

## TABLE OF CONTENTS

<b>MEMBER’S RESPONSIBILITIES</b>	<b>3</b>
<b>INTRODUCTION</b>	<b>5</b>
Plan Name	5
Taxpayer Identification and Plan Numbers	5
Administration of Plan	5
Type of Plan	5
Plan Year	5
Collective Bargaining	5
Contributions and Funding	5
Agent for Service of Legal Process	5
Qualified Medical Child Support Orders (QMCSO)	6
Plan Eligibility	6
Plan Purpose	6
COEHA Board of Directors	7
<b>COEHA MEMBERS</b>	<b>9</b>
Active Employees	9
COBRA Members	9
Leave of Absence Members	12
Suspended Members	12
Dismissed Members	13
Furloughed Employees	13
Off Sick Members	13
Disabled Members	15
Separated Employees Who Are Not Receiving an Annuity	16
Early Retirement Members	16
60/30 Major Medical Members	16
60/30 Major Medical Spouse Members	16
Medicare Members (Referral to Medicare Supplemental Handbook)	17
<b>COEHA NETWORK</b>	<b>18</b>
In-Network Services	18
Out-of-Network Services/Major Medical Benefits	18
Selecting a Participating Provider	19
Providers not in the Network	19
Out-of-Network Referrals	19
<b>COEHA PLANS</b>	<b>20</b>
Plan One	20
Plan Two	20
Plan Three	20
Plan Four	21
Plan Five	21
Plan Five A	21
Plan Six	22
Plan Eight	22
Plan Nine	22

Plan Eleven	22
Plan Twelve	22
Plan Thirteen	23
<b>BENEFITS</b>	<b>24</b>
Grandfathered Health Plan Under the Patient Protection and Affordable Care Act	24
Membership Identification Card	24
Time Limit for Filing Claims & How to File Claims	24
Ambulance Services	25
Chemo/Radiation Therapy	25
Chiropractic Services	25
Cosmetic and Plastic Surgery	25
Dental Work	26
Diabetic Testing Supplies	26
Durable Medical Equipment	27
Emergency Room Benefits	27
Gastric Bypass Surgery/Stomach Stapling/Lap Belt	28
Hearing Examinations/Hearing Aids	28
Home Health Services	28
Hospitalization	28
Inpatient Rehabilitation in a Hospital or Rehabilitation Center	29
Jaw Joint Disorders	29
Kidney Dialysis	29
Maternity	29
Mental Health	29
Ophthalmology	29
Organ Transplants	30
Orthotics	30
Outpatient Office Visits, Consultations & Diagnostic Testing	30
Outpatient Physical, Occupational, and Speech Therapy	30
Podiatry	31
Prescription Drugs	31
Preventative Services	32
Prosthetic Devices	32
Reconstructive Surgery Following Mastectomy	33
Removal of Excess Skin After Gastric Bypass or Extreme Weight Loss/Tummy Tuck	33
Skilled Nursing Facility Care	33
Smoking Deterrents	34
Substance Abuse	34
Vasectomy and Tubal Ligation Procedures	34
Exceptional Cases	35
<b>EXCLUSIONS</b>	<b>36</b>
<b>SUBROGATION AND REIMBURSEMENT</b>	<b>38</b>
<b>CLAIMS AND APPEALS PROCEDURE</b>	<b>42</b>
<b>EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) RIGHTS</b>	<b>45</b>

## **MEMBER'S RESPONSIBILITIES**

- Be considerate and respectful to all COEHA staff and participating providers
- Seek services of COEHA participating providers if applicable
- Read all COEHA document materials and ask questions if you do not understand
- Know the benefits for your classification of membership
- Provide complete health status information as needed to receive appropriate care
- Respond to our letters promptly
- Always utilize your membership identification card when seeking healthcare services
- Notify COEHA when a change in your employment status occurs such as a change from active status to off sick, furloughed, suspended, dismissed, separated, leave of absence or retirement
- Forward to COEHA any bills you receive more than once for the same services
- Maintain your health and participate in decisions concerning your treatment

**IF YOU HAVE ANY QUESTIONS REGARDING BENEFITS,  
CLAIMS OR ELIGIBILITY, CONTACT THE C AND O  
EMPLOYEES' HOSPITAL ASSOCIATION AT:**

**C and O Employees' Hospital Association  
511 Main Street, 2<sup>nd</sup> Floor  
Clifton Forge, Virginia 24422-1166**

**Telephone Numbers:  
(800) 679-9135 (toll free)  
(540) 862-5728 (bell, locally)  
(8) 443-1463 (RR)**

**Fax Numbers:  
(540) 862-3552 (claims)  
(540) 862-4958 (membership eligibility)**

**Hours of Operation:  
Monday through Friday, 8:30am to 5:00pm**

**You may also visit our web site at [www.coeha.com](http://www.coeha.com)**

## **INTRODUCTION**

The members who support the C and O Employees' Hospital Association and the dedicated staff of professionals who administer the benefits keep this Organization operating efficiently.

The Year 1997 was the C and O Employees' Hospital Association's 100<sup>th</sup> anniversary. We would like to recognize one of the Administrators who successfully managed these Offices for forty years from 1946 through 1986:

**WILLIAM E. LEECH**

### **Plan Name:**

C and O Employees' Hospital Association (COEHA)

### **Taxpayer Identification and Plan Numbers:**

Employer Identification Number is 23-7082348

Plan Number is 501

### **Administration of Plan:**

The Plan is administered by the C and O Employees' Hospital Association, 511 Main Street, 2<sup>nd</sup> Floor, Clifton Forge, Virginia 24422-1166.

### **Type of Plan:**

COEHA is a welfare benefit plan providing medical, surgical, and hospital care.

### **Plan Year:**

January 1 through December 31

### **Collective Bargaining:**

COEHA was established through a collective bargaining agreement that was negotiated through the Cooperating Railway Labor Organizations and National Railway Labor Conference. Members and beneficiaries may obtain a copy of such agreement upon written request to the Plan Administrator. The agreement also is available for examination at the COEHA office.

### **Contributions and Funding:**

The Plan is funded by membership contributions through a monthly dues assessment and contributions from Chessie Systems X Transportation (CSXT).

### **Agent for Service of Legal Process:**

Jack N. Pate

President and Administrator

C and O Employees' Hospital Association

511 Main Street, 2<sup>nd</sup> Floor

Clifton Forge, Virginia 24422-1166

### **Qualified Medical Child Support Orders (QMCSOs):**

Copies of the Plan's QMCSO procedures will be provided to members and beneficiaries upon request to the Plan Administrator, without charge.

### **Plan Eligibility:**

Generally, all Brotherhood of Locomotive Engineers (BLE) and United Transportation Union (UTU) employees and former employees on the former C and O Railway territory and other individuals, which the Board of Directors may from time to time decide to admit to COEHA, are eligible for membership.

An employee who returns to work after a status of furloughed, separated, suspended, dismissed, leave of absence or disabled will be eligible for coverage on the first day of the month following the month in which they have worked at least seven (7) calendar days. **For example, if an employee returns to work in January, and works seven days in January, the employee will be eligible for coverage in February.** In the event such employee returns to work at a time during a month when there is not opportunity to render compensated service on at least seven calendar days during that month, such employee will be deemed to have satisfied the seven-day rule, provided that they are available or actually work every available work opportunity.

An eligible active employee who returns to work after completion of service in the armed forces of the United States will be eligible for coverage on the day they first render compensated service upon their return.

As a cost containment measure for members not actively working and paying dues direct, COEHA has instituted an automatic dues deduction program for monthly membership premiums from your checking account. You will be required to participate in the automatic dues deduction program **or** you may remit your dues directly to COEHA either quarterly, semi-annually, or annually. Your check should be made payable to the C and O Employees' Hospital Association and we must receive it by the 5<sup>th</sup> of each month. If you choose to participate in the automatic dues deduction program, your premiums will be deducted on the fifth (5<sup>th</sup>) day of each month unless the 5<sup>th</sup> of the month is on a weekend or holiday.

Any member of COEHA who fails to submit current membership premiums for his class of membership, shall be notified by certified mail of the delinquency and given thirty (30) days to bring membership status up to date. Failure to comply with this notice will result in forfeiture of membership.

Any request for reinstatement must be submitted to the COEHA Finance Committee in accordance with the guidelines outlined in the **Appeal Procedure Section** of these Rules and Regulations.

### **Plan Purpose:**

The C and O Employees' Hospital Association was established in 1897 as a joint effort between the Chesapeake and Ohio Railway Company and its employees to provide certain healthcare benefits for the employees and retirees of the Chesapeake and Ohio Railway Company.

Healthcare benefits will be furnished in accordance with such rules and regulations as may from time to time be approved by the Board of Directors of COEHA, provided, that at all times COEHA shall conduct itself strictly as a non-profit organization pursuant to Section 501 (c) (9) of the Internal Revenue Code of 1986 as same may be amended, or the comparable section of any future Revenue Act.

All benefits are subject to the limitations and exclusions in these Rules and Regulations and are payable when determined by the Plan to be medically necessary. **No oral statement of any person can modify or otherwise affect the benefits, limitations, and exclusions of these Rules and Regulations, convey or void any coverage, increase or reduce any benefits under this Plan, or be used in the prosecution or defense of a claim under this Plan.**

## COEHA Board of Directors

COEHA is governed by a Board of Directors. The members of the current Board of Directors are:

### Director

Jack N. Pate  
**President; Administrator,**  
**COEHA**  
422 Sullivan Road  
Glen Morgan, WV 25847  
(304) 252-5227

Norman V. Smith  
**Vice President, COEHA**  
1707 Jones Street  
Flatwoods, KY 41139  
(606) 834-1766

Kenneth Farley  
**Secretary-Treasurer, COEHA**  
271 Township Road 1167  
Proctorville, Ohio 45669  
(304) 638-2343

Jonathan Barron  
**Director, COEHA**  
17295 Shiloh Church Road  
Montpelier, VA 23192  
(804) 449-1583

Tim Braden  
**Director, COEHA**  
P. O. Box 274  
Russell, KY 41169  
(606)923-7407

Glenn Hazelwood  
**Director, COEHA**  
2423 Old Geneva Road  
Henderson, KY 42420  
(270) 826-3740

Howard Knight  
**Director, COEHA**  
100 Bells Island Drive  
Hampton, VA 23664  
(757) 851-5945

### Union Affiliation

Local Chairman  
United Transportation Union

Brotherhood of Locomotive Engineers

Local Chairman, E Craft  
United Transportation Union

Local Chairman  
United Transportation Union

Junior Vice General Chairman  
Brotherhood of Locomotive Engineers

General Chairman, Yardmasters  
United Transportation Union

At Large Director

Matt Thornton  
**Director, COEHA**  
P. O. Box 49  
Etowah, TN 37331-0049  
(423) 263-0909

Jim Townsend  
**Director, COEHA**  
1319 Chestnut Street  
Kenova, WV 25530  
(304) 453-1102

General Chairman  
Brotherhood of Locomotive Engineers

General Chairman  
United Transportation Union

## **COEHA MEMBERS**

The following classifications of membership are eligible for benefits through COEHA. For members obtaining employment elsewhere and receiving Healthcare benefits from such employment, COEHA will only provide such benefits that are in excess of the other Healthcare Plan benefits and in accordance with the Rules and Regulations governing operation of COEHA. In no instance will COEHA provide a duplication of benefits. For those members relocating more than 100 miles by road from the main line of the former C&O Railway, please refer to the Plan Section for **Off-Line Members**. Please refer to the **COEHA Plan Section** of these Rules and Regulations for a summary of your benefits. The **Benefits Section** provides coverage information regarding specific healthcare services.

Our coverage is limited to treatment of the actual COEHA member. We do not cover services billed as “family services”.

### **Active Employees (Plan One):**

BLE and UTU members who are actively employed with CSXT and work within 100 miles by road of the main line of the former Southern Region, Cincinnati-Chicago Division of the former Chesapeake and Ohio Railway Company whose membership premiums are remitted to COEHA. **(Refer to Plan One for benefits)**

Dependents of actively employed members who are covered by the National Health and Welfare Plan are eligible for supplemental coverage with COEHA upon payment of dues premiums. **(Refer to Plan Six for benefits)**

An active member of COEHA becoming a full-time employee of the BLE or UTU is eligible for benefits of COEHA upon payment of premiums directly to COEHA as specified for active members. **(Refer to Plan One for benefits)**

Active employees age 65 or older and eligible for Medicare coverage will still be covered by COEHA as their primary insurer. **(Refer to Plan One for benefits)**

Active members of COEHA transferred outside of the COEHA territory are eligible to maintain their membership in COEHA. These members would be covered by the National Health and Welfare Plan as their primary insurer, and COEHA would be secondary. **(Refer to Plan Eight for benefits)**

### **COBRA (Plan One):**

#### **Right to Continuation Coverage.**

Qualifying Events. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, (COBRA) members are entitled to elect to continue participation in COEHA, for a limited period of time, if the member loses his regular coverage under the Plan as a result of either of the following events commonly referred to as “Qualifying Events”:

- (1) Termination of employment (for reasons other than gross misconduct); or
- (2) A reduction in hours of work.

A “loss of Plan coverage” includes an increase in the premiums the member is required to pay.

If a member's spouse is covered under the COEHA, he or she also has the right to elect Continuation Coverage if he or she loses coverage under the medical option as a result of any of the following events also known as "Qualifying Events":

- (1) The end of the member's employment (for reasons other than gross misconduct);
- (2) A reduction in the member's hours of work;
- (3) The death of the member;
- (4) Divorce or legal separation from the member; or
- (5) The member becomes entitled to Medicare benefits under Title XVIII of the Social Security Act.

A member's covered dependent child also has the right to elect Continuation Coverage for himself or herself if he or she loses regular coverage under the Plan as a result of any of the following events also known as "Qualifying Events":

- (1) The end of the covered parent's employment relationship (for reasons other than gross misconduct);
- (2) A reduction in the covered parent's hours of work;
- (3) The death of a covered parent;
- (4) The parents' divorce or legal separation;
- (5) The covered parent becomes entitled to Medicare benefits under Title XVIII of the Social Security Act; or
- (6) The child loses dependent status under the terms of the Plan.

A dependent child includes a child born to or placed for adoption with a covered employee during the period of COBRA coverage.

Separate elections. If there is a choice among types of coverage under the Plan, each person who is eligible for Continuation Coverage (known as a "Qualified Beneficiary") is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect Continuation Coverage even if the covered employee does not make that election. Similarly, a spouse or dependent child may elect different coverage from the coverage that the covered employee elects.

**Duties of Qualified Beneficiaries.** A covered employee or family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child's loss of dependent status under the Plan within 60 days of the event or the date on which regular Plan coverage would be lost because of the event. In addition, the covered employee or a family member must inform the Plan Administrator before the end of the original 18-month Continuation Coverage period and within 60 days of a determination by the Social Security Administration that the individual concerned was disabled at the time of the covered employee's termination of employment relationship or reduction in hours of employment. The individual may extend Continuation Coverage if they were disabled at any time during the first 60 days of Continuation Coverage. The extension of Continuation Coverage due to disability is also available to the non-disabled spouse and dependent children of the disabled individual.

If, during Continued Coverage, the covered employee or family member is later determined by the Social Security Administration as no longer being disabled, the individual must inform the Plan Administrator within 30 days of the date the re-determination was made. When the Plan Administrator is notified that one of these events has occurred, the member will be notified of his or her Continuation Coverage rights.

**Election of Continuation Coverage.** Under COBRA, a Qualified Beneficiary is entitled to have an election period of 60 days to decide whether to elect Continuation Coverage. The 60-day election period begins on the later of (1) the date the individual would lose regular Plan coverage because of one of the qualifying events described above or (2) the date the individual is sent a notice of the right to elect Continuation Coverage. If a Qualified Beneficiary informs the COEHA within the 60-day election period that he or she wants Continuation Coverage, Continuation Coverage begins on the date the individual's regular Plan coverage ends. There is one exception, however. If a Qualified Beneficiary waives Continuation Coverage, he or she may revoke the waiver at any time before the 60-day election period ends. In that case, the Continuation Coverage begins on the date the waiver is revoked. Coverage will not be provided for the period between the date regular Plan coverage ends and the date the waiver is revoked.

If a Qualified Beneficiary dies or becomes legally incapacitated before the 60-day election period ends, then a personal representative has the right to make an election on the Qualified Beneficiary's behalf, provided the election is made before the end of the 60-day election period. The period between the date of death or legal incapacity and the date the personal representative is appointed will not be included for purposes of calculating such 60-day period.

If a Qualified Beneficiary does not choose Continuation Coverage within the 60 day election period, the individual's eligibility for Continuation Coverage will end.

**Cost of Continuation Coverage.** The cost of regular Continuation Coverage is the full cost of the monthly premium plus a two percent administrative charge. The cost of Continuation Coverage provided after the 18<sup>th</sup> month on account of disability under Title II or XVI of the Social Security Act is 150 percent of the full cost of the monthly premium. If you experience a Qualifying Event, you will be notified about the premium rates and the due dates for payments. The premium costs will increase during the Qualified Beneficiary's period of Continuation Coverage to the extent such premium increases have increased for non-COBRA coverage under the Plan.

The initial premium for Continuation Coverage will be due 45 days after the date of the initial Continuation Coverage election. There is a 30-day grace period after the due date for each of the subsequent premiums.

**Continuation Coverage.** The Continuation Coverage is identical to the coverage then being provided under the Plan to similarly situated employees, their spouses, and their dependent children who have not experienced a qualifying event. If their coverage changes, Continuation Coverage will change in the same way. COEHA reserves the right to terminate Continuation Coverage retroactively for an individual determined to be ineligible for such coverage.

**Duration of Coverage.** If the member or a covered family member loses regular Plan coverage due to a termination of employment or a reduction in hours of work, Continuation Coverage generally may last for only 18 months.

**Special rule for disability.** If a Qualified Beneficiary loses regular Plan coverage due to a termination of employment or a reduction in hours of employment and is determined to have been disabled under Title II or XVI of the Social Security Act at the time of the termination or reduction in hours or within the first 60 days of COBRA coverage, then Continuation Coverage may last for up to 29 months, provided, however, that COEHA is notified of the disability determination before the end of the regular 18-month period and within 60 days of

the date the determination is made. (A Qualified Beneficiary must also notify COEHA within 30 days if a final determination is made that the member is no longer disabled under Title II or XVI of the Social Security Act).

**Second qualifying event.** This 18-month (or 29- month) period of Continuation Coverage may be extended for up to 36 months if a second “qualifying event” (for example, death, divorce or legal separation, or Medicare entitlement) occurs during the 18-month (or 29-month) period, but only for those individuals who were Qualified Beneficiaries in connection with the first qualifying event and are Qualified Beneficiaries at the time of the second qualifying event. For example, if a terminated employee chooses Continuation Coverage for himself and his spouse and the employee dies before the 18-month (or 29-month) period ends, the spouse may elect to receive Continuation Coverage for a total of 36 months. The 36 months would be measured from the date of the employee’s termination of employment. A termination that follows a reduction in hours is not a Qualifying Event that creates a right to Continuation Coverage.

**Continuation coverage will be terminated.** COBRA provides that Continuation Coverage will be terminated, if any of the following events occurs:

- (1) The premium for Continuation Coverage is not paid within 30 days of the due date;
- (2) The Qualified Beneficiary first becomes covered, after the date of his or her COBRA election, under another group health plan (as an employee or otherwise) even if such group health plan contains a preexisting condition limitation or exclusion so long as such limitation or exclusion does not apply to you because of the new rules enacted under the Health Insurance Portability and Accountability Act of 1996.
- (3) The Qualified Beneficiary becomes entitled to the Medicare benefits under Title XVIII of the Social Security Act;
- (4) Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled under Title II or XVI of the Social Security Act. In that case, Continuation Coverage will end as of the first day of the month that begins more than 30 days after the date the final determination is made; or
- (5) The end of the maximum eligibility period is reached.

Once Continuation Coverage terminates *for any reason*, it cannot be reinstated.

**Leave of Absence Members (Other Than For Health Reasons) (Plan One):**

Actively employed members of COEHA who are granted a leave of absence from CSXT pursuant to applicable collective bargaining agreement

Leave of Absence members are classified as active employees and are eligible for coverage through COEHA through the remainder of the month in which they last worked. Membership in COEHA can be continued in a COBRA status upon payment of dues premiums. **(Refer to Plan One for benefits)** Once COBRA coverage has been exhausted, the member is eligible for continuation of benefits. **There will be a change in benefits and premiums. (Refer to Plan Twelve for benefits)**

**Suspended Members (Plan One):**

Actively employed members who are suspended from CSXT

Suspended members are classified as active employees and are eligible for coverage through COEHA through the remainder of the month in which they last worked and the following calendar month without payment of membership premiums. For the second, third and fourth months, the employee is covered by the National Health and Welfare Plan. After the fourth month, coverage with the National Health and Welfare Plan will terminate and membership in COEHA can be continued in a COBRA status upon payment of dues premiums. **(Refer to Plan One for benefits)** Once COBRA coverage has been exhausted, the member is eligible for continuation of benefits. **There will be a change in benefits and premiums. (Refer to Plan Twelve for benefits)**

#### **Dismissed Members (Plan One):**

Actively employed members who are dismissed from CSXT

Dismissed members are covered by the National Health and Welfare Plan effective with the date of dismissal. They will continue to be covered by the National Plan for the next four months following the month in which they last rendered any compensated service or received vacation pay. **However, the vacation pay must be received prior to dismissal to be considered vacation pay.** After the fourth month, coverage with the National Plan will terminate and membership in COEHA can be continued in a COBRA status upon payment of dues premiums. **(Refer to Plan One for benefits)** Once COBRA coverage has been exhausted, the member is eligible for continuation of benefits. **There will be a change in benefits and premiums. (Refer to Plan Twelve for benefits)**

#### **Furloughed Employees (Plan One):**

Active members of COEHA who are furloughed from their employment with CSXT

##### **For the first four months:**

Active members of COEHA who are furloughed from their employment with CSXT are entitled to benefits of COEHA identical to those as an active member, without payment of membership premiums for four (4) months following the month in which the last compensated service was performed. Vacation payments received subsequent to the month in which furlough occurs will not extend healthcare benefits beyond the four (4) month period. **(Refer to Plan One for benefits)**

If such furloughed member becomes disabled while covered as a furloughed employee during this four month period, coverage will continue as long as disability is the **only** reason the employee does not perform work in his regular occupation if recalled, and member will be covered by the provisions for Disabled Members. **The Association will require medical certification from the member's attending physician stating member is under medical care and unable to return to work.**

##### **After the first four months:**

Beginning with the fifth (5th) month, members who continue on furlough are eligible to continue their benefits through COEHA in a COBRA status upon payment of membership premiums. Once COBRA has been exhausted, the member is eligible for continuation of benefits. **There will be a change in benefits and premiums. (Refer to Plan Twelve for benefits)**

#### **Off Sick (Plan One):**

Members of COEHA who are out of service on account of illness, injury, disability or pregnancy, which continues to prevent their return to service in their CSXT occupations (these members are not receiving an annuity)

Off sick members are eligible for coverage with COEHA for the remainder of the year in which they last rendered compensated service or received vacation pay and the following calendar year. They will be entitled to benefits identical to those of an active member without payment of premiums as long as they continue to be out of service on account of illness, injury, disability or pregnancy, which continues to prevent their return to service in their CSXT occupation. They are no longer eligible for coverage with COEHA without payment of premiums should they accept other regular employment or their disability ends. **(Refer to Plan One for benefits)** Beginning with the next calendar year, the member is given the option to choose between two types of coverage.

- Benefits paid at 80% with no premium **(Refer to Plan Nine for benefits)**
- Full coverage, both in and out-of-network, with a premium **(Refer to Plan Eleven for benefits)**

**Vacation pay is construed to be for the calendar year in which pay is due, and not the calendar year in which it might be paid. (Example: employee last worked July 2010, vacation pay (for 2011) received in 2012 for time worked in 2010, will extend full benefits without payment of premiums only through December 2012.) We will need a copy of your check stub showing vacation pay was received, regardless of when it was received, to extend your benefits.**

Coverage is determined by the last year member qualified for vacation. (Example: a member worked enough in 2009 to qualify for vacation for 2010. The member only worked three months in 2010, but did not qualify for vacation in 2011. Therefore, for 2012, the member would qualify for benefits at 80% (Plan Nine), without payment of premiums, or upon payment of premiums, the member would qualify for full benefits under Plan Eleven.)

If a member does not qualify for at least eighteen (18) months of coverage identical to an active member under the above ruling for Off Sick Members, they may be eligible for continuation of this coverage under the COBRA guidelines. Please contact COEHA for more information. (Example: employee was off sick and did not work January through May of 2010—employee returned to work June 2010 and worked through August 2010—effective September 2010 the employee is unable to return to work due to illness—employee would be eligible for coverage as follows: the remainder of 2010 and the entire year of 2011 without payment of membership dues (16 months)—effective January 2012, the employee would be eligible for two (2) months of coverage under COBRA **(Refer to Plan One for benefits)** upon payment of membership premiums and once the employee has exhausted COBRA coverage (16 plus 2), employee would be eligible for continuation of coverage through COEHA upon payment of membership premiums **(Refer to Plan Eleven for benefits)** or employee would be eligible for 80% coverage the entire year of 2012 without payment of membership premiums **(Refer to Plan Nine for benefits)**)

COEHA will require medical certification from the member's attending physician, stating that the member is under medical care and is unable to return to work. The medical certification is required every six months or until a member returns to work in their regular occupation with CSXT. In the event an annuity is awarded, a copy of the Railroad Retirement Award Notice Letter is required and, in some instances, medical certification may still be required.

Off sick members who have exhausted their one year "waiver of premium" coverage **or** their one year full benefits "with premium" coverage and have **not** been awarded a disability annuity are eligible for continuation of coverage in the COEHA. There will be a change in premiums and benefits. **(Refer to Plan Twelve for benefits)**

In the event an off sick member is furloughed during a period of disability of four or more months, the member would be required to begin payment of premiums to COEHA in a COBRA status as provided in the section of the Rules and Regulations for Furloughed Members, immediately upon termination of disability status.

### **Disabled Members (Plan Thirteen):**

Members of COEHA who are out of service on account of illness, injury, disability or pregnancy, which continues to prevent their return to service in their CSXT occupations and are receiving a disability annuity.

Disabled members are eligible for coverage with COEHA for the remainder of the year in which they last rendered compensated service or received vacation pay and the following calendar year. They will be entitled to benefits identical to those of an active member without payment of premiums as long as they continue to be out of service on account of illness, injury, disability or pregnancy, which continues to prevent their return to service in their CSXT occupation. They are no longer eligible for coverage with COEHA without payment of premiums should they accept other regular employment or their disability ends. **(Refer to Plan Thirteen for benefits)** Beginning with the next calendar year, the member is given the option to choose between two types of coverage.

- Benefits paid at 80% with no premium **(Refer to Plan Two for benefits)**
- Full coverage, both in and out-of-network, with a premium **(Refer to Plan Three for benefits)**

**Vacation pay is construed to be for the calendar year in which pay is due, and not the calendar year in which it might be paid. (Example: employee last worked July 2010, vacation pay (for 2011) received in 2012 for time worked in 2010, will extend full benefits without payment of premiums only through December 2012.) We will need a copy of your check stub showing vacation pay was received, regardless of when it was received, to extend your benefits.**

Coverage is determined by the last year member qualified for vacation. (Example: a member worked enough in 2009 to qualify for vacation for 2010. The member only worked three months in 2010, but did not qualify for vacation in 2011. Therefore, for 2012, the member would qualify for benefits at 80% (Plan Two), without payment of premiums, or upon payment of premiums, the member would qualify for full benefits under Plan Three.)

If a member does not qualify for at least eighteen (18) months of coverage identical to an active member under the above ruling for Disabled Members, they may be eligible for continuation of this coverage under the COBRA guidelines. Please contact COEHA for more information. (Example: employee was off sick and did not work January through May of 2010—employee returned to work June 2010 and worked through August 2010—effective September 2010 the employee is unable to return to work due to illness—employee would be eligible for coverage as follows: the remainder of 2010 and the entire year of 2011 without payment of membership dues (16 months)—effective January 2012, the employee would be eligible for two (2) months of coverage under COBRA **(Refer to Plan One for benefits)** upon payment of membership premiums and once the employee has exhausted COBRA coverage (16 plus 2), employee would be eligible for continuation of coverage through COEHA upon payment of membership premiums **(Refer to Plan Three for benefits)** or employee would be eligible for 80% coverage the entire year of 2012 without payment of membership premiums **(Refer to Plan Two for benefits)**)

Disabled members who have exhausted their one year “waiver of premium” coverage **or** their one year full benefits “with premium” coverage and have been awarded a disability annuity are eligible for continuation of coverage in COEHA. There will be a change in premiums and benefits. **(Refer to Plan Four for benefits)**

Members who are awarded a disability annuity will continue to be eligible for benefits of COEHA without payment of premiums for the same period of time the eligibility would have continued had the member not been awarded an annuity; **however, those members qualifying for Medicare must become a member of Parts A and B of Medicare (both Parts A & B should be effective with the same date), paying premiums as**

**prescribed in accordance with the effective date of your Medicare coverage. (Refer to Plans Seven and Ten of the COEHA Medicare Supplemental Handbook for benefits)**

**Separated Employees Who Are Not Receiving An Annuity (Plan Twelve):**

Members 55 years of age or more, or with fifteen (15) years or more of membership accepting lump sum separation allowance and deferring or ineligible for retirement pension whose premiums are remitted to COEHA

Separated employees are classified as active employees and are entitled to benefits as active employees through the remainder of the month in which the employees last worked. **(Refer to Plan Twelve for benefits after the first month)** Membership under COBRA is also available. **(Refer to Plan One for benefits)**

**Separated members applying for a disability pension after being awarded separation are not entitled to a waiver of premium on the basis of their disability.**

**Early Retirement Members (Plan Four):**

Members who retire between the ages of 60 and 65 and do not meet the requirements for the 60/30 Major Medical membership

Members are entitled to the in-network benefits upon payment of membership premiums. Premiums are due according to the effective date of your Railroad Retirement or Social Security Annuity. **(Refer to Plan Four for benefits)** Membership under COBRA is also available. **(Refer to Plan One for benefits)**

**60/30 Major Medical Members (Plans Five or Five A):**

Those members retiring at 60 years of age or older, with 30 or more years of service with the Railroad Retirement Board, but not yet 65 years of age

Members who retire effective January 1, 2002 or later, are entitled to one of two different plans of benefits. Plan Five entitles the members to both in-network benefits and major medical benefits. The in-network benefits are paid in full less the deductible and office visits co-pays upon payment of premium. Premiums are due according to the effective date of your Railroad Retirement or Social Security Annuity.

Plan Five A pays a percentage less the deductible and office visits co-pays and has a lifetime maximum of \$100,000 with no premium. If you choose Plan Five A with no premium, you have four months (the month you retire, plus three months) to change to the other 60/30 plan. **(Refer to Plans Five & Five A for benefits)** Membership under COBRA is also available. **(Refer to Plan One for benefits)**

Certain employees who retire on disability **may be** eligible for these same benefits upon attaining age 60. These members must have continued their membership in COEHA until age 60 and should contact the COEHA Offices for eligibility information.

Once a member becomes eligible for Medicare benefits, COEHA membership must be converted to the Medicare Supplemental Plan. **(See the COEHA Medicare Supplemental Handbook)**

**60/30 Major Medical Spouse Members (Plan Six):**

A spouse of a 60/30 Major Medical COEHA member is eligible for our supplemental coverage to the National Health and Welfare Plan upon payment of membership premiums. **(Refer to Plan Six for benefits)**

**Medicare Members:**

**Please refer to our Medicare Supplemental Handbook—if you are eligible for Medicare coverage soon, you should request a copy of the COEHA Medicare Supplemental Handbook.**

## **COEHA NETWORK**

To give you the highest quality medical care available, we have created an extensive network of healthcare providers by partnering with Anthem Blue Cross Blue Shield. Anthem offers COEHA and its members access to the BlueCard program. This program electronically links all Blue Cross and Blue Shield Plans and their providers—creating one large, national network. The network includes more than 80 percent of the hospitals and nearly 90 percent of the physicians in the United States and, COEHA and its members have access to all of them.

COEHA has an open network, which means you can use the services of providers who belong to our network without first getting a referral from another physician.

COEHA's designation of a physician or other provider as a participating provider is not an endorsement of that provider. Except as to the payment of benefits for covered services, COEHA has no responsibility for the care or services rendered by a participating provider or for the manner in which that care or service is rendered.

You can easily find a participating provider online at [www.anthem.com](http://www.anthem.com) or call 1-800-810-BLUE (2583). The Anthem web site address and the phone number are located on the back of your ID card. You can also call your provider directly and ask if they participate in the BlueCard PPO network. As always, COEHA is available if additional assistance is required.

## **IN-NETWORK SERVICES**

Whenever possible, you should seek medical care from participating providers in the COEHA network.

Full benefit payment is made for medically necessary treatment from COEHA participating providers for covered services, less applicable co-pays and/or deductibles.

## **OUT OF-NETWORK SERVICES OR MAJOR MEDICAL BENEFITS**

Some categories of our membership are eligible for out of network coverage. If you choose to utilize this option, your services are paid at a reduced level of benefits as outlined below:

Also, some benefits are only covered under your Major Medical level of benefits as outlined below: (Please refer to the Benefits Section for those services only covered under Major Medical)

- Annual deductible must be satisfied (please see the COEHA **Plans Section** for your appropriate deductible)
- Payment is made at 80% of our fee schedule for covered charges (**provider may bill you for charges in excess of our fee schedule**)
- Out-of-pocket expense in the amount of \$1500 must be satisfied before our payment percentage reverts to 100% of our fee schedule for covered charges (**provider may bill you for charges in excess of our fee schedule**)

(Non-covered services, deductibles, \$20 co-payments, and charges in excess of our fee schedule are not included in the \$1500 out-of-pocket expense—example: member with a \$650 deductible would pay \$2150 out of pocket before expenses would be covered at 100%--\$650 deductible + \$1500 out-of-pocket=\$2150)

## **SELECTING A PARTICIPATING PROVIDER**

COEHA members may select any participating provider in our network without a referral. Some members live in towns or cities where no participating providers are available. If this is the case for you, locate the nearest town or city where COEHA providers are available. If the closest COEHA provider is within 30 miles by road, you must utilize those providers, unless you are eligible for the out-of-network coverage outlined above and you prefer to utilize your out-of-network benefits at a reduced rate.

## **PROVIDERS NOT IN THE NETWORK**

There are some areas where network providers have not yet been contracted and the nearest COEHA provider is more than 30 miles away. Members in these areas are permitted to use providers of their choice. However, if you choose a physician more than 30 miles away in an area where we have the specialty available in network, you should seek the services of our network physician unless you are eligible for the out-of-network coverage outlined above and you prefer to utilize your out-of-network benefits at a reduced rate.

## **OUT-OF-NETWORK REFERRALS**

Out-of-network referrals are covered if the required specialty is not participating in your area within 30 miles by road **and** if the referral comes from a participating physician. Referrals must be approved **prior to treatment** in order to receive full benefit payment.

Requests made by a patient to see a different physician who is not a COEHA provider are not considered approved referrals and are not covered unless you are eligible for out-of-network coverage at a reduced rate.

## **COEHA PLANS**

Plan benefits are highlighted below. For specific benefits, please refer to the **Benefits Section**.

### **Plan One (Active, COBRA, Leave of Absence, Suspended, Furloughed)**

- **In-Network:** 100% payment for covered services less the \$20 co-pay for office visits and consultations
- **Out-of-Network:** 80% payment of our fee schedule for covered services less the \$20 co-pay for office visits and consultations after the annual \$100 deductible has been satisfied
- Unlimited lifetime and annual maximum on most **in-network** benefits
- Use of any COEHA network provider with no referral required
- Prescription drug coverage at local pharmacy and mail order pharmacy through our prescription drug program

### **Plan Two (Disabled Members, with an annuity, who have elected 80% coverage with waiver of premium)**

- Annual deductible of \$1500 on **all** covered services (in or out-of-network, including inpatient and outpatient services)
- All services (in or out-of-network) covered at 80% of our fee schedule for covered services less the \$20 co-pay for office visits and consultations after annual deductible has been satisfied
- Lifetime maximum of \$1,000,000
- Prescription drug coverage at local pharmacy and mail order pharmacy through our prescription drug program

### **Plan Three: (Disabled Members, with an annuity, who have exhausted their waiver of premium and are still entitled to full benefits for one year)**

- Annual deductible of \$650 for **all** covered services (in and out-of-network, including inpatient and outpatient services)
- **In-Network** - 100% payment for covered services less \$20 co-pay for office visits and consultations after \$650 deductible has been satisfied
- **Out-of-Network** – 80% payment of our fee schedule for covered services less \$20 co-pay for office visits and consultations after \$650 deductible has been satisfied
- Unlimited lifetime and annual maximum on most **in-network** benefits
- Use of any COEHA network provider with no referral required
- Prescription drug coverage at local pharmacy and mail order pharmacy through our prescription drug program

### **Plan Four (Early Retirement and Disability Annuitants who have exhausted their Major Medical benefits)**

- Annual deductible of \$650 for **all** covered services
- **In-Network** benefits paid at 100% for covered services less \$20 co-pay for office visits and consultations after annual deductible has been satisfied
- **Emergency** benefits paid at 100% after annual deductible has been satisfied when such services are provided at the nearest treatment facility (There will be a \$40 emergency room co-pay on charges for emergency room physician visits)
- Unlimited lifetime and annual maximum on most **in-network** benefits
- Use of any COEHA network provider with no referral required
- Eligible for consumer prescription card through our prescription drug program which entitles the member to group discounts on prescription drugs

### **Plan Five (60/30 Major Medical Members)**

- Annual deductible of \$750 for **all** covered services (in or out-of-network, including inpatient and outpatient services)
- **In-Network:** 100% payment for covered services less the \$20 co-pay for office visits and consultations after the annual deductible has been satisfied
- **Out-of-Network:** 80% payment of our fee schedule for covered services less the \$20 co-pay for office visits and consultations after the annual deductible has been satisfied
- Unlimited lifetime and annual maximum on most **in-network** benefits
- Use of any COEHA network provider with no referral required
- Prescription drug coverage at local pharmacy and mail order pharmacy through our prescription drug program

### **Plan Five A (60/30 Major Medical Members – No Premium—for members who retire January 1, 2002 or later)**

- Annual deductible of \$100 for **all** covered services (in or out-of-network, including inpatient and outpatient services)
- All covered services (in or out-of-network) covered at 80% of our fee schedule less the \$20 co-pay for office visits and consultations after annual deductible has been satisfied **(Please keep in mind that not all physicians will accept our fee schedule—you could be responsible for the amount above the fee schedule—for instance, your surgery costs \$6,000—our fee schedule determines \$3,000 to be reasonable—the provider can bill you the \$3,000 not covered by us, plus your 20%)**
- Lifetime maximum of \$100,000 (if you retire at age 60, this lifetime maximum would have to last you for ages 60-64—once you have exhausted the maximum, you have no coverage)

- Prescription drug coverage at local pharmacy and mail order pharmacy through our prescription drug program

**Plan Six (Dependents of actively employed members and spouses of 60/30 Major Medical Members who are primarily covered by the National Health and Welfare Plan)**

- Covers the annual deductible not paid under the National Health and Welfare Plan
- Covers up to 85% of the amount approved, but not paid by the National Health and Welfare Plan

**Plan Eight (Active Off-Line Member)**

- Covers the annual deductible not paid under the National Health and Welfare Plan
- Covers the balance of covered services not paid by the National Health and Welfare Plan

**Plan Nine (Off Sick Members who have elected 80% coverage with waiver of premium):**

- Annual deductible of \$1500 on **all** covered services (in or out-of-network, including inpatient and outpatient services)
- All services (in or out-of-network) covered at 80% of our fee schedule for covered services less the \$20 co-pay for office visits and consultations after annual deductible has been satisfied
- Prescription drug coverage at local pharmacy and mail order pharmacy through our prescription drug program

**Plan Eleven (Off Sick Members who have exhausted their waiver of premium and are still entitled to full benefits for one year):**

- Annual deductible of \$650 for **all** covered services (in and out-of-network, including inpatient and outpatient services)
- **In-Network** - 100% payment for covered services less \$20 co-pay for office visits and consultations after \$650 deductible has been satisfied
- **Out-of-Network** – 80% payment of our fee schedule for covered services less \$20 co-pay for office visits and consultations after \$650 deductible has been satisfied
- Unlimited lifetime and annual maximum on most **in-network** benefits
- Use of any COEHA network provider with no referral required
- Prescription drug coverage at local pharmacy and mail order pharmacy through our prescription drug program

**Plan Twelve (Separated Employees who are not receiving an annuity and Off Sick Members who have exhausted their one year waiver of premium coverage):**

- Annual deductible of \$650 for **all** covered services

- **In-Network** benefits paid at 100% for covered services less \$20 co-pay for office visits and consultations after annual deductible has been satisfied
- **Emergency** benefits paid at 100% after annual deductible has been satisfied when such services are provided at the nearest treatment facility (There will be a \$40 emergency room co-pay on charges for emergency room physician visits)
- Unlimited lifetime and annual maximum on most **in-network** benefits
- Use of any COEHA network provider with no referral required
- Prescription drug coverage at local pharmacy and mail order pharmacy through our prescription drug program

**Plan Thirteen (Disabled Members with annuity and a waiver of premium)**

- **In-Network:** 100% payment for covered services less the \$20 co-pay for office visits and consultations
- **Out-of-Network:** 80% payment of our fee schedule for covered services less the \$20 co-pay for office visits and consultations after the annual \$100 deductible has been satisfied
- Unlimited lifetime and annual maximum on most **in-network** benefits
- Use of any COEHA network provider with no referral required
- Prescription drug coverage at local pharmacy and mail order pharmacy through our prescription drug program

## **BENEFITS**

### **GRANDFATHERED HEALTH PLAN UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**

The C and O Employees' Hospital Association believes our plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("the Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. A grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. For example, the requirement for the provisions of preventative health services without cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from a grandfathered health plan status can be directed to the plan administrator at 1-800-679-9135 or locally in the Clifton Forge, VA area at 862-5728. You may also contact the Employee Benefits Security Administration, U. S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

### **MEMBERSHIP IDENTIFICATION CARD**

Your membership identification card identifies you as a member of COEHA. It contains a unique member identification number which helps COEHA protect you against possible identity theft. To ensure your provider has the proper insurance information, have the provider copy the front and back of your card. Please have this number available when you call COEHA. Also, please list this number on any correspondence sent to COEHA.

Your membership card does not guarantee coverage of all services or current eligibility. You or your provider can verify your eligibility by contacting COEHA. Should your membership card become lost, stolen or damaged, you can call COEHA with a replacement request at 1-800-679-9135 or locally at 862-5728.

### **TIME LIMIT FOR FILING CLAIMS & HOW TO FILE CLAIMS**

All claims for services provided our members must be received within one year from the date the services were rendered to be eligible for payment by COEHA. All corrected rebills should be received within one year from the original denial date to be eligible for payment by COEHA.

Your network provider will file your claims for you to the local Blue Cross and Blue Shield Plan. Many healthcare providers will file your claims with the local Blue Cross and Blue Shield Plan even if they are not participating in the network. If a non-participating provider will not file the claim for you, you will be responsible for filing the claim. Assistance with filing the claim will be provided by COEHA.

Claims should contain the following information:

- Patient's full name and COEHA ID Number
- ICD-9 Codes (diagnosis codes)
- CPT Codes (procedure codes)
- Date(s) of service
- Name, address, and Tax Identification Number of provider
- National Provider Identifier Number (NPI)

- Referring physician if applicable

All benefits described in this Section are subject to individual plan limitations and benefit exclusions.

For members whose Plan of coverage has a deductible:

*If your plan of membership is subject to a \$650, \$750 or \$1500 annual deductible, this deductible must be satisfied before any of the benefits described in this Section are covered with the exception of the prescription drug benefit through our prescription drug program and the diabetic testing supply benefit through Neighborhood Diabetes.*

For members eligible for Major Medical or Out-of-Network coverage:

*If you are eligible for Major Medical coverage, your annual deductible must be satisfied before any services are covered under the Major Medical or Out-of-Network coverage with the exception of the prescription drug benefit through our prescription drug program and the diabetic testing supply benefit through Neighborhood Diabetes..*

### **AMBULANCE SERVICES**

COEHA will provide medically necessary service to the nearest treatment facility under **emergency** circumstances. In the event necessary specialty service is not available at this facility, COEHA will provide medically necessary ambulance service to the nearest designated facility where specialty service is available.

### **CHEMO/RADIATION THERAPY**

COEHA covers these services when they are prescribed by a COEHA network provider.

Oral chemotherapy will be classified as prescription drugs and handled accordingly. Please refer to your **Benefit Section** for prescription drug coverage.

### **CHIROPRACTIC SERVICES**

Only those members entitled to our Major Medical coverage (**Plans One, Three, Five, Five A, Eleven & Thirteen**) are eligible for chiropractic benefits under the Major Medical Benefits. Refer to page 18 for Major Medical coverage. **Plans Two and Nine** are eligible for chiropractic coverage at 80%. **Plans Six and eight are eligible for chiropractic benefits under the guidelines summarized in the Plan Section for such members.** Major Medical and Plan Two chiropractic benefits are outlined below:

- Applicable annual deductible must be satisfied before any payment is made
- Limit of 40 visits per calendar year—one chiropractic visit per day
- All other covered charges will be paid at 80% of our fee schedule
- Co-pay of \$20 for office visits or consultations

### **COSMETIC AND PLASTIC SURGERY**

Coverage for hospital and/or professional services in connection with cosmetic surgery shall be limited to the repair or alleviation of damage to the person caused solely by bodily injury sustained while the member is covered. Repairs shall be made within one (1) year of the injury unless special extension is requested by the attending surgeon.

## **DENTAL WORK**

Elective or routine dental work, not associated with injury, is provided through the National Dental Plan for active employees of CSXT, and is not a responsibility of COEHA.

COEHA coverage is limited to the expense of necessary dental repair to natural teeth due to accidental injuries resulting from a direct blow to the mouth. This expense must have prior approval from the COEHA Offices. Repairs shall be made within six (6) months of the injury unless special extension is requested by the attending physician.

Emergency services involving acute dental problems and requiring the services of a medical doctor rather than a dentist, and which do not involve direct repair to natural teeth, are considered the responsibility of COEHA.

Neither the cost for dentures nor implants is covered under any circumstances.

## **DIABETIC TESTING SUPPLIES**

**For Members covered under Plans One, Two, Three, Five, Five A, Nine, Eleven, Twelve & Thirteen:**

Effective July 1, 2010, we entered into a partnership with Neighborhood Diabetes, a fully accredited organization with more than a decade of success in helping people with diabetes. **If you want COEHA to be responsible for the cost of your diabetic testing supplies, you are required to purchase these supplies through Neighborhood Diabetes. They are no longer covered through Informed RX, which includes the local retail pharmacies.**

When you enroll with Neighborhood Diabetes, you will not be required to get a new prescription from your physician for the diabetic testing supplies. Once you contact Neighborhood Diabetes, they will contact your physician and get all of the necessary information. However, you must initially contact Neighborhood Diabetes to enroll, and you will need to answer a few questions.

Neighborhood Diabetes is a mail order program. They will be providing you with a 90-day supply of the following test items and you will be responsible for a co-payment for each supply. Your co-payment can be paid by credit or debit card at the time of your order with Neighborhood Diabetes.

- Test Strips
- Lancets
- Lancing Device
- Control Solution

**You are also eligible for a free Prodigy Autocode blood glucose meter.** The Prodigy Autocode requires very little blood, is easy to use with no coding required, and will ‘speak’ your results in English or Spanish. If you are comfortable with your existing meter and you prefer not to change, Neighborhood Diabetes will be able to provide supplies for your existing meter.

**You can reach Neighborhood Diabetes at 1-866-784-5647.**

*Diabetic medications, such as insulin and syringes are still covered through our prescription drug plan with Informed RX.*

## **For Members covered under Plan Four:**

You are eligible to order your supplies from Neighborhood Diabetes at a discounted price. **You are not required to change vendors.** You may still get your testing supplies through Informed RX; however, we wanted to let you know that you have another option that may save you money.

*Diabetic medications, such as insulin, and syringes are still covered through our prescription drug plan with Informed RX.*

## **DURABLE MEDICAL EQUIPMENT**

This is equipment needed for medical reasons which is sturdy enough to be used many times without wearing out. COEHA covers certain durable equipment items such as oxygen, oxygen equipment, wheelchairs, hospital beds, etc. **Only one of each article is covered. COEHA does not cover maintenance, repair, or replacement of such items.**

A certificate of medical necessity must accompany the bill for these services or a copy of the physician's orders showing length of time equipment is needed.

For durable medical equipment, purchase vs. rental is based on length of time for which this equipment is prescribed. COEHA will not pay more than the purchase price for rentals.

Not all durable medical equipment is covered. This benefit is administered on a case by case basis.

**For members eligible for Major Medical coverage: (Plans One, Three, Five, Five A, Eleven & Thirteen)**

These items will be covered under your Major Medical level of benefits

**For Plans Two, Nine & Twelve:**

Covered at 80%

**For Plan Four,** coverage for these items is limited to \$2,000 per calendar year, not to exceed a lifetime limitation of \$4,000.

**Plans Six and Eight** are eligible for appliance benefits under the guidelines summarized in the Plans Section for such members.

## **EMERGENCY ROOM BENEFITS**

In case of life-threatening or physically impairing emergencies, members are expected to get care immediately regardless of the provider's network affiliation. Please notify our Offices within 24 hours if these emergency services are obtained from providers not participating in the COEHA network.

Member is responsible for a \$40 co-pay for services rendered in the emergency room. In cases where the member is admitted to the hospital or to observation through the emergency room, the co-pay will be waived.

**Payment for services rendered in hospital emergency rooms is limited to treatment of emergency problems only.** Although a particular hospital may be a COEHA network facility, this does not mean that the members will have access to the emergency room as a responsibility of COEHA for treatment of non-emergency problems that can be handled in the offices of COEHA network providers.

Charges determined to be of a non-emergency nature will be handled at a reduced rate under the Major Medical level of benefits for those eligible for this coverage, and denied for members not eligible for Major Medical benefits.

### **GASTRIC BYPASS SURGERY/STOMACH STAPLING/LAP BELT**

**Prior authorization by COEHA is required.** This surgery is limited to \$25,000 and is defined as all services included during the visit for the actual procedure with exceptions listed below. This surgery will only be covered once.

Exceptions:

- Lap belt adjustments are included in the \$25,000
- Reversal procedures are included in the \$25,000

### **HEARING EXAMINATIONS/HEARING AIDS**

**Coverage for Active Members Only:**

Up to a maximum of \$600 each calendar year for:

- Tests and examinations, including those by an audiologist or a hearing aid dispenser, to diagnose and determine the cause of a hearing loss, and
- Charges for a hearing aid necessary to restore lost or help impaired hearing.

### **HOME HEALTH SERVICES**

Members entitled to Major Medical benefits are eligible for home health services under the Major Medical Benefit. **(Plans One, Three, Five, Five A, Eleven & Thirteen)**

**Plans Two, Nine & Twelve:** Covered at 80%.

**Plans Six and Eight** are also eligible for the home health services as listed below under the guidelines summarized in the COEHA Plans Section for such members.

Part-time nursing care rendered by or supervised by a registered nurse or licensed practical nurse and prescribed by the attending physician.

### **HOSPITALIZATION**

Semi-private room accommodations and ancillary charges (e.g., supplies) provided in COEHA network facilities are covered.

Private rooms are covered when it has been determined by the attending physician that it is medically necessary.

COEHA will provide private duty nursing care only to the extent such services are certified as **medically necessary** and **prescribed** by the attending physician. Services beyond such certified period will not be covered. Private duty nursing is limited to fifteen (15) shifts during any one spell of illness. A spell of illness is defined as successive periods of hospital confinement separated by less than sixty (60) days and due to the same or related causes. Special duty nursing is also limited to services provided by a **registered nurse** or **licensed practical nurse**.

## **INPATIENT REHABILITATION IN A HOSPITAL OR REHABILITATION CENTER**

Inpatient rehabilitation in a hospital or rehabilitation center is limited to 30 days per spell of illness or injury.

## **JAW JOINT DISORDERS**

Payment for treatment in connection with the temporomandibular joint (jaw joint) and the complex of muscles, nerves and other tissues related to this joint.

## **KIDNEY DIALYSIS**

This benefit is limited to thirty (30) months during which time it will be the member's responsibility to enroll in Medicare (both Parts A & B) benefits for end-stage renal disease (ESRD). COEHA will be the primary insurer during this 30-month period. Medicare will be the primary insurer once this 30 month period has been exhausted.

## **MATERNITY**

Effective January 1, 2006, COEHA is the primary insurer for any pregnancy related claims for active female members for both inpatient and outpatient services.

Members in a furlough, leave of absence, disabled, suspended, or separated status will be provided obstetrical benefits (both inpatient and outpatient services) for as long as their coverage in applicable category is defined. **(See appropriate category under the Section entitled "COEHA MEMBERS".)**

For those eligible members, COEHA shall provide benefits for a hospital stay in connection with childbirth for the mother and newborn child for (i) 48 hours following a vaginal delivery and (ii) 96 hours following a cesarean section, except to the extent the attending provider, in consultation with the mother, discharged the mother or newborn child prior to the expiration of the applicable minimum length of stay.

## **MENTAL HEALTH**

Effective January 1, 2010, coverage for mental health will be identical to the benefits provided under medical and surgical. Please refer to Benefits Section entitled: *Outpatient Office Visits, Consultations & Diagnostic Testing and Hospitalization* for coverage guidelines.

## **OPHTHALMOLOGY**

Routine eye examinations are covered through the National Vision Plan for active employees of CSXT. Ophthalmological services which are other than routine are covered through COEHA. **Please keep in mind that although your routine eye care may be covered by a National Vision Plan provider, this provider may not be in the COEHA network. If you utilize the services of a National Vision Plan provider for a routine eye exam, and during the examination, other medical services are indicated to be necessary, please keep in mind that you should seek those services from a COEHA network provider in order for your expense to be handled at your highest level of benefits.**

For other non-active members, coverage for ophthalmological services is provided by COEHA.

## **ORGAN TRANSPLANTS**

**For Plans, One, Nine, Eleven and Twelve,** COEHA covers human kidney, cornea, bone marrow, liver and heart transplants. **Transplant services must be preauthorized by COEHA.** COEHA does not cover transplant cases which are considered experimental.

**For Plans, Two, Three, Four, Five, Five A and Thirteen,** there is a one-time limit of \$100,000 for each organ per lifetime for human kidney, cornea, bone marrow, liver and heart transplants. **Transplant services must be preauthorized by COEHA.** COEHA does not cover transplant cases which are considered experimental. The \$100,000 limit includes the actual hospital stay for the organ transplant and all services incident to the hospital stay, including charge for procurement of the organ from a living donor. Bone marrow harvesting which may be done as an outpatient prior to the hospital stay for the actual transplant of the marrow, will also count towards the \$100,000 limit.

**Plans Six and Eight** are eligible for organ transplant coverage under the guidelines summarized in the COEHA Plans Section for such members up to \$100,000 for each organ per lifetime for human kidney, cornea, bone marrow, liver and heart transplants. COEHA does not cover transplant cases which are considered experimental. The \$100,000 limit includes the actual hospital stay for the organ transplant and all services incident to the hospital stay, including charge for procurement of the organ from a living donor. Bone marrow harvesting which may be done as an outpatient prior to the hospital stay for the actual transplant of the marrow, will also count towards the \$100,000 limit. **Transplant services must be preauthorized by COEHA.**

## **ORTHOTICS**

These are items serving to protect, restore or improve function. COEHA covers certain orthotic devices such as braces and supports when these items are prescribed by a COEHA network provider. **Only one of each article is covered. Repair, replacement or maintenance of such item is not covered.**

**Foot Orthotics—Please refer to Benefits Section entitled: *Podiatry*.**

Not all orthotic devices are covered. This benefit is administered on a case by case basis.

## **OUTPATIENT OFFICE VISITS, CONSULTATIONS & DIAGNOSTIC TESTING**

Member is responsible for a \$20 co-pay per office visit or office consultation. COEHA covers the remaining charge when services are provided by COEHA network physicians. (The \$20 co-pay is not due for an office visit or office consultation when only laboratory and/or radiology procedures are performed and there is no charge by the physician for the office visit.)

COEHA covers the charge for medically necessary diagnostic testing such as laboratory and x-rays when such services are provided by COEHA network providers.

## **OUTPATIENT PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY**

**For Plans One, Nine, Eleven and Twelve,** outpatient therapy is paid at 80% of our fee schedule to the extent such therapy is certified as necessary and prescribed by an authorized physician.

**Non-prescribed treatments will be the responsibility of the member.**

**For Plans Two, Three, Four, Five, Five A and Thirteen**, outpatient therapy is limited to \$5,000 per calendar year and is paid at 80% of our fee schedule to the extent such therapy is certified as necessary and prescribed by an authorized physician.

**Non-prescribed treatments will be the responsibility of the member.**

**Plans Six & Eight** are eligible for therapy benefits under the guidelines summarized in the COEHA Plans Section for such members.

**Non-prescribed treatments will be the responsibility of the member.**

### **PODIATRY**

The services of a Podiatrist are covered only when such services are not provided by a COEHA network orthopedist.

General foot care is not covered.

Foot orthotics, such as inserts, are covered for those members eligible for Major Medical coverage under the Major Medical Benefit. (**Plans One, Three, Five, Five A, Eleven & Thirteen**). **For Plans Two & Nine**, they are covered at 80%. Arch supports are not covered for any plan of membership.

### **PRESCRIPTION DRUGS**

**For Members covered under Plans One, Two, Three, Five, Five A, Nine, Eleven, Twelve & Thirteen:**

Prescription drug coverage is provided through our prescription drug program. Under this program you have a prescription drug card for use in local participating pharmacies (retail) for up to a thirty (30) day supply of generic and brand name medications. For a ninety (90) day supply of generic and brand name medications, you may use the mail order program. Generally, it takes 14 days to process your order and ship it to you.

You are not required to use the mail order program to get a 90 day supply of medication. You can also get a 90 day supply through some retail network pharmacies. Some retail pharmacies may agree to accept the mail order co-pay for a 90 day supply of medication. (**All Walmart and Kroger Pharmacies will handle 90 day fills for mail order co-pays.**)

You are responsible for co-payments on both the retail pharmacy and the mail order pharmacy medications. **These co-pays are not refundable.** Effective October 1, 2010, we moved to a 3-tier plan as listed below:

- Tier 1 – Generics
- Tier 2 – Brand Name
- Tier 3 – Non-Preferred

Medications that have a less expensive generic (or bio equivalent) will become Tier 3 medications. Tier 3 medications are considered non-preferred.

*For example, if your doctor writes you a prescription for a medication that has a generic available for it, but you chose the brand name medication, it will be considered Tier 3, non-preferred. You may choose to continue to receive Tier 3 medications; however, Tier 1 or Tier 2 medications will cost you less in co-payments.*

**Utilization Management:** For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our members. The following are management tools for the utilization management:

- **Prior Authorization:** This means that you have to get approval in advance from us before your drug can be filled.
- **Quantity Limitations:** This means that there is a limit on the amount of the drug that we cover per prescription or a limit on the period of time we cover the drug for quality, safety or utilization reasons.

#### **For Members covered under Plan Four:**

You are eligible for a consumer drug card through our prescription drug program which entitles you to group discounts when purchasing drugs through this drug program.

#### **Noncovered Drugs and Medications for All Plans:**

- Drugs used for non-FDA approved indications
- Prescriptions used for cosmetic purposes
- Drugs used for experimental or investigational use
- Fertility drugs
- Replacement for drugs lost, stolen or destroyed
- Any drug item or medication obtainable without a prescription (except Prilosec OTC, Claritin OTC and Zyrtec OTC—for which you must have a written prescription from your physician and purchase through the prescription drug program)
- Retin-A
- Smoking deterrents (except as defined for Active employees)
- Injectables other than Insulin and Imitrex
- Drugs used for the treatment of Opioid dependence nor the office visit to obtain a prescription for this drug
- Nutrients and supplements

#### **PREVENTATIVE SERVICES**

##### **Covered for Plans One, Nine, Eleven and Twelve:**

Preventative services as outlined in the guidance provided by the U.S. Services Task Force relevant to the Affordable Care Act.

#### **PROSTHETIC DEVICES**

This includes artificial substitutes that replace missing body parts. COEHA covers certain prosthetic devices such as artificial limbs, eyes, etc. A copy of the physician's orders must accompany the bill for these services. **Only one of each article is covered. COEHA does not cover maintenance, repair, or replacement of such items.**

Prosthetic devices also include items used to replace an internal body part or function.

Not all prosthetic devices are covered. This benefit is administered on a case by case basis.

For coverage of breast prosthetics, see Section on Reconstructive Surgery following Mastectomy.

**For members eligible for Major Medical coverage: (Plans One, Three, Five, Five A, Eleven & Thirteen)**

These items will be covered under your Major Medical level of benefits.

**For Plans Two, Nine & Twelve:**

Covered at 80%.

**For Plan Four,** coverage for these items is limited to \$2,000 per calendar year, not to exceed a lifetime limitation of \$4,000.

**Plans Six and Eight** are eligible for appliance benefits under the guidelines summarized in the Plan Section for such members.

**RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY**

COEHA provides coverage, in the case of a Member who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, (i) all stages of reconstruction of the breast on which the mastectomy has been performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and physical complications of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient. Such coverage is subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the Plan.

**REMOVAL OF EXCESS SKIN AFTER GASTRIC BYPASS OR EXTREME WEIGHT LOSS/TUMMY TUCK**

**Prior authorization by COEHA is required.** This surgery is paid at 80% and is limited to \$7,500 and is defined as all services included during the visit for the actual procedure. The surgery will only be covered once.

**SKILLED NURSING FACILITY CARE**

Skilled Nursing Facility (SNF) care is health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. These skilled care services are needed daily on a short-term basis.

Our benefits for SNF care are similar to what the Medicare Plan covers for a Medicare member. COEHA will cover the first 20 days in a SNF—**preauthorization by COEHA is required.** If SNF care is required beyond the first 20 days, COEHA will pay the equivalent to what Medicare would pay up to 100 days. The percentage that Medicare does not cover from the 21<sup>st</sup> to the 100<sup>th</sup> day changes each calendar year. That percentage would be due by the patient. COEHA will not cover SNF care beyond 100 days for the same spell of illness or injury.

**COEHA does not cover custodial care. Custodial care is care that helps you with usual daily activities like walking, eating, or bathing.**

**COEHA does not cover long-term care facility charges. Long-term care is a variety of services that help people with health or personal needs and activities of daily living over a period of time. Most long-term care is custodial care.**

Effective January 1, 2008, COEHA will cover certain medical services provided a member while a resident in a long-term care facility, such as physician visits and physical therapy.

## **SMOKING DETERRENTS**

### **Coverage for Active Members Only:**

Active members must enroll and participate in the CSX Nicotine Cessation Program to be eligible for COEHA coverage. For more information call (904) 359-7500 or email at: Smoking\_Cessation@CSX.com.

The following will be covered:

- Initial and follow-up physician cessation visits less \$20 co-pay
- Prescription therapy less drug co-pay

**Plans One, Nine, Eleven and Twelve** are entitled to Tobacco Use Counseling as outlined in the guidance provided by the U.S. Services Task Force relevant to the Affordable Care Act.

## **SUBSTANCE ABUSE**

Effective January 1, 2010, coverage for substance abuse will be identical to the benefits provided under medical and surgical. Please refer to Benefits Section entitled: *Outpatient Office Visits, Consultations & Diagnostic Testing and Hospitalization* for coverage guidelines.

## **VASECTOMY AND TUBAL LIGATION PROCEDURES**

These procedures are covered when performed solely for the purpose of voluntary sterilization and **only** when performed by COEHA network physicians. COEHA will only cover this type of surgery once.

Costs associated with subsequent surgery for the purpose of restoring virility or fertility after previous elective sterilization has been carried out are not covered.

**Sterilization procedures are not covered outside of the COEHA network under any circumstances.**

## **EXCEPTIONAL CASES**

Cases may arise involving medical care that is not specified in these Rules and Regulations. In these cases, contact COEHA for instructions.

## **EXCLUSIONS**

- A dependent child's pregnancy or the resulting childbirth, abortion or miscarriage
- Acupuncture
- Arch supports
- Charge for completion of insurance papers, reports, etc.
- Cochlear implants
- Cosmetic/Reconstructive surgery, except for repair or alleviation of damage to the member caused solely by bodily injury while the member is covered and except for breast reconstruction following a mastectomy covered by the Plan
- Custodial or long-term care (except as defined in the Skilled Nursing Facility Care Section)
- Evaluation and studies performed in connection with litigation
- Experimental procedures
- Fertility drugs
- Fertility procedures
- Food supplements
- General foot care
- Glasses or other visual aids
- Half-way house
- Hearing aids, batteries (except as defined for active members)
- Hospital admissions for diagnostic testing only
- In vitro fertilization, embryo transfer procedures, artificial insemination, immunotherapy for treatment of infertility or any other infertility procedures
- Instructional booklets or videos
- Marriage counseling
- Massage therapy
- Medical services or testing provided a member incident to treatment of a spouse and/or dependent
- Membership to YMCA or other fitness organization
- On-duty injuries that occur while working and receiving compensation from a person, firm, company, or organization other than the CSXT and/or subsidiaries and affiliated companies
- Personal convenience items (television, radios, telephone calls, guest trays, private room differential, etc.)
- Pharmacy consultations
- Physician visits in the home, domiciliary, assisted-living home or rest home
- Prescribed drugs or items which can be purchased over-the-counter (with the exception of Prilosec OTC, Claritin OTC and Zyrtec OTC—for which you must have a written prescription from your physician and purchase through the prescription drug program)
- Radial Keratotomy; Lasik Surgery, etc.
- Retin-A
- Reversal of sterilization
- Sales tax, shipping and handling for medical supplies
- Sex change surgery
- Special lift chairs, or separate chair lift for patient owned furniture, geriatric chairs
- Special shoes, unless they are attached to braces
- Supplemental feeding
- Treatment for Gambling Addiction
- Treatment for Sexual Addiction

- Treatment outside the United States (You may want to check into purchasing trip/travel medical insurance through your travel agent, airline, cruise line, etc.)
- Treatment rendered by a family member (spouse, mother, father, children, sister, brother, in-laws, grandparents, grandchildren, etc.)
- **Vaccines for Plans Two, Three, Four, Five, Five A & Thirteen:** (except for a yearly flu vaccine and a tetanus vaccine when it is incident to an injury and is medically necessary)
- **Vaccines for Plans One, Nine, Eleven & Twelve:** all vaccines except those specified in the preventative service guidelines provided by the U.S. Services Task Force relevant to the Affordable Care Act
- Water beds
- Work hardening

## **SUBROGATION AND REIMBURSEMENT**

### **Benefits Subject to this Provision**

This provision shall apply to all benefits provided under any section of the C and O Employees' Hospital Association Plan.

### **Statement of Purpose**

*Subrogation* and *reimbursement* represent significant C and O Employees' Hospital Association Plan assets and are vital to the financial stability of the Plan. *Subrogation* and *reimbursement* recoveries are used to pay future claims for other C and O Employees' Hospital Association members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of C and O Employees' Hospital Association. The Plan Administrator has a fiduciary obligation under ERISA to pursue and recover these Plan assets to the fullest extent possible.

### **Definitions**

#### **“Another Party”**

“*Another party*” shall mean any individual or entity, other than C and O Employees' Hospital Association, who is liable or legally responsible to pay expenses, compensation or damages in connection with a *covered member's* injuries or illness.

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

#### **“Covered Member”**

A “*Covered Member*” shall mean any person, dependents or representatives, other than C and O Employees' Hospital Association, who is bound by the terms of the Subrogation and Reimbursement Provision herein.

A “*Covered Member*” shall include but is not limited to any beneficiary, dependent, spouse or person who has or will receive benefits under the C and O Employees' Hospital Association Plan, and any legal or personal representatives of that person, including parents, guardians, attorneys, trustees, administrators or executors of an estate of a covered member, and heirs of the estate.

#### **“Recovery”**

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

#### **“Subrogation”**

“*Subrogation*” shall mean C and O Employees' Hospital Association's right to pursue the *covered member's* claims for medical or other charges paid by the Plan against *another party*.

## **“Reimbursement”**

“*Reimbursement*” shall mean repayment to C and O Employees’ Hospital Association of recovered medical or other benefits that it has paid toward care and treatment of the injury or illness for which there has been a *recovery*.

### **Plan Administrator Discretion**

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

### **When this Provision Applies**

A *covered member* may incur medical or other charges related to injuries or illness caused in part or in whole by the act or omission of the *covered member* or another person; or *another party* may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the *covered member* may have a claim against that other person or *another party* for payment of the medical or other charges. In that event, the C and O Employees’ Hospital Association Plan will be secondary, not primary. The *covered member* agrees, if charges are paid by C and O Employees’ Hospital Association, to transfer all rights to recover damages in full to C and O Employees’ Hospital Association.

### **Duties of the Covered Member**

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

The *covered member* must:

- Execute and deliver a subrogation and reimbursement agreement, if requested by the Plan Administrator;
- Authorize C and O Employees’ Hospital Association to sue, compromise and settle in the *covered member’s* name to the extent of the amount of medical or other benefits paid for the injuries or illness under the C and O Employees’ Hospital Association Plan and the expenses incurred by C and O Employees’ Hospital Association in collecting this amount, and assign to C and O Employees’ Hospital Association the *covered member’s* rights to *recovery* when this provision applies;

- Include the benefits paid by C and O Employees' Hospital Association as a part of the damages sought against another party. Immediately reimburse C and O Employees' Hospital Association, out of any *recovery* made from *another party*, the amount of medical or other benefits paid for the injuries or illness by C and O Employees' Hospital Association up to the amount of the *recovery* and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;
- Notify C and O Employees' Hospital Association in writing of any proposed settlement and obtain C and O Employees' Hospital Association's written consent before signing any release or agreeing to any settlement; and
- Cooperate fully with C and O Employees' Hospital Association in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by C and O Employees' Hospital Association.

**First Priority Right of Subrogation and/or Reimbursement**

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

**When a Covered Member Retains an Attorney**

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

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

for C and O Employees' Hospital Association, because neither the *covered member* nor his attorney is the rightful owner of the portion of the *recovery* subject to C and O Employees' Hospital Association's lien.

#### **When the Covered Member is a Minor or is Deceased or Incapacitated**

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

#### **When a Covered Member Does Not Comply**

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

#### **Recovery of Future Benefits**

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

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

## **CLAIMS AND APPEALS PROCEDURE**

The claims procedures described below are effective January 1, 2003 and supercede any conflicting language in these Rules and Regulations.

If a member's claim under the Plan is wholly or partially denied, he or she will be notified of the decision, after the Plan's receipt of the claim, within:

- (i) 72 hours for an urgent care claim,
- (ii) 15 days for a pre-service claim,
- (iii) 30 days for a post-service claim, or
- (iv) 45 days for a disability claim, as applicable.

A determination regarding a request for the Plan to approve an on-going course of treatment will be made in sufficient advance of the proposed reduction or termination of treatment to allow the member to appeal before the benefit is reduced or terminated.

Under special circumstances, the notice period may be extended for an additional:

- (i) 48 hours for urgent care claims,
- (ii) 24 hours for concurrent care decisions,
- (iii) 15 days for pre-service claims,
- (iv) 15 days for post-service claims, or
- (v) 30 days for disability claims.

If an extension is required, the member will be notified of the special circumstances involved and the date by which the Plan Administrator expects to render a final decision.

If the member's claim is denied, the Plan Administrator will provide the member with a written or electronic notification of an adverse benefit determination. The notice will:

- (i) provide the specific reason(s) for the denial,
- (ii) refer the member to the pertinent Rules and Regulations provisions on which the denial is based,
- (iii) describe any additional information necessary for the member to perfect his or her claim and explain why such information is necessary,
- (iv) describe the Plan's review procedure and time limits applicable to the member's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review,
- (v) (A) in the case of an adverse benefit determination, refer the member to the criteria that was relied upon in making the adverse determination, or a statement that certain criteria was relied upon and that a copy of such rule(s) will be provided to the member free of charge upon request, or (B) if the adverse determination is based on a medical necessity, experimental treatment or similar exclusion or limit, provide either an explanation of the clinical judgment for the determination or a statement that such an explanation will be provided free of charge, upon request, and
- (vi) in the case of an adverse determination for urgent care, describe the expedited review process applicable to such claims.

In the case of an adverse benefit determination involving a claim for urgent care, the information described above may be provided to the member orally within the permitted time frame provided that written or electronic notification is furnished to the member no later than three days after such oral notification.

**Appeal of Denied Claims.** If the member's claim is denied, the member will be provided:

- (i) a full and fair review with at least 180 days to appeal an adverse benefit determination,
- (ii) a review that does not defer to the initial adverse benefit determination, and is conducted by an appropriate named fiduciary who is not involved with the adverse appeal,
- (iii) a determination which is based on a medical judgment and for which the named fiduciary has consulted with a health care professional with suitable expertise related to the area of medicine required, and
- (iv) the identity of the experts whose advice was solicited on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination.

Further, the review must provide that neither the consulted health care provider nor his or her subordinate were consulted for the adverse determination which is subject to the appeal. In the case of an urgent care claim, the member is provided an expedited review process, to which their request may be submitted orally or in writing. All necessary information may be transmitted between the Plan and the member by telephone, facsimile, or other available method.

The Plan Administrator will notify the member of the Plan's benefit determination upon review of a denied claim within:

- (i) for an urgent care claim, within 72 hours;
- (ii) for pre-service claims, within a reasonable period of time appropriate to the medical circumstances. The notification shall be provided no later than 30 days after the Plan's receipt of the member's request of a review of an adverse benefit determination;
- (iii) for post-service claims, within a reasonable period of time. The notification shall be provided no later than 60 days after the Plan's receipt of the member's request of a review of an adverse benefit determination.

The Plan's decision on review may be either a written or electronic notification. The notification will set forth for the member:

- (i) the specific reason for the adverse determination,
- (ii) reference the specific Plan provisions on which the benefit determination is based,
- (iii) a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the claim for benefits,
- (iv) a statement describing any voluntary appeal procedures offered by the Plan and the member's right to obtain the information about such procedures, and a statement regarding the member's right to bring an action under ERISA section 502(a); and
- (v) if an internal rule or protocol was relied upon in making the adverse determination, a copy of such rule or protocol shall be provided free of charge to the member upon request,
- (vi) if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and the following statement: "You and your plan may have other voluntary alternative dispute resolution options,

such as mediation. One way to find out what may be available is to contact your local U.S. Dept. of Labor Office and your State insurance regulatory agency.”

## **EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) RIGHTS**

As a COEHA member, 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:

### **Receive Information About Your Plan and Benefits**

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

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

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

### **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan on the rules regulating your COBRA continuation coverage rights.

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

### **Prudent Actions by Plan Fiduciaries**

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

## **Enforce Your Rights**

If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## **Assistance with Your Questions**

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