (of a retired Medicare employee who is a member of UPREHS) is eligible for the UPREHS Medicare Plans when the spouse is entitled to Medicare Part A and enrolled in Medicare Part B. Benefits are the same for the Medicare spouse as those available to all eligible Medicare members. Spouse eligibility for UPREHS Medicare Plans membership terminates upon divorce.

MEDICARE WIDOW(ER) — A Medicare widow(er) is eligible for the UPREHS Medicare Plans when they first become entitled to Medicare Part A and enrolled in original Part B if the deceased spouse was a UPREHS member at the time of death. Eligibility for the UPREHS Medicare Plans terminates upon remarriage.

MEDIGAP - (MEDICARE SUPPLEMENT INSURANCE) POLICY — Many people who get their Medicare through Original Medicare buy “Medigap” or Medicare supplement insurance policies to fill “gaps” in Original Medicare coverage. UPREHS is not a Medigap plan.

MEMBER (MEMBER OF UPREHS, (OR PLAN MEMBER) — A person with Medicare who is eligible to get covered services, who has enrolled in UPREHS, and whose enrollment has been confirmed by the Centers for Medicare and Medicaid Services (CMS).

NETWORK PROVIDER OR PARTICIPATING PROVIDER — *Provider* is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them **network providers or participating providers** when they have an agreement with UPREHS to accept our payment as payment in full. UPREHS pays network providers based on Medicare payment amounts.

NONPARTICIPATING PROVIDER OR NONPARTICIPATING FACILITY — A provider or facility that we have not arranged with to coordinate or provide covered services to members of the UPREHS Medicare Plans. Also known as out-of-network or non-plan providers, they are providers that are not contracted with UPREHS to deliver covered services to you. UPREHS MSP payment is reduced to 40% for services from nonparticipating providers.

(Benefits chart continued from previous page)

ORIGINAL MEDICARE — Some people call it “traditional Medicare” or “fee-for-service” Medicare. Original Medicare is the way UPREHS members get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. UPREHS MSP pays your deductible. Medicare pays its share of the Medicare-approved amount, and UPREHS MSP pays your share for services from participating providers. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

PALMETTO GOVERNMENT BENEFITS ADMINISTRATOR (GBA) — Palmetto GBA may process your Medicare Part B claims that are not sent to UPREHS HCPP. Palmetto GBA is the Railroad Medicare Part B carrier. Palmetto GBA would process all of your Medicare claims from out-of-network nonparticipating providers, but whether or not the provider is participating with UPREHS, Palmetto GBA is still able to process your claims. You can call Palmetto GBA at 1-800-833-8455, or write to Palmetto GBA, PO Box 10066, Augusta, GA 30999-0001.

PART D — The voluntary Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Medicare Part D.)

PART D DRUGS — Any drug that can be covered under a Medicare Prescription Drug Plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Part D Drug. Part D Drugs that are listed on our formulary, and that we pay for based on an exception or an appeal, are called “Covered Part D Drugs.” Refer to your UPREHS Prime Medicare Plan Benefit Guide.

PROVIDER — See Network Provider or Non-Participating Provider.

PRIMARY CARE PHYSICIAN (PCP) — A health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing covered services while you are their patient. UPREHS does not require that you have a PCP, but strongly encourages you to have one.

QUALITY IMPROVEMENT ORGANIZATION (QIO) — Groups of practicing doctors and other health care experts who are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private fee-for-service plans and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in your state and Section 10 for information about making complaints to the QIO.

RAILROAD MEDICARE — Medicare Part A and B program for retirees of the railroad. Most UPREHS Medicare members receive their Medicare benefits through the Railroad Retirement Board. You can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). The TTY number is 1-312-751-4701. You can also visit their Website at www.rrb.gov.

REFERRAL — Your UPREHS Medicare Plans do not require a referral from UPREHS or your Primary Care Physician to see any participating specialist or to receive certain covered services.

REHABILITATION SERVICES — These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a



(Benefits chart continued from previous page)

plan provider. See Section 7 for more information.

SERVICE AREA — The UPREHS service area is national. That means that UPREHS has participating providers in all states of America including Alaska and Hawaii. Our “Service area” is the geographic area approved by the Centers for Medicare and Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

SKILLED NURSING FACILITY (SNF) CARE — A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

UNION PACIFIC RAILROAD EMPLOYEES HEALTH SYSTEMS (UPREHS) — A voluntary employee benefit administration program that administers health care benefits to certain employees of UPRR and their subsidiaries and affiliated companies, UPRR retirees, UPRR pensioners and their qualified spouse, and dependants of UPRR employees.

UPREHS DEPOT DRUG MAIL ORDER PHARMACY — The pharmacy mail service owned and operated by UPREHS for use by members to obtain maintenance prescriptions and most diabetic medications and supplies.

UPREHS MEDICARE SECONDARY PLAN (MSP) — A Medicare secondary insurance plan for qualified UPREHS Medicare retirees and their qualified spouse. Members must be entitled to Medicare Part A and enrolled in Part B. The UPREHS MSP pays the Medicare Part A and B annual deductible amounts and coinsurance for allowed charges for covered benefits (out-of-network reductions apply). All Medicare members who elect coverage under the UPREHS Medicare Plans are also automatically enrolled in the UPREHS HCPP and the UPREHS Prime Medicare Plan.

URGENTLY NEEDED CARE — Section 3 explains about urgently needed services. These are different from emergency services.

