Amtrak Agreement-Covered Employee Benefits Handbook

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SECTION 1:
Introduction

KEEPING ON TRACK WITH YOUR BENEFITS

As you travel through life, you can be sure of one thing – your life will change. The things you need today may be very different from your needs of tomorrow. Sometimes you can see what's coming in your life, sometimes you can't.

To help you keep your life on track, you receive a comprehensive package of benefits from Amtrak. Benefits play a role in some of the most important times of our lives: when we get married, have a child, experience a serious illness or injury, etc. But, as important as our benefits are, we don't usually think about them until we need them. And, when we need them, we have to get up to speed pretty quickly.

ABOUT THIS HANDBOOK

Your employee benefits handbook is made up of a series of different chapters or sections.

The following provides a summary of each section.

Section 2: Life Events That Affect Your Benefits gives you a quick picture of how your benefits may be affected at different times of your life. For example, you'll find guidelines on what to do if you get married, have a baby, get divorced, or get hurt on the job.

Section 3: Eligibility & Participation provides information about who is eligible for benefits and when coverage begins and ends.

Sections 4 through 11 explain your benefits in detail, including what expenses are covered, how to file a claim, and overall information about how to use your benefits. The benefits covered in each section are as follows:

- Section 4: Medical Benefits (including prescription drugs, mental health, and substance abuse benefits);
- Section 5: Dental Benefits;
- Section 6: Vision Benefits;
- Section 7: Spending Accounts;
- Section 8: Commuter Reimbursement Accounts;
- Section 9: Survivor Benefits;
- Section 10: On-Duty Injury Coverage; and
- Section 11: Retirement 401(k) Savings Plan.

Section 12: Administrative Information provides information required by the federal government that will help protect your rights as an employee.

Section 13: Who To Call contains a list of numbers to call if you have questions about your benefits that are not answered in this handbook. Of course, you can always call the Amtrak Benefits Service Center at 1-800-481-4887. This toll-free number is available from 8:00 am to 8:00 pm, Eastern Time, Monday through Friday (except holidays).

SPECIAL ICONS

Throughout the sections, you will see boxes with icons inside them. These boxes point out special hints, notes, or reminders that may be helpful to you.

These icons are as follows:

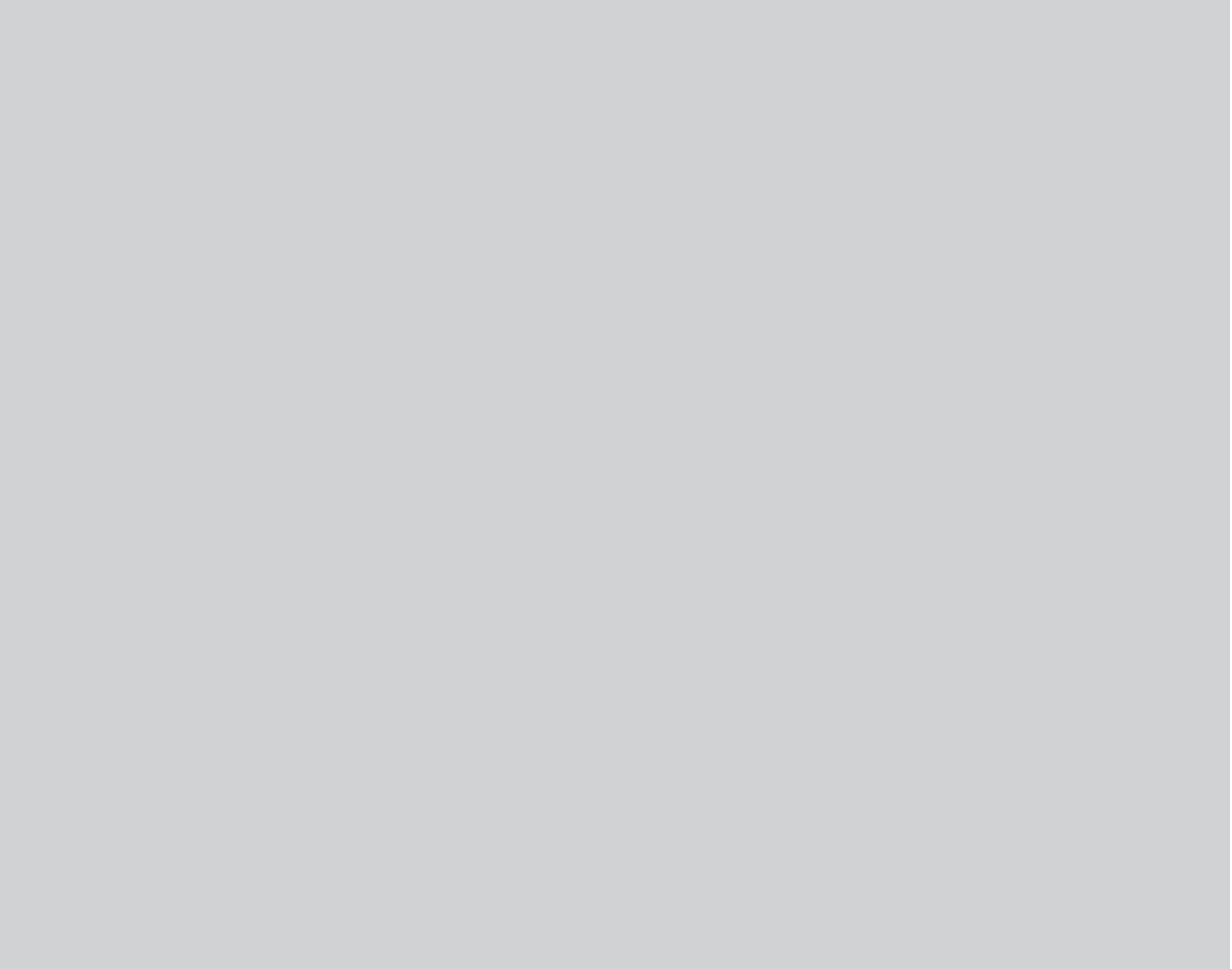
ICON	WHAT IT MEANS
✎	Important Note
✓	Life Event Reminder
?	Definition
!	Helpful Hint
P	Pre-Approval Is Required

OFFICIAL PLAN DOCUMENTS

We have made every effort to make the information in this handbook as accurate and as easy for you to understand as possible. However, this handbook and any oral statements are not a substitute for the official plan documents and insurance policies. If there is a difference between what is in this handbook, told to you orally, and the official plan documents and insurance policies, the official plan documents and insurance policies will govern.

Nothing in this handbook is a guarantee or contract of employment. In addition, this handbook supersedes all prior handbooks and summary plan descriptions.

Helpful Hint: Your Amtrak benefits also include Supplemental Sickness benefits, vacation pay, educational assistance, and rail travel privileges. These benefits are not described in this handbook. Please contact your local Human Resources representative for information about these benefits.



SECTION 2:

Life Events That Affect Your Benefits

WHEN LIFE REQUIRES YOU TO CHANGE TRACKS

Just when you think things are going smoothly and you know the direction your life will take, something happens that causes you to switch tracks. Sometimes we see the track change and can plan for it. Other times, we're in the middle of a change before we even know it.

Amtrak realizes that changes are a big part of your life and can help you prepare for them. When you experience a life event, you probably don't think of your employee benefits right away. But, soon after, you may begin to wonder how the change in your life affects your benefits.

ABOUT THIS SECTION

This handbook section is designed to help you consider your benefits when your life changes. It will help you see what actions you may want to take and when. So, whenever your life takes a turn, use this section to help you stay on track.

This section contains a series of checklists for the following life events:

- If you become eligible for benefits;
- If you move to a new address;
- If you get married;
- If you have a baby or adopt a child;
- If your dependent is no longer eligible for coverage;
- If you get divorced;
- If you change from an agreement-covered employee to a management employee;
- If you change from a management employee to an agreement-covered employee;
- If you become disabled and the disability is **not** job-related;
- If you become disabled and the disability is job-related;
- If you take an unpaid leave of absence;
- If you become furloughed or suspended from service;
- If you retire;
- If you end your employment with Amtrak;
- If you die while an Amtrak employee; and
- If your spouse or dependent child dies.

In addition, throughout this handbook, you may see an icon that looks like this: ✓

The information with this icon will remind you to consider your benefits when a life event occurs.

IF YOU BECOME ELIGIBLE FOR BENEFITS

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Medical, Dental, Vision, Spending Accounts, Commuter Reimbursement Accounts	An enrollment package will automatically be mailed to your home. Benefits become effective on the first of the month on or following one month of Amtrak service. However, you may participate in dental and vision coverage after completing one year of Amtrak service. To enroll in Amtrak benefits, call the automated enrollment system at 1-800-481-4887 or log onto the benefits website: www.amtrakbenefits.com.	Within 31 days of becoming eligible for benefits	See Section 3 for enrollment information See Section 4 for information about medical benefits See Section 5 for information about dental benefits See Section 6 for information about vision benefits See Section 7 for information about spending accounts See Section 8 for information about commuter reimbursement accounts
Life Insurance and AD&D	You will automatically be enrolled for Life Insurance and AD&D; however, you will need to designate a beneficiary. A *Beneficiary Designation* Form will be included in your enrollment package, or you may print a copy from the benefits website:www.amtrakbenefits.com. Return this completed form to the Amtrak Benefits Service Center.	As soon as possible	See Section 9 for information about survivor benefits
Retirement 401(k) Savings Plan	Enroll in the 401(k) Plan – an enrollment package from Vanguard will automatically be mailed to your home.	As soon as possible	See Section 11 for information about Retirement 401(k) Savings Plan benefits

IF YOU MOVE TO A NEW ADDRESS

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Medical, Dental, Vision, Health Care Spending Account, Dependent Day Care Spending Account	You must complete an *Employee Information* form (NRPC Form 2001) as soon as possible and return it to your local Human Resources representative. If your are in the Network Plan and you move in or out of a network service area, you will automatically receive an enrollment package. To enroll, log onto www.amtrakbenefits.com or call the Amtrak Benefits Service Center at 1-800-481-4887. You may change Spending Account contributions if the move causes a change in health care or dependent care expenses. All changes must be consistent with the family status change.	As soon as possible, but no later than 31 days after event	See Section 3 for enrollment information See Section 4 for information about medical benefits See Section 5 for information about dental benefits See Section 7 for information about spending accounts
Commuter Reimbursement Accounts	Log onto www.amtrakbenefits.com or call the Amtrak Benefits Service Center at 1-800-481-4887 to change contributions to a Commuter Reimbursement Account if your new address means your commute to work involves a change in mass transit, car pooling, or paying parking expenses at work.	As soon as possible	See Section 8 for information about commuter reimbursement benefits

IF YOU GET MARRIED

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Medical, Dental, Vision, Health Care Spending Accounts	Add your new spouse to your medical, dental, and/or vision coverage by calling the Amtrak Benefits Service Center (1-800-481-4887) or logging onto the benefits website: www.amtrakbenefits.com. If your marriage means that stepchildren meet the definition of eligible dependents, you may add them to your coverage, as well. You will need to send proof of your marriage (such as a copy of the marriage certificate) to the Amtrak Benefits Service Center. As a result of your marriage, you may also: ■ Enroll in a Spending Account; ■ End your participation in a Spending Account; or ■ Change your Spending Account contributions if you already participate in one or both of these accounts. All changes must be consistent with the family status change. You may be asked to provide proof of the marriage.	No later than 31 days after your marriage	See Section 3 for information about eligible dependents and enrolling in benefits See Section 4 for information about medical benefits See Section 5 for information about dental benefits See Section 6 for information about vision benefits See Section 7 for information about spending accounts
Life Insurance and AD&D	You may also want to review your beneficiary designation and consider naming your new spouse and/or dependents as a beneficiary for your Life Insurance and AD&D benefits. To change your beneficiary, please complete a *Change of Beneficiary Designation* form (NRPC Form 3202). You may request a copy of this form by calling the Amtrak Benefits Service Center at 1-800-481-4887, or you may print one from the benefits website: www.amtrakbenefits.com. Return this completed form to the Amtrak Benefits Service Center at the address on the form.	No later than 31 days after your marriage – a beneficiary change will not be effective until the Amtrak Benefits Service Center receives an original written notice of the change	See Section 9 for information about survivor benefits
Retirement 401(k) Plan	You may want to review your contributions and investment strategy, especially if your spouse contributes to a similar plan. You may want to review your beneficiary designation for your 401(k) benefits – according to federal law, your spouse is your beneficiary for your 401(k) benefits unless he/she provides written, notarized consent for you to name someone else. Call Vanguard at 1-800-523-1188 or download a form from www.amtrakbenefits.com to change your beneficiary for your 401(k) benefits. Return this completed form to Vanguard.	As soon as possible – a beneficiary change will not be effective until the Vanguard receives an original written notice of the change	See Section 11 for information about Retirement 401(k) Savings Plan benefits

Special Note: *If your name changes as a result of your marriage, you should also update your records with your union, the Railroad Retirement Board, and the Social Security Administration. Your local Human Resources representative can help you do this.*

IF YOU ADD A DEPENDENT THROUGH BIRTH, ADOPTION, BECOMING A LEGAL GUARDIAN, ETC.

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Medical, Dental, Vision, Spending Accounts	Add your new dependent to your medical, dental, and/or vision coverage by calling the Amtrak Benefits Service Center (1-800-481-4887) or logging onto the benefits website: www.amtrakbenefits.com. As a result of adding a new dependent, you may also: ■ Enroll in a Spending Account; or ■ Increase your Spending Account contributions if you already participate in one or both of these accounts. All changes must be consistent with the family status change. You will need to send written proof of the birth, adoption, legal guardianship, etc. to the Amtrak Benefits Service Center.	No later than 31 days after the birth or adoption	See Section 3 for information about eligible dependents and enrolling in benefits See Section 4 for information about medical benefits See Section 5 for information about dental benefits See Section 6 for information about vision benefits See Section 7 for information about spending accounts
Life Insurance and AD&D	You may also want to review your beneficiary designation and consider naming your new spouse and/or dependents as a beneficiary for your Life Insurance and AD&D benefits. To change your beneficiary, please complete a *Change of Beneficiary Designation* form (NRPC Form 3202). You may request a copy of this form by calling the Amtrak Benefits Service Center at 1-800-481-4887, or you may print one from the benefits website: www.amtrakbenefits.com. Return this completed form to the Amtrak Benefits Service Center at the address on the form.	No later than 31 days after the birth or adoption – a beneficiary change will not be effective until the Amtrak Benefits Service Center receives an original written notice of the change	See Section 9 for information about survivor benefits
Retirement 401(k) Plan	You may want to review your contributions and investment strategy to help plan for your child's education, etc. You may want to review your beneficiary designation for your 401(k) benefits and consider naming your new dependent as a beneficiary. However, according to federal law, your spouse is your beneficiary for your 401(k) benefits unless he/she provides written, notarized consent for you to name someone else. Call Vanguard at 1-800-523-1188 or download a form from www.amtrakbenefits.com to change your beneficiary for your 401(k) benefits. Return this completed form to Vanguard.	As soon as possible – a beneficiary change will not be effective until Vanguard receives an original written notice of the change	See Section 11 for information about Retirement 401(k) Savings Plan benefits

IF YOUR DEPENDENT CHILD IS NO LONGER ELIGIBLE FOR COVERAGE

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Medical, Dental, Vision, Spending Accounts	When your dependent child reaches the maximum age for coverage (19th birthday unless full-time student, then 25th birthday), medical and dental coverage for that dependent will automatically end. Call the Amtrak Benefits Service Center at 1-800-481-4887 or log onto the benefits website: www.amtrakbenefits.com to remove your dependent from your coverage. Your dependent will automatically receive a notice to continue medical and/or dental coverage through COBRA. To enroll your dependent in medical COBRA coverage, call the Amtrak COBRA Service Center at 1-866-381-2859. To enroll your dependent in COBRA dental coverage, call UnitedHealthcare at 1-800-842-4252. If your dependent child is between the ages of 19 and 25 and is a full-time student, you will need to provide proof of student status to the insurance carrier each semester to continue coverage for that dependent child. You may make a corresponding change to your Spending Account contributions.	No later than 31 days after your dependent loses eligibility	See Section 3 for information about when a dependent is no longer eligible for coverage See Section 12 for information about COBRA coverage
Life Insurance and AD&D	You may want to review your beneficiary designation for Life Insurance and AD&D benefits, especially if your dependent is now self-supporting. To change your beneficiary, please complete a *Change of Beneficiary Designation* form (NRPC Form 3202). You may request a copy of this form by calling the Amtrak Benefits Service Center at 1-800-481-4887, or you may print one from the benefits website: www.amtrakbenefits.com. Return this completed form to the Amtrak Benefits Service Center at the address on the form.	As soon as possible – a beneficiary change will not be effective until the Amtrak Benefits Service Center receives an original written notice of the change	See Section 9 for information about survivor benefits
Retirement 401(k) Plan	You may want to review your contributions and investment strategy for the future. You may want to review your beneficiary designation for your Retirement 401(k) Savings Plan benefits, especially if your dependent is now self-supporting. Call Vanguard at 1-800-523-1188 or download a form from www.amtrakbenefits.com to change your beneficiary for your 401(k) benefits. Return this completed form to Vanguard.	As soon as possible – a beneficiary change will not be effective until Vanguard receives an original written notice of the change	See Section 11 for information about Retirement 401(k) Savings Plan benefits

IF YOU GET DIVORCED

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
General	You must notify the Amtrak Benefits Service Center of the annulment or final divorce by logging onto www.amtrakbenefits.com or by calling 1-800-481-4887. If your name changes as a result of the divorce or annulment, you must complete an *Employee Information* form (NRPC Form 2001) as soon as possible.	As soon as possible	N/A
Medical, Dental, Vision, Spending Accounts	You must remove your former spouse from your coverage by logging onto www.amtrakbenefits.com or by calling the Amtrak Benefits Service Center at 1-800-481-4887. You will automatically receive a notice to continue coverage for your former spouse through COBRA. For additional information, call the Amtrak COBRA Service Center at 1-866-381-2859. If there is a court order requiring you to maintain coverage for your former spouse, you must do so through COBRA. Your former spouse **cannot** remain covered under an Amtrak medical plan for active employees. Call the Amtrak Benefits Service Center at 1-800-481-4887 if you are required to provide for or drop coverage for your dependent children through a Qualified Medical Child Support Order. If you and/or your dependent were covered under your former spouse's benefits and you wish to enroll yourself and/or your dependents in Amtrak benefits, log onto www.amtrakbenefits.com or call the Amtrak Benefits Service Center at 1-800-481-4887. Call Member Services (on your medical ID card) or access the insurance carrier's website to get a new medical ID card if your name changes as a result of the divorce. As a result of the divorce or annulment, you may: ■ Enroll in a Spending Account if you lose participation in your former spouse's Spending Account; ■ End participation in either Spending Account; or ■ Increase or decrease your contributions if you already participate in one or both of these accounts. All changes must be consistent with the family status change. You will be asked to provide proof of the divorce or annulment to the Amtrak Benefits Service Center.	No later than 31 days after your divorce or annulment	See Section 3 for information about enrolling for benefits See Section 4 for information about Qualified Medical Child Support Orders See Section 12 for information about COBRA coverage

IF YOU GET DIVORCED (CONTINUED)

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Life Insurance and AD&D	You may want to review your beneficiary designation for your Life Insurance and AD&D benefits if your former spouse is a beneficiary. To change your beneficiary, please complete a *Change of Beneficiary Designation* form (NRPC Form 3202). You may request a copy of this form by calling the Amtrak Benefits Service Center at 1-800-481-4887, or you may print one from the benefits website: www.amtrakbenefits.com. Return this completed form to the Amtrak Benefits Service Center at the address on the form.	As soon as possible – a beneficiary change will not be effective until the Amtrak Benefits Service Center receives an original written notice of the change	See Section 9 for information about survivor benefits
Retirement 401(k) Savings Plan	You may want to review your contributions and investment strategy for the future. You may want to review your beneficiary designation for your Retirement 401(k) Savings Plan benefits, if your former spouse is a beneficiary. Call Vanguard at 1-800-523-1188 or download a form from www.amtrakbenefits.com to change your beneficiary for your 401(k) benefits. Return this completed form to Vanguard. Contact the Amtrak Benefits Department if your benefit is subject to a Qualified Domestic Relations Order (QDRO).	As soon as possible – a beneficiary change will not be effective until Vanguard receives an original written notice of the change	See Section 11 for information about Retirement 401(k) Savings Plan benefits

IF YOU TRANSFER FROM AGREEMENT-COVERED TO MANAGEMENT EMPLOYEE STATUS

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Medical, Dental, Vision, Spending Accounts, Commuter Reimbursement Accounts	Your Department Administrator or local Human Resources representative will complete a *Personnel Action Request* form (NRPC Form 2000) on your behalf and send it to the local Human Resources Department. Enroll in Management benefits – an enrollment package will automatically be mailed to your home. You may enroll yourself, spouse, and/or dependents in Management benefits by logging onto www.amtrakbenefits.com or calling the Amtrak Benefits Service Center at 1-800-481-4887. Your Management benefits become effective on your first day as a Management employee. You may enroll in a Management Health Care or Dependent Day Care Spending Account by logging onto www.amtrakbenefits.com or calling the Amtrak Benefits Service Center at 1-800-481-4887. If you are currently enrolled in a Commuter Reimbursement Account, you don't have to do anything. Your participation will continue.	No later than 31 days after becoming eligible for management benefits	See Section 3 for information about enrollment See Section 4 for information about medical benefits See Section 5 for information about dental benefits See Section 6 for information about vision benefits See Section 8 for information about commuter reimbursement accounts
Life Insurance and AD&D	Enroll in Management benefits – an enrollment package will automatically be mailed to your home. You may enroll yourself, spouse, and/or dependents in Management benefits by logging onto www.amtrakbenefits.com or calling the Amtrak Benefits Service Center at 1-800-481-4887. Your Management benefits become effective on your first day as a Management employee.	No later than 31 days after becoming eligible for management benefits	See Section 9 for information about survivor benefits
Retirement 401(k) Savings Plan	Enroll in the Management 401(k) Plan – an enrollment package from Vanguard will automatically be mailed to your home.	No later than 31 days after becoming eligible for management benefits	See Section 11 for information about Retirement 401(k) Savings Plan benefits

IF YOU TRANSFER FROM MANAGEMENT TO AGREEMENT-COVERED EMPLOYEE STATUS

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Medical, Dental, Vision, Spending Accounts, Commuter Reimbursement Accounts	Your Department Administrator or local Human Resources representative will complete a *Personnel Action Request* form (NRPC Form 2000) on your behalf and send it to the local Human Resources Department. Enroll in Union benefits – an enrollment package will automatically be mailed to your home. You may enroll yourself, spouse, and/or dependents in Union benefits by logging onto www.amtrakbenefits.com or calling the Amtrak Benefits Service Center at 1-800-481-4887. Your Union medical benefits become effective on the first of the month on or following your first day as a Union employee. You may participate in dental coverage after completing one year of eligible railroad service. If you have not completed one year of service as of the date of the transfer, contact the Amtrak COBRA Service Center at 1-866-381-2859 for information about COBRA dental coverage. You may enroll in a Union Health Care or Dependent Day Care Spending Account by logging onto www.amtrakbenefits.com or calling the Amtrak Benefits Service Center at 1-800-481-4887. If you are currently enrolled in a Commuter Reimbursement Account, you don't have to do anything. Your participation will continue.	No later than 31 days after your transfer	See Section 3 for enrollment information See Section 4 for information about medical benefits See Section 5 for information about dental benefits See Section 6 for information about vision benefits See Section 7 for information about spending accounts See Section 8 for information about commuter reimbursement accounts
Life Insurance and AD&D	You will automatically be enrolled for Life Insurance and AD&D; however, you will need to designate a beneficiary by completing a *Beneficiary Designation form* (NRPC Form 3202), which will be mailed to your home. Or, you may print a copy from the benefits website: www.amtrakbenefits.com. Your Union benefits become effective on the first of the month on or following your first day as a Union employee.	No later than 31 days after your transfer	See Section 9 for information about survivor benefits
Retirement 401(k) Savings Plan	Enroll in the Union 401(k) Plan – an enrollment package from Vanguard will automatically be mailed to your home.	No later than 31 days after your transfer if you have one year of service	See Section 11 for information about Retirement 401(k) Savings Plan benefits

IF YOU BECOME DISABLED AND YOUR DISABILITY IS NOT JOB-RELATED

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Medical, Dental, Vision, Spending Accounts, Commuter Reimbursement Accounts	Notify your supervisor immediately. Your Department Administrator will complete a *Personnel Action Request* form (NRPC Form 2000) on your behalf and send it to the local Human Resources Department. You will automatically receive a notice about COBRA coverage. However, Amtrak coverage will continue (concurrently with COBRA coverage) as follows: ■ TCU, ASWC, ARASA-OBS employees: Your coverage ends on the earlier of the following: the date you return to work or 24 months from the date the disability leave of absence without pay began. Vacation pay does not extend medical coverage beyond 24 months. ■ All other employees: Your medical coverage continues until the end of the second year following the year in which you last rendered compensated service or received vacation pay. ■ Medical coverage for your dependents continues until the end of the year following the year in which you last rendered compensated service or received vacation pay (vacation pay will not apply to dependents of TCU, ASWC, or ARASA-OBS members). ■ Dental and vision coverage for you and your dependents continues until the end of the year following the year in which you last rendered compensated service or received vacation pay. Participation in Spending Accounts will end. You will automatically be sent a notice about continuing participation in a Health Care Spending Account by electing COBRA coverage (after-tax contributions). Participation in a Commuter Reimbursement Account will end until you return to work and resume making contributions.	As soon as possible after you become disabled	See Section 3 for information about benefits when coverage ends See Section 12 for information about COBRA coverage

IF YOU BECOME DISABLED AND YOUR DISABILITY IS NOT JOB-RELATED (CONTINUED)

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Life Insurance and AD&D	Call the Amtrak Benefits Service Center at 1-800-481-4887 for information about continuing coverage during a disability; however, coverage will continue until the end of the year following the year in which you last rendered compensated service or received vacation pay.	As soon as possible after you become disabled	See Section 9 for information about survivor benefits
Retirement 401(k) Savings Plan	If your disability is permanent, you may want to review your investment strategy for the future. You must continue to repay any outstanding loans. If your employment ends, you will have to repay any outstanding loans within 90 days.	As soon as possible after you become disabled	See Section 11 for information about Retirement 401(k) Savings Plan benefits
Railroad Retirement benefits	Contact the Railroad Retirement Board at 1-800-808-0772 to determine what benefits you may be eligible to receive.	As soon as possible after you become disabled	N/A

Note: *Please contact your union about possible Supplemental Sickness benefits. You should also receive a package of information from Amtrak's Health Services Department. Contact your local Human Resources representative if you do not receive this package.*

IF YOU BECOME DISABLED AND YOUR DISABILITY IS JOB-RELATED

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Medical, Dental, Vision, Spending Accounts, Commuter Reimbursement Accounts	Notify your supervisor of your injury immediately. You and your supervisor must complete a *First Report of Injury* form (NRPC Form 260), including a *Personal Statement* from you. Your supervisor must report your injury by calling the Injury Reporting Hotline at 1-800-505-5549. Your supervisor, in conjunction with your medical provider, will complete an *Amtrak Medical Information* form (NRPC Form 488) on your behalf. You will automatically receive a notice about COBRA coverage. However, Amtrak coverage will continue (concurrently with COBRA coverage) as follows: ■ Medical coverage continues until the end of the second year following the year in which you last rendered compensated service or received vacation pay; coverage for your dependents continues until the end of the year following the year in which you last rendered compensated service or received vacation pay. ■ Dental and vision coverage for you and your dependents continues until the end of the year following the year in which you last rendered compensated service or received vacation pay. Participation in Spending Accounts will end. You will automatically be sent a notice about continuing contributions to a Health Care Spending Account for the rest of the plan year by electing COBRA coverage (contributions will be made on an after-tax basis). Your participation in a Commuter Reimbursement Account will end until you return to work and resume making contributions.	As soon as possible after you become disabled	See Section 10 for information about on-duty injury benefits See Section 3 for information about benefits when coverage ends See Section 12 for information about COBRA coverage
Life Insurance and AD&D	Call the Amtrak Benefits Service Center at 1-800-481-4887 for information about continuing coverage during a disability; however, coverage will continue until the end of the year following the year in which you last rendered compensated service or received vacation pay. At that time, you may convert your benefit to an individual policy.	As soon as possible after you become disabled	See Section 3 for information about benefits when coverage ends

IF YOU BECOME DISABLED AND YOUR DISABILITY IS JOB-RELATED (CONTINUED)

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
On-Duty Injury	Notify your supervisor of your injury. You and your supervisor must complete a *First Report of Injury* form (NRPC Form 260), including a *Personal Statement* from you. Your supervisor must report your injury by calling the Injury Reporting Hotline at 1-800-505-5549. Your supervisor, in conjunction with your medical provider, will complete an *Amtrak Medical Information* form (NRPC Form 488) on your behalf and send it to the local Human Resources Department.	As soon as possible after you become disabled	See Section 10 for information about on-duty injury benefits
Retirement 401(k) Savings Plan	If your disability is permanent, you may want to review your investment strategy for the future. You may request a distribution from your account. You must continue to repay any outstanding loans. If your employment ends, you will have to repay any outstanding loans within 90 days.	As soon as possible after you become disabled	See Section 11 for information about Retirement 401(k) Savings Plan benefits
Railroad Retirement benefits	Contact the Railroad Retirement Board to determine what benefits you may be eligible to receive.	As soon as possible after you become disabled	N/A

Note: *Please contact your union about possible Supplemental Sickness benefits. You should also receive a package of information from Amtrak's Health Services Department. Contact your local Human Resources representative if you do not receive this package.*

IF YOU TAKE AN UNPAID LEAVE OF ABSENCE

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Medical, Dental, Vision, Spending Accounts, Commuter Reimbursement Accounts	Notify your supervisor to request leave. Your Department Administrator will complete a *Personnel Action Request* form (NRPC Form 2000) on your behalf and send it to the local Human Resources Department. Under some circumstances, Amtrak medical, dental, and vision coverage may continue – call the Amtrak Benefits Service Center at 1-800-481-4887 for more information. Call the Amtrak COBRA Service Center at 1-866-381-2859 for information about continuing medical and dental coverage under COBRA. Contributions to Spending Accounts will be suspended for the rest of the plan year; however, you may request reimbursement for eligible expenses incurred **before** the leave date. You may continue participation in a Health Care Spending Account (with after-tax contributions) through COBRA – call the Amtrak COBRA Service Center at 1-866-381-2859 for more information. Your participation in a Commuter Reimbursement Account will end until you return to work and resume making contributions.	As soon as you know about the leave	See Section 3 for information about benefits during a leave of absence See Section 12 for information about COBRA coverage
Life Insurance and AD&D	Contact the Amtrak Benefits Service Center at 1-800-481-4887 for information about continuing your coverage while on an unpaid leave of absence.	As soon as you know about the leave	See Section 9 for information about survivor benefits
Retirement 401(k) Savings Plan	Your contributions will stop; however, your account balance may remain in the Plan. You must continue to make payments to any outstanding loans. If your employment ends, **you will have to repay any outstanding loans within 90 days**.	As soon as you know about the leave	See Section 11 for information about Retirement 401(k) Savings Plan benefits

Special Note: *You should also refer to your labor contract for more information about benefits during a leave of absence.*

IF YOU BECOME FURLOUGHED OR SUSPENDED FROM SERVICE

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Medical, Dental, Vision, Spending Accounts, Commuter Reimbursement Accounts	Your supervisor will notify you about the furlough or suspension. Your Department Administrator will complete a *Personnel Action Request* form (NRPC Form 2000) on your behalf and send it to the local Human Resources Department. You will automatically receive a notice about COBRA coverage; however, your Amtrak coverage will continue concurrently with COBRA coverage until the end of the fourth month following the last month in which you rendered compensated service, if you meet the service requirements. When your Amtrak coverage ends, you may elect COBRA coverage for the amount of time remaining in the COBRA period. Contributions to Spending Accounts will be suspended for the rest of the plan year; however, you may request reimbursement for eligible expenses incurred **before** the leave date. You may continue participation in a Health Care Spending Account (with after-tax contributions) through COBRA – call the Amtrak COBRA Service Center at 1-866-381-2859 for more information. Your participation in a Commuter Reimbursement Account will end until you return to work and resume making contributions.	As soon as you know about the furlough or suspension	See Section 3 for information about benefits during a furlough or suspension
Life Insurance and AD&D	Life Insurance coverage will continue until the end of the month following the last month in which you rendered compensated service, if you meet the service requirements. AD&D coverage will continue until the end of the fourth month following the last month in which you rendered compensated service, if you meet the service requirements.	N/A	See Section 9 for information about survivor benefits
Retirement 401(k) Savings Plan	Your contributions will stop; however, your account balance may remain in the Plan. You must continue to make payments to any outstanding loans. If your employment ends, **you will have to repay any outstanding loans within 90 days**.	As soon as you know about the furlough or suspension	See Section 11 for information about Retirement 401(k) Savings Plan benefits
Railroad Retirement benefits	Contact the Railroad Retirement Board at 1-800-808-0772 to determine what benefits you may be eligible to receive.	As soon as you know about the furlough or suspension	N/A

Special Note: *You should also refer to your labor contract for more information about benefits during a furlough or suspension.*

IF YOU RETIRE

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
General	Notify your supervisor at least 30 days before your retirement date.	30 days before retirement	N/A
Medical, Dental, Vision, Spending Accounts, Commuter Reimbursement Accounts	Medical, dental, and vision coverage continues under Amtrak benefits for active employees through the month following the month in which you retire. If you are at least 60 and have at least 360 credited months of total railroad service: Contact the Amtrak Benefits Service Center at 1-800-481-4887 for information about early retiree medical coverage. If you are age 65 or older: If you have less than five years of railroad service, contact the Social Security Administration at 1-800-772-1213 about enrolling in Medicare. If you have five or more years of railroad service, contact the Railroad Retirement Board at 1-800-808-0772 about enrolling in Medicare Parts A and B. Call 1-800-633-4227 about enrolling in Medicare Part D prescription drug benefits. You will automatically be sent a notice about continuing medical, dental, and vision coverage by electing COBRA coverage. Contributions to Spending Accounts and Commuter Reimbursement Accounts will be suspended for the rest of the plan year; however, you may request reimbursement for eligible expenses incurred **before** the leave date. You may continue participation in a Health Care Spending Account (with after-tax contributions) through COBRA – call the Amtrak COBRA Service Center at 1-866-381-2859 for more information.	Within 30 days of your retirement	See Section 3 for information about enrollment See Section 12 for information about COBRA coverage
Life Insurance and AD&D	You will automatically be enrolled in retiree life insurance coverage worth $2,000. Contact the Amtrak Benefits Service Center at 1-800-481-4887 for information about retired employee life insurance benefits.	Within 30 days of your retirement	See Section 9 for information about retiree life insurance
Retirement 401(k) Savings Plan	Contact Vanguard at 1-800-523-1188 for information about receiving distributions from your account. You will have to **repay any outstanding loans within 90 days of your retirement date**. Adjust your investment mix to reflect a change in investment strategy if you will have an account balance after retirement.	Within 30 days of your retirement	See Section 11 for information about Retirement 401(k) Savings Plan benefits
Railroad Retirement benefits	Contact the Railroad Retirement Board at 1-800-808-0772 to determine what benefits you may be eligible to receive.	At least 90 days before your retirement date	N/A

IF YOU END YOUR EMPLOYMENT WITH AMTRAK

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Medical, Dental, Vision, Spending Accounts, Commuter Reimbursement Accounts	You will automatically be sent a notice about COBRA coverage; however, in some instances, your Amtrak coverage may continue (for example, if you end your employment because of pregnancy). Call the Amtrak COBRA Service Center at 1-800-381-2859 for information. Contributions to Spending Accounts and Commuter Reimbursement Accounts will end on your termination date; however, you may request reimbursement for eligible expenses incurred **before** your termination date. You may continue participation in a Health Care Spending Account (with after-tax contributions) through COBRA – call the Amtrak COBRA Service Center at 1-866-381-2859 for more information.	No later than 31 days after your employment ends	See Section 12 for information about COBRA coverage
Life Insurance and AD&D	Contact the Amtrak Benefits Service Center at 1-800-481-4887 about converting to an individual policy. Otherwise, your coverage ends on your termination date.	No later than 31 days after your employment ends	See Section 9 for information about converting to an individual policy
Retirement 401(k) Savings Plan	Contact Vanguard at 1-800-523-1188 for information about receiving distributions from your account (penalties may apply), rolling over your account balance into an IRA or another employer's qualified plan, or leaving your balance in the Retirement 401(k) Savings Plan. You will have to repay any outstanding loans within 90 days.	No later than 31 days after your employment ends	See Section 11 for information about Retirement 401(k) Savings Plan benefits

Special Note: *You should also refer to your labor contract for more information about benefits if you leave employment with Amtrak.*

IF YOU DIE WHILE AN AMTRAK EMPLOYEE

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Medical, Dental, Vision, Spending Accounts, Commuter Reimbursement Accounts	Coverage for your dependents will continue until the end of the fourth month following the month of your death. Your dependents will automatically receive information about continuing medical coverage (COBRA) beyond the four-month period. Contributions to Spending Accounts and Commuter Reimbursement Accounts will end; however, your eligible dependents may request reimbursement for eligible expenses incurred during the plan year.	N/A	See Section 3 for information about continuing benefits following the death of an employee
Life Insurance and AD&D	Your beneficiary(ies) should contact the Amtrak Benefits Service Center at 1-800-481-4887 to process benefits. An **original certified** copy of the death certificate will be required. An AD&D benefit is paid if death is from an accident.	No later than 31 days after your death	See Section 9 for information about survivor benefits
Retirement 401(k) Savings Plan	Your beneficiary should contact Vanguard at 1-800-523-1188 for information about receiving any account balances.	N/A	See Section 11 for information about Retirement 401(k) Savings Plan benefits
Railroad Retirement benefits	Contact the Railroad Retirement Board at 1-800-808-0772 to determine what benefits, if any, survivors may be eligible to receive.	No later than 31 days after your death	N/A

Special Note: *Your beneficiary(ies) should also refer to your labor contract for more information about benefits following your death.*

IF YOUR SPOUSE OR DEPENDENT CHILD DIES WHILE YOU ARE AN AMTRAK EMPLOYEE

BENEFITS	ACTION YOU MAY TAKE	WHEN	WHERE TO GO IN THIS HANDBOOK FOR MORE INFORMATION
Medical, Dental, Vision, Spending Accounts	Call the Amtrak Benefits Service Center at 1-800-481-4887 or log onto the benefits website: www.amtrakbenefits.com to remove your dependent from your coverage. Call the Amtrak Benefits Service Center at 1-800-481-4887 or log onto the benefits website: www.amtrakbenefits.com to enroll in Amtrak coverage if you were covered under your deceased spouse's benefits. As a result of the death, you may make a corresponding change to your Spending Accounts.	No later than 31 days after the death	See Section 3 for information about enrolling in benefits
Life Insurance and AD&D	You may want to review your beneficiary designation, especially if your deceased spouse or dependent was your beneficiary for Life Insurance and AD&D benefits. To change your beneficiary, please complete a *Change of Beneficiary Designation* form (NRPC Form 3202). You may request a copy of this form by calling the Amtrak Benefits Service Center at 1-800-481-4887, or you may print one from the benefits website: www.amtrakbenefits.com. Return this completed form to the Amtrak Benefits Service Center at the address on the form.	As soon as possible – a beneficiary change will not be effective until the Amtrak Benefits Service Center receives an original written notice of the change	See Section 9 for information about converting to an individual policy
Retirement 401(k) Savings Plan	You may want to review your contributions and investment strategy for the future. You may want to review your beneficiary designation for your Retirement 401(k) Savings Plan benefits, especially if your deceased spouse or dependent was your beneficiary. Call Vanguard at 1-800-523-1188 or download a form from www.amtrakbenefits.com to change your beneficiary for your 401(k) benefits. Return this completed form to Vanguard.	As soon as possible – a beneficiary change will not be effective until Vanguard receives an original written notice of the change	See Section 11 for information about Retirement 401(k) Savings Plan benefits

SECTION 3:
Eligibility And Participation

AN OVERVIEW OF YOUR BENEFITS

Many people think of their benefits as only medical "insurance." But, your benefits include many different types of coverage, not just medical benefits. As an agreement-covered employee of Amtrak, you are eligible to participate in a number of employee benefit plans.

The benefits described in this handbook are as follows:

Medical – you have two medical options from which to choose, depending on where you live:

- *Network Plan* (if you live in an area serviced by the UnitedHealthcare network, the Tufts Health Plan network in Massachusetts only, or the Aetna network in Central Pennsylvania – Lancaster area); and
- *Comprehensive Plan.*

(Caremark administers prescription drug benefits for both medical options. In addition, MHN administers mental health and substance abuse benefits for both medical options.)

Dental – provided through the Railroad Employees National Plan and administered by Aetna Dental (except for Police – whose dental benefits are administered by Delta Dental).

Vision – administered through Vision Service Plan (VSP).

Spending Accounts – you may participate in one or both of these accounts (administered through SHPS Inc.):

- Health Care Spending Account; and
- Dependent Day Care Spending Account.

Commuter Reimbursement Accounts – you may participate in one or both of these accounts (administered through SHPS Inc.):

- Transportation Reimbursement Account; and
- Parking Reimbursement Account.

On-Duty Injury (ODI) – administered through MCMC.

Important Note: You may also be eligible for other benefits offered to agreement-covered employees. Please see your labor agreement for more information.

Life and Accidental Death & Dismemberment (AD&D) Insurance – insured through Aetna Life Insurance.

Amtrak Retirement 401(k) Savings Plan – a 401(k) plan (administered through The Vanguard Group) to help you save for retirement on a tax-deferred basis.

Your Medical, Spending Accounts, Life and AD&D, and ODI coverage are provided under AmPlan, the benefits program for Amtrak agreement-covered employees. Dental coverage is provided through the Railroad Employees National Dental Plan.

In addition to your AmPlan and Railroad Employees National Dental Plan benefits, you also may participate in the Retirement 401(k) Savings Plan.

For more information about the organizations that administer your benefits, see **Section 12: Administrative Information.**

WHO IS ELIGIBLE FOR BENEFITS

You are eligible for the benefits described in this handbook if you are a regular, full-time employee of Amtrak and are covered by a collective bargaining agreement.

Seasonal, part-time, and temporary employees are not eligible for the benefits outlined in this handbook.

Helpful Hint: Part-time employees who are members of the TCU and ASWC unions are eligible for medical benefits through the Allied Services Division Welfare Fund. Prescription drug benefits are administered through Sav-Rx. Dependents are not eligible for medical or prescription drug benefits. Call 1-847-981-0491 for information about these benefits.

WHO IS ELIGIBLE FOR BENEFITS (CONTINUED)

In addition to the eligibility requirements previously outlined, as an active employee, you are eligible to participate in Amtrak benefits if you have a certain amount of compensated service or vacation during the previous calendar month. The amount of compensated service required depends on your union, as shown in this chart:

UNION	COMPENSATED SERVICE REQUIRED DURING THE PREVIOUS MONTH
Brotherhood of Railroad Signalmen (BRS) United Transportation Union (UTU) Zone 1 Conductors	1 day
Amtrak Service Workers Council (ASWC) United Transportation Union (UTU) Stewards	56 hours
All other unions	7 days

You continue to be covered during the month following each month in which you render compensated service in the amount shown above.

For example, if you are a member of ASWC, to be eligible for benefits in the month of April, you must have worked or received vacation pay for at least 56 hours during the month of March.

Your eligible dependents may also be covered under the benefits described in this handbook. Your eligible dependents are your:

- Legally-married husband or wife (common law marriages are **not** eligible);
- Unmarried children age 18 or younger who are primarily dependent on you for care and financial support, until midnight of the day before the child's 19th birthday;
- Unmarried children from age 19 until midnight of the day before the child's 25th birthday who:
  - Are registered students attending school full-time (12 credits or more per semester or term), **and**
  - Are primarily dependent on you for care and financial support;
- Unmarried children age 19 or older who:
  - Are primarily dependent on you for care and financial support; **and**
  - Have a permanent physical or mental handicap that began before age 19, **and**
  - Became handicapped while covered under this Plan or any other group plan;
- Children who are otherwise eligible and who are alternate recipients under a Qualified Medical Child Support Order.

Your children include:

- Your natural children;
- Your stepchildren who live with you;
- Legally adopted children (beginning on the date the legal adoption proceedings started) and children placed for adoption; and
- Other children related to you by blood or marriage (such as grandchildren), provided the children live with you and are primarily dependent on you for care and financial support.

To be eligible, your dependents must live in the United States (U.S.).

Domestic Partner Coverage For California Residents
Beginning January 1, 2007, if you live in California, you may enroll your registered domestic partner in your Amtrak medical, vision, and life insurance plans.

Your registered domestic partner is the person with whom you have filed a Declaration of Domestic Partnership with the State of California. This Declaration establishes that you:

- Are not married to someone else or a member of another domestic partnership;
- Are financially responsible for each other's basic living expenses;
- Share a common residence; and
- Are not related by blood.

The Declaration also requires that you be of the same gender, unless one or both of you are over age 62 and eligible for Social Security. You will need to provide a copy of the notarized Declaration as proof of your partner's eligibility for these benefits.

If you live in California and would like more information about adding your registered domestic partner to your benefits and the possible federal tax implications, call the Amtrak Benefits Service Center at 1-800-481-4887 and speak with a Customer Service Representative.

✓ **Life Event Reminder:** Be sure to call the Amtrak Benefits Service Center within 31 days of your child's birth/adoption to enroll him/her for medical benefits. Refer to **Section 2: Life Events That Affect Your Benefits** for additional information.

WHEN COVERAGE BEGINS

Your medical and life and AD&D coverage generally begins on the first day of the calendar month following the first day you work and are eligible to receive pay, as long as you complete the enrollment process.

Dental and vision coverage begins after one year of service. Participation in the Retirement 401(k) Savings Plan may begin after one year of service.

Participating in Flexible Spending Accounts and Commuter Reimbursement Accounts begins after you enroll and contributions are deducted from your pay.

Coverage for your eligible dependents begins on the same day as yours. If you have or adopt a child after your coverage begins, coverage for the child is provided for the first 31 days. Then, you must enroll your child within 31 days of the birth/adoption to continue coverage beyond the first 31 days.

COST OF BENEFITS

Amtrak pays most of the cost of your Medical, Dental, Vision, and Life and AD&D benefits for you. However, if you wish to participate in a Health Care or Dependent Day Care Spending Account or Commuter Reimbursement Account, you will make tax-free contributions to these accounts. You may also make tax-deferred contributions to a Retirement Savings 401(k) Plan account.

Members of the TCU, ASWC, and ARASA-OBS unions will pay $75 a month toward the cost of medical coverage. These contributions are deducted from the fourth pay-check of the month on a tax-free basis. This means that you do not pay federal or state (in most states) income taxes or Railroad Retirement taxes on the amount of your benefit contributions.

Important Note: Tax-free contributions you make to your benefits (including medical benefits, Spending Accounts, and Commuter Reimbursement Accounts) will reduce the amount of salary on which your eventual retirement benefits from the Railroad Retirement Board will be based. This may result in a reduction in the amount of Railroad Retirement benefits you may receive at retirement. However, in most cases, the amount of taxes you save will be more than any reduction in Railroad Retirement benefits. For additional information, consult with your tax advisor.

HOW TO PARTICIPATE IN BENEFITS

New Employees

An enrollment package will be mailed to your home. The following chart shows the decisions you will need to make when you enroll.

BENEFITS	ENROLLMENT DECISION
Medical	■ To enroll in the Network Plan or the Comprehensive Plan **(if you live in an area serviced by a network, you will automatically be enrolled in the Network Plan up through December 31 of your first year of service)** ■ To select a primary care physician if you enroll in the Network Plan administered through Tufts Health Plan ■ To enroll yourself only or yourself and your eligible dependents
Dental and Vision (after one year of service)	■ No decisions needed – coverage is automatic
On Duty Injury	■ No decisions needed – coverage is automatic
Spending Accounts	■ To enroll in a Health Care Spending Account or Dependent Day Care Spending Account, or both ■ Amount to contribute per year
Commuter Reimbursement Accounts	■ To enroll in a Transportation Reimbursement Account or Parking Reimbursement Account, or both ■ Amount to contribute per year
Life and AD&D Insurance	■ To designate a beneficiary for Life and AD&D insurance
Retirement 401(k) Savings Plan (after one year of service)	■ To enroll in this Plan ■ Amount to contribute ■ How contributions will be invested ■ To designate a beneficiary for your Retirement 401(k) Savings Plan benefits

Current Active Employees

Once you have enrolled for benefits, your coverage for most benefits remains in place until the end of that plan year (December 31). Every year (usually in the autumn), you will have the chance to change your medical benefit option and enroll/re-enroll in a Spending Account. However, if you are enrolled in the Comprehensive Medical Plan and wish to change to the Network Medical Plan, you may do so at any time. If you are enrolled in the Network Plan, you may not change your election until the next Open Enrollment period for the following plan year (January 1 through December 31).

If you gain a new dependent through marriage, birth, adoption, or placement for adoption, you may add this dependent to your medical coverage provided you do so within 31 days of the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or your dependents (including your spouse) because of other health coverage, you may be able to enroll yourself or your dependents in this plan in the future, provided you request enrollment within 30 days after your other coverage ends.

If you enroll in a spending account, your contributions to these accounts will remain in place during the plan year (January 1 through December 31) unless you have an IRS-qualified change in family status. Changes in family status and their effect on Spending Accounts are explained in more detail in **Section 7: Spending Accounts**.

Important Note: If you do not complete the enrollment process when first eligible for benefits, your benefits and eligibility for benefits may be affected. Call the Amtrak Benefits Service Center at 1-800-481-4887 or access the benefits website: www.amtrakbenefits.com for information on how to enroll for benefits.

Returning Employees

If you become ineligible for medical benefits, return to active service with Amtrak, and are again eligible for benefits, the following will apply:

- If you return to eligibility within 24 months, you and your eligible dependents will be enrolled in the same medical plan in which you were enrolled when your eligibility ended:
  - Provided the same plan still exists, and
  - If you were a participant in the Network Plan – you live in an area serviced by the Network; or
- If you return to eligibility after 24 months, you will be considered a new employee and will have to follow the enrollment process for a new employee.

Continuing your medical coverage under COBRA will not change the date you lost eligibility for purposes of calculating the 24-month period.

Transferred Employees

If you are transferred to another work location, the following chart shows what will happen to your medical coverage.

IF YOU WERE ENROLLED IN THIS MEDICAL PLAN BEFORE THE TRANSFER:	AND, YOU ARE TRANSFERRED TO AN AREA WHERE THE POS NETWORK IS:	THEN, YOU WILL BE ENROLLED IN THIS MEDICAL PLAN:
Network Plan	Available	Network Plan
	Not available	Comprehensive Plan
Comprehensive Plan	Available	Your choice of Network or Comprehensive Plan
	Not available	Comprehensive Plan

Important Note: If you are enrolled in the Network Plan and are transferred out of the network service area, you may elect to remain in the Network Plan and travel a longer distance to a network provider. However, you will need to sign a form stating that you wish to stay in the Network Plan.

Important Note: Vacation pay received after you are furloughed will not extend coverage or benefits after coverage ends. In addition, vacation pay received after an employment relationship ends will not extend coverage or benefits after coverage ends. This includes vacation pay you receive after you resign, are dis-missed, or retire.

WHEN COVERAGE ENDS

All coverage ends on the earlier of:

- The date you become covered as an employee under another health and welfare benefit or retirement savings plan;
- The date the class of Amtrak employees to which you belong stops being covered under the Plan.
- The last day of the month following the month you last rendered the necessary amount of active, compensated service or received the necessary amount of vacation pay; or
- The date your employment with Amtrak ends for a reason other than retirement (such as resignation).

Coverage for a dependent also ends on the earlier of the following:

- He or she is no longer an eligible dependent (for example, your dependent reaches the maximum age for coverage – age 19 or age 25, if a full-time student); or
- He or she becomes covered as an employee under this Plan.

The information that follows provides more details about when coverage ends.

Important Note: If you become divorced, you must contact the Amtrak Benefits Service Center to remove your former spouse from your coverage. If you are required to maintain medical coverage for your former spouse, you may do so through COBRA.

Continuing Medical Benefits For Employees

If your coverage ends, you will continue to receive medical benefits for only those illnesses or injuries (including pregnancy) that began while you were covered. Your benefits will continue for three months from the date coverage ends unless you are under a doctor's care and prevented by your disability from performing work in your last regular job and any other comparable job.

See the heading **Benefits For Disabled Employees** for more information about benefits during disability.

Benefits will not be paid for an illness or injury that occurred after your coverage ended.

There are special provisions for pregnant employees, as described under the heading **Pregnant Employees**.

Important Note: You may be eligible for COBRA benefits when your Amtrak coverage ends. However, in many cases, Amtrak-sponsored benefits will continue when you experience a COBRA qualifying event. If your Amtrak-sponsored benefits continue, COBRA coverage will run concurrently with any Amtrak continued coverage. For example, if you are furloughed, Amtrak medical coverage continues until the end of the fourth month following the month in which you last rendered compensated service. When the Amtrak-sponsored medical coverage ends, you may continue medical coverage through COBRA for up to 18 months **minus** the amount of Amtrak continued coverage (approximately four months). If your Amtrak continued coverage runs for longer than the typical 18-month COBRA period, you will **not** be eligible for COBRA at the end of the Amtrak continued coverage period. See **Section 12: Administrative Information** for additional information about COBRA coverage.

WHEN COVERAGE ENDS (CONTINUED)

Benefits For Disabled Employees

If you are unable to work because you are disabled, your medical benefits will continue until the end of the second calendar year following the year in which you last rendered compensated service or received vacation pay. Dental and vision benefits will continue until the end of the year following the year in which you last rendered compensated service or received vacation pay.

TCU, ASWC, ARASA-OBS employees: Employee coverage for medical benefits will end on the date you return to work or 24 months from the date of the disability, whichever is earlier.

To qualify, the disability must prevent you from performing work in your last regular job and any other comparable job. The disability must be caused by an illness or injury that occurred while you were covered. No benefits are payable if your disability ends unless you return to active work at Amtrak.

Medical, dental, and vision benefits for your dependents and your Life Insurance and AD&D coverage will stop when your coverage ends or at the end of the calendar year following the year in which you last rendered compensated service or received vacation pay. Receiving vacation pay will extend dental and vision coverage for both you and your eligible dependent.

Unless your benefits ended earlier, benefits will end when your disability ends or you end your employment with Amtrak for reasons other than retirement.

Helpful Hint: If your Amtrak medical coverage ends due to disability and you qualify for Medicare, you may be eligible for a Medicare Supplemental Plan. You may also be eligible to purchase supplemental coverage for your dependents when Amtrak medical coverage ends. Call 1-800-809-0453 for more information.

Pregnant Employees

If you end your employment because of your pregnancy, your benefits will continue as follows:

- Medical, dental, and vision benefits for you and your dependents and AD&D coverage for you will continue until the end of the fifth month following the month in which you last rendered compensated service; and
- Your life insurance coverage will continue until the end of the month following the month in which you last rendered compensated service.

If you return to work before your coverage ends, your coverage will not be interrupted. If you return to work after your coverage ends, your coverage will begin on the first day of the month following the month you return to active work.

Medical, Dental, And Vision Coverage For Your Disabled Spouse And Children

If one of your dependents is disabled on the date your coverage ends, medical, dental, and vision benefits for that disabled dependent will continue through:

- The end of the year in which your coverage ends; and
- The next two calendar years.

Benefits will only be paid for the illness, injury, or pregnancy (spouse only) which caused your dependent's disability. Medical benefits related to pregnancy will be payable if the conception occurred while you were covered for benefits.

Benefits For Furloughed, Suspended, And Dismissed Employees

Your medical, dental, vision, life insurance, and AD&D benefits will continue if you:

- Have worked for Amtrak for three months; or
- Are suspended or dismissed after working at Amtrak for six months or more and you have participated in the Plan for at least three months.

WHEN COVERAGE ENDS (CONTINUED)

You will be covered for benefits as follows:

- You will be covered for employee and dependent medical, dental, and vision benefits and AD&D coverage during your furlough or suspension and after your dismissal. Your coverage will continue until the end of the fourth month following the month in which you last rendered compensated service (or received vacation pay if you are suspended).
- You will be covered for life insurance benefits during your furlough or suspension and after your dismissal. Your coverage will continue until the end of the month following the month in which you last rendered compensated service (or received vacation pay if you are suspended).

If you are furloughed, suspended, or dismissed, your participation in a Spending Account or Commuter Reimbursement Account will end with your last paycheck. However, you will have 90 days from your last day of employment to submit claims for expenses incurred **up to your last day** of employment. However, if you wish to continue participating in your Health Care Spending Account through the rest of the plan year, you may do so with after-tax contributions through COBRA coverage. In this case, you will have 90 days from the end of the plan year to submit claims for expenses incurred during the plan year. See **Section 12: Administrative Information** for more information about COBRA coverage.

> **Important Note:** Vacation pay received **after** your furlough or dismissal does not count in calculating extended coverage.

When you return to work, your medical, life insurance, and AD&D benefits will continue as outlined in the following chart:

IF YOU RETURN TO WORK:	THEN:
Before your coverage ends	You will continue to receive benefits during the month in which you return to active work.
After coverage ends	You will be covered on the first day of the month following the month you return to active work.

If you become disabled before your coverage ends, your benefits will continue as explained earlier under the heading **Benefits For Disabled Employees.** If you are awarded full back pay for all time lost as a result of the suspension or dismissal, your coverage will be provided as though you had not been suspended or dismissed in the first place.

Benefits For Retired Employees

When you retire, medical, dental, and vision benefits for you and your dependents will continue until the end of the month following the month in which you last rendered compensated service or received vacation pay. Accidental Death and Dismemberment (AD&D) coverage ends on your retirement date. However, you will have Life Insurance coverage of $2,000 once you retire.

> **Important Note:** Vacation pay received **after** your retirement does not count in calculating your extended coverage.

If you are over age 60 and have 360 credited months or more of total railroad service when you retire, you may be eligible for medical benefits under the AmPlan Early Retirement Major Medical Benefits Plan. For more information, call the Amtrak Benefits Service Center at 1-800-481-4887 before you retire. Also refer to the booklet: *Planning For Retirement – Your Benefits*, available at www.amtrakbenefits.com and the Amtrak Benefits Department.

Helpful Hint: Once you reach age 65, you may be eligible for medical coverage through Medicare (1-800-MEDICARE) and through a Medicare Supplemental Plan (1-800-809-0453).

When you retire, you will have life insurance coverage equal to $2,000.

Benefits For Dependents Of Employees Who Die While Actively Employed By Amtrak

If you die while covered under Amtrak benefits, medical, dental, and vision benefits for your dependents will continue until the end of the fourth month following the month of your death. If your surviving spouse and dependent children wish to continue medical, dental, and vision coverage or Health Care Spending Account participation after coverage ends, they may do so through COBRA coverage. **See Section 12: Administrative Information** for details about COBRA coverage.

A life insurance benefit of $10,000 will be paid to your beneficiary(ies) as soon as practical after your death. If your death was the result of an accident, your beneficiary(ies) will receive an additional AD&D benefit of $8,000. Your beneficiaries will need to provide an **original certified** death certificate to receive benefits.

Medical Benefits While Serving In The U.S. Armed Forces

If you are serving in the U.S armed forces for 30 days or more, you and your dependents will not be covered for Amtrak medical, dental, and vision benefits during your active military duty. You may elect to continue your Amtrak coverage for up to 24 months – call the Amtrak Benefits Service Center at 1-800-481-4887 for details. You will be responsible for 100% of the cost of coverage, plus a 2% administrative fee. You should also contact your military unit for information about the coverage available to you by the U.S. Government.

However, if you are a member of one of the following unions and your military duty meets the criteria for Emergency Military Leave, your contributions for coverage will be the same as they were when you were an active employee:

- Amtrak Service Workers Council;
- Brotherhood of Maintenance of Way Employees;
- Brotherhood of Locomotive Engineers – ATDD;
- Transportation Communications Union;
- United Transportation Union Stewards; and
- International Brotherhood of Electrical Workers.

This will continue until the end of the fourth month following the month in which you last rendered compensated service or received vacation pay. At the end of the Emergency Military Leave continuation period, you may continue coverage for up to a total of 24 months (which includes the Emergency Medical Leave continuation period). You will be responsible for 102% of the cost of coverage.

Benefits For Returning Veterans

If you had coverage under Amtrak benefits and return to work at Amtrak following your service in the armed forces of the U.S., your medical, dental, life insurance, and AD&D coverage begins on your first day back to active work.

If you are called for military service, you may make up your employee contributions to the Retirement 401(k) Savings Plan for the period you were on military leave. This make-up payment period begins when you become re-employed, and cannot exceed three times the period of military service or five years, whichever is less.

WHEN COVERAGE ENDS (CONTINUED)

Benefits For Employees Under Compensation Maintenance Agreements, Etc.
All coverage will continue for as long as Amtrak is obligated to provide such coverage because of an agreement, statute, or order of a regulatory authority, but only if you have not relinquished your employment rights.

Benefits During Family And Medical Leave
Except for Spending Accounts and Commuter Reimbursement Accounts, your coverage will continue while you are out on Family and Medical Leave. Family and Medical Leave Act (FMLA) coverage is available to you to care for your own serious health condition, to care for a family member with a serious health condition, or to care for a newborn or newly adopted child.

If you pay a portion of any benefit premium, you must continue payment(s) while on FMLA leave. Also, if you do not return to active work at the end of the leave period, you may have to reimburse Amtrak for any premiums that Amtrak paid during your leave.

If you are out on Family and Medical Leave, your participation in a Spending Account will end for the rest of the calendar year. However, you may continue your participation in a Health Care Spending Account by electing after-tax contributions through COBRA coverage. For more information about COBRA coverage, see **Section 12: Administrative Information**.

Family and Medical Leave will not be treated as service for the purpose of continuing or extending benefits as described in this section of your handbook.

EMPLOYEES COVERED BY HOSPITAL ASSOCIATION ONLY

If your benefits are provided by a Hospital Association, the following are administered through UnitedHealthcare:

- Medical benefits if you are furloughed, suspended, or dismissed (you are covered under the Hospital Association until the end of the month the furlough, suspension, or dismissal occurs; then you are covered through UnitedHealthcare for the next three months); and
- Medical benefits for your eligible dependents.

If your medical benefits are provided through a Hospital Association, the participation rules outlined earlier in this handbook section apply to your eligible dependents.

If you lose Hospital Association coverage and become eligible for coverage under one of the AmPlan medical options, you will be enrolled in the same option as your eligible dependents. If you do not have dependents, you will automatically be enrolled in the Network Plan if you live in an area serviced by a network. Otherwise, you will be enrolled in the Comprehensive Plan.

If you end your Hospital Association medical benefits and enroll in an AmPlan medical options, you cannot re-enroll in Hospital Association medical benefits at a later date.

Your other medical benefits are provided by your Hospital Association under its eligibility rules, and not by the plans described in this handbook.

KEEPING YOU ON THE TRACK TO GOOD HEALTH

When asked which benefit is the most important to them, the majority of employees would say "medical benefits." Without medical benefits, the cost of health care could take a big bite out of your household budget.

TWO MEDICAL OPTIONS

Amtrak offers eligible employees two medical care options: the Network Plan and the Comprehensive Plan. UnitedHealthcare administers the Comprehensive Plan. The administrator for the Network Plan depends on where you live, as shown in this chart:

LOCATION	NETWORK PLAN ADMINISTRATOR
Massachusetts only	Tufts Health Plan Point-of-Service Option
Central Pennsylvania (Lancaster area)	Aetna
All others	UnitedHealthcare

MHN is the network manager for mental health and substance abuse benefits under both options. In addition, Caremark administers prescription drugs under both options.

Helpful Hints: The term "network" refers to a different network of physicians for the purposes of mental health and substance abuse treatment. See the sub-heading **Mental Health and Substance Abuse** under the heading **Benefit Descriptions** for more information.

UnitedHealthcare, Tufts Health Plan, and Aetna frequently add doctors to their network of providers. It's a good idea to check these networks periodically to find out if a doctor you wish to see has been added.

Refer to these websites for lists of network providers:

- UnitedHealthcare – www.provider.uhc.com/Amtrak
- Tufts Health Plan – www.tufts-healthplan.com
- Aetna – www.aetna.com

Important Note: If you live in an area serviced by the Network Plan and do not select a medical option when you enroll, you will automatically be enrolled in the Network Plan.

Definition: The reasonable and customary (R&C) amount for a type of service is determined by the claims administrator (UnitedHealthcare, Tufts Health Plan, or Aetna). The claims administrator makes this decision by comparing the fees charged by similar providers for the same service in the same geographic area.

If your doctor charges more than the R&C amount for care, you will be responsible for any amounts over R&C. The amount you pay that is more than R&C does not apply toward your deductible, coinsurance, or out-of-pocket maximum.

ABOUT THE NETWORK PLAN

The Network Plan is a point-of-service (POS) plan where the level of benefits is determined by where you choose to receive care. You will receive the highest level of benefits and pay a minimal copay, if any, when your care is obtained through a network provider.

Selecting A PCP – Tufts Only

If you elect to participate in the Network Plan administered through the Tufts Health Plan, you need to choose a primary care physician (PCP) who will coordinate your medical care. You'll receive the highest level of benefits when your PCP provides your care or you see a specialist referred to you by your PCP.

For information about the PCPs in your area, you can:

- Access the Tufts Health Plan website: www.tufts-healthplan.com
- Call the Tufts Health Plan: 1-800-462-0224
- Call the Amtrak Benefits Service Center: 1-800-481-4887 or log onto: www.amtrakbenefits.com

> **Important Note:** UnitedHealthcare and Aetna Network Plan participants do not need to select a PCP. However, to receive the in-network level of benefits, you must obtain care from a network provider.

In-Network Benefits

You'll receive the in-network level of benefits when you see a network provider. After a small copay (usually $15), the Plan pays 100% of the cost of in-network care.

> **Helpful Hint:** Although UnitedHealthcare and Aetna do not require you to choose a PCP or get referrals to see a specialist, it's a good idea to have a doctor that you see for routine care. Call the UnitedHealthcare or Aetna Member Services or access the appropriate website for a list of network doctors in your area.

Out-Of-Network Benefits

You may also seek care that is not coordinated by a network provider. You will still receive benefits; however, they will be paid at a lower level. For example, the Plan typically pays 75% of the R&C cost of out-of-network care, after you satisfy the annual deductible.

Annual Deductible

The annual deductible for out-of-network care will depend on your union, as follows:

- TCU, ASWC, and ARASA-OBS members:
  - – $200 per person
  - – $600 per family
- All other Agreement-Covered members:
  - – $100 per person
  - – $300 per family

The individual deductible applies separately to each covered member of your family when you have a two-person family. If you have three or more covered family members, the family deductible is a combined deductible for all covered family members.

Out-Of-Pocket Limit

Once your out-of-pocket expenses reach $1,500 per person or $3,000 per family in a particular year, the Plan pays 100% of eligible expenses for the rest of that calendar year. The family out-of-pocket maximum is a combined maximum for all covered family members, no matter what the size of your family.

The out-of-pocket limit does not include deductibles or the following expenses:

- Charges that are more than the R&C cost of care;
- Charges that are more than specific Plan limits or exclusions (explained in more detail under **Benefits Descriptions**);
- Copays for in-network medical services and copays or coinsurance for prescription drugs; and

ABOUT THE NETWORK PLAN (CONTINUED)

- Penalties for not pre-approving a claim when required (explained in more detail under the heading **Pre-Approval**).

Lifetime Maximum

The Plan will provide out-of-network benefits up to $1,000,000 per lifetime (no lifetime maximum for in-network benefits). Each January 1, if you are a participant of the UnitedHealthcare Choice Plus POS Network Plan, the Plan will restore up to $5,000 of your benefits. The amount restored will be based on claims you incur during the previous plan year, up to $5,000.

> **Important Note:** Mental health and substance abuse claims **will** apply toward your annual deductible, annual out-of-pocket limit, and lifetime maximum.

Care When You Are Out Of The Network Area

There may be times when you are away from home and require medical care. For example, you may be traveling on vacation, or have a covered dependent who is a student living away from home.

You'll receive the in-network level of benefits for care you receive away from home provided you meet the following requirements:

- For Tufts Health Plan participants, a PCP will coordinate routine care, such as physicals, maternity care, and immunizations. In the case of students living away from home, routine care, such as physicals and immunizations, should be done during school breaks.
- If you need medical care outside of the network area, call the Member Services number on your medical ID card. A Member Services representative will let you know of any network providers who are available where you are located and will provide you with the information you need to make an appointment with a network provider. If there is no network provider available where you are located, you may seek care from a qualified provider.
- As always, in the case of a medical emergency, go to the nearest appropriate medical facility for care. Tufts participants: Don't forget to notify your PCP within two business days if you are admitted to the hospital. You should also contact your PCP as soon as possible after the emergency to arrange for follow-up care. See the sub-heading **Emergency Care** under the heading **Benefit Descriptions** for additional information.

Other Information About The Network Plan

For a list of expenses covered under the Network Plan, refer to the heading **Benefit Descriptions** that you will find later in this section of your handbook. For information about treatments requiring pre-approval and patient care management, refer to the heading **Pre-Approval**, also in this section of your handbook.

> **Definition:** The reasonable and customary (R&C) amount for a type of service is determined by the claims administrator (UnitedHealthcare). The claims administrator makes this decision by comparing the fees charged by similar providers for the same service in the same geographic area.
>
> If your doctor charges more than the R&C cost of care, you will be responsible for any amounts over R&C. The amount you pay that is more than R&C is not included in your deductible, coinsurance, or out-of-pocket maximum.

ABOUT THE COMPREHENSIVE PLAN (UNITEDHEALTHCARE ONLY)

The Comprehensive Plan is a traditional indemnity plan that pays a percentage of the cost of care, after you satisfy an annual deductible. You may see any medical provider you choose and receive benefits.

The Comprehensive Plan is administered only through UnitedHealthcare.

ABOUT THE COMPREHENSIVE PLAN (CONTINUED)

Plan Benefits

The Comprehensive Plan pays a percentage of the reasonable and customary (R&C) cost of most medical care, after you meet the annual deductible.

Members of TCU, ASWC, and ARASA-OBS

The amount of coinsurance the Plan pays will depend on if you live in an area that is within a Network Plan service area:

- Comprehensive Plan A – The Plan pays 85% of the reasonable and customary (R&C) cost of care for participants who live outside of a Network Plan service area.
- Comprehensive Plan B – The Plan pays 75% of the R&C cost of care for participants who live in areas that are serviced by the Network Plan.

To find out if you are a participant of Comprehensive Plan A or B, refer to your personalized benefits worksheet. Or, call the Amtrak Benefits Service Center (1-800-481-4887) and speak with a Customer Service Representative.

See the **Summary of Your Medical Benefit Options** for more information about coinsurance amounts for different types of care.

Annual Deductible

Once you meet the $100 per person or $300 per family annual deductible, the Plan begins to pay benefits.

> **Helpful Hint:** If you switch from the Comprehensive Plan to the Network Plan during the year, any expenses that applied toward your Comprehensive Plan deductible will apply to your out-of-network deductible under the Network Plan for the rest of that calendar year.

Out-Of-Pocket Limit

Once your out-of-pocket expenses reach $1,500 per person or $3,000 per family in a particular year, the Plan pays 100% of R&C expenses for the rest of that calendar year. The family out-of-pocket maximum is a combined maximum for all covered family members, no matter what the size of your family.

The out-of-pocket limit does not include deductibles or the following expenses:

- Charges that are more than the R&C cost of care;
- Charges that are more than specific Plan limits or exclusions (explained in more detail under the heading **Benefit Descriptions**);
- Copays or coinsurance for prescription drugs; and
- Penalties for not contacting Care Coordination when required (explained in more detail under the heading **Care Coordination**).

Lifetime Maximum

The Plan will provide benefits up to $1,000,000 per lifetime. Each January 1, the Plan will restore up to $5,000 of your benefits. The amount restored will be based on claims you incur during the previous plan year, up to $5,000.

> **Important Note:** Mental health and substance abuse claims **will** apply toward your annual deductible, annual out-of-pocket limit, and lifetime maximum.

Preferred Provider Organization (PPO) Feature

If you participate in the Comprehensive Medical Plan, you may take advantage of the Preferred Provider Organization (PPO) feature this plan offers.

A PPO is a network of doctors, hospitals, and other health care providers who have agreed to charge Comprehensive Plan participants a discounted or lower amount for services.

ABOUT THE COMPREHENSIVE PLAN (CONTINUED)

Seeing a doctor in the PPO network is voluntary. However, when you see a provider who is part of the Options PPO network (UnitedHealthcare), the doctor or provider will charge you less for medical care. So, you pay less out of your pocket. In addition, when you see an Options PPO network doctor or provider, you do not have to file claim forms – it will be done for you.

To locate a PPO doctor or check to see if your doctor is in the PPO network:

- Call the Amtrak Benefits Service Center at 1-800-481-4887; or
- Call UnitedHealthcare Member Services at 1-888-675-RAIL (7245); or
- Visit the UnitedHealthcare Internet site at www.myuhc.com/groups/Amtrak.

Other Information About The Comprehensive Plan

For a list of expenses covered under the Comprehensive Plan, refer to the heading **Benefit Descriptions** that you will find later in this section of your handbook. For information about treatments that require pre-approval and patient care management, refer to the heading **Pre-Approval**, also in this section of your handbook.

MEDICALLY NECESSARY

To be considered an eligible expense, the service or supply must be **medically necessary**, as determined by the claims administrator (UnitedHealthcare, Tufts Health Plan, MHN, or Caremark).

A service or supply may not be considered medically necessary just because it is provided or recommended by your provider. The definition of medically necessary used by this Plan may differ from the way in which your provider practices medicine. If you are not sure if a service or supply is medically necessary, contact Member Services at the number on your ID card.

BENEFITS HIGHLIGHTS CHART

The chart on the following pages provides an at-a-glance summary of your medical benefits.

Definition: Medically necessary services are those health care services and supplies that the claims administrator determines to be:

- Medically appropriate;
- Given in the most appropriate setting for the delivery of the service or supply;
- Given only for an appropriate length of time;
- Consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical, research, health care coverage organizations, or governmental agencies that are accepted by the Plan Administrator;
- Consistent with the diagnosis of the condition;
- Required for reasons other than your or your doctor's convenience;
- Essential to identify or treat your illness or injury; and
- Demonstrated through prevailing peer-reviewed medical literature to be safe and effective for either:
  - treating or diagnosing the condition or sickness for which their use is proposed; or
  - treating a life-threatening* condition or sickness in a controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

The claims administrator will determine, in its discretion, whether a service or supply is medically necessary for purposes of coverage under this Plan.

*Life-threatening refers to those sicknesses or conditions which are more likely than not to cause death within one year of the date you request treatment.

SUMMARY OF YOUR MEDICAL BENEFIT OPTIONS

	AMTRAK NETWORK PLAN		AMTRAK
COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK*	COMPREHENSIVE PLAN**
Calendar year deductible	None	**TCU, ASWC, and ARASA-OBS members:** $200 per person $600 per family **All other Agreement-Covered employees:** $100 per person $300 per family	$100 per person $300 per family
Annual out-of-pocket maximum expenses[1]	None	$1,500 per person $3,000 per family	$1,500 per person $3,000 per family
Lifetime maximum benefit	None	$1,000,000 per person	$1,000,000 per person
PREVENTIVE CARE			
Routine physical exams	$15 copay, then covered at 100%	Routine childhood immunizations, including PKU and blood stool slide, scheduled Pap smears, mammograms, rectal exams, proctosigmoidoscopy screenings, and PSAs covered at 75% after deductible (cost of exam not covered)	Routine childhood immunizations, including PKU and blood stool slide, scheduled Pap smears, mammograms, rectal exams, proctosigmoidoscopy screenings, and PSAs covered at 85% after deductible (cost of exam not covered)
Well child care	$15 copay, then covered at 100%	Not covered	**TCU, ASWC, ARASA-OBS members:** 100% of R&C cost of one annual routine exam (including diagnostic testing and immunizations in connection with such exam), up to $150, then at 75% of R&C
Routine mammography and Pap smears	Covered as part of a well-woman exam		
Well woman exam	$15 copay, then covered at 100%		
INPATIENT HOSPITAL EXPENSES (INCLUDING INPATIENT REHABILITATION FACILITY)[2]			
Room & board (semi-private)	100% for unlimited days	75%, after deductible	85%, after deductible
Other in-hospital charges	100% for unlimited days	75%, after deductible	85%, after deductible
OUTPATIENT HOSPITAL EXPENSES			
Outpatient surgical facility[2]	100%	75%, after deductible	85%, after deductible
Emergency services[3]	$15 copay (waived if admitted), then covered at 100% **TCU, ASWC, ARASA-OBS members:** $50 copay (waived if admitted)	75%, after deductible	85%, after deductible
Diagnostic X-ray and lab[2]	100%	75%, after deductible	85%, after deductible
Radiation, chemotherapy, hemodialysis[2]	100%	75%, after deductible	85%, after deductible
PHYSICIAN CHARGES			
Office visit	$15 copay, then covered at 100%	75%, after deductible	85%, after deductible
Urgent care center	$15 copay, then covered at 100%	75%, after deductible	85%, after deductible
Inpatient visit	100%	75%, after deductible	85%, after deductible
Surgery[2]			
Inpatient	100%	75%, after deductible	85%, after deductible
Outpatient	100%	75%, after deductible	85%, after deductible
Anesthesia	100%	75%, after deductible	85%, after deductible
Obstetrical care	$15 copay for 1st visit, then covered at 100%	75%, after deductible	85%, after deductible

SUMMARY OF YOUR MEDICAL BENEFIT OPTIONS (CONTINUED)

COVERED SERVICES	AMTRAK NETWORK PLAN IN-NETWORK	AMTRAK NETWORK PLAN OUT-OF-NETWORK*	AMTRAK COMPREHENSIVE PLAN*
OTHER SERVICES			
Extended care or skilled nursing facility[2]	100%, up to 60 days per calendar year (combined in-network and out-of-network maximum)	75%, after deductible, up to 60 days per calendar year (combined in-network and out-of-network maximum)	85%, after deductible, up to 31 days per confinement)
Home health care[2]	100%, no limit	75%, after deductible, up to 40 visits per calendar year	85%, after deductible
Hospice care[2]	100%	75%, after deductible	85%, after deductible
Outpatient private nursing[2]	100%	75%, after deductible	85%, after deductible
Ambulance[2]	100%	75%, after deductible	85%, after deductible
Physical Therapy	100%, after $15 copay per office visit 100% at an outpatient facility	75%, after deductible	85%, after deductible
Chiropractic care	100%, after $15 copay (15-visit limit per year for Tufts Health Plan participants)	75%, after deductible (15-visit limit per year for Tufts Health Plan participants)	85%, after deductible
Durable medical equipment[2], including foot orthotics and prosthetic devices	100%	75%, after deductible (expenses over $1,000 require pre-authorization)	85%, after deductible
PRESCRIPTION DRUGS			
Pharmacy	In-network: $2 copay for generic, $6 copay for brand name if no generic is available or physician prescribes “dispense as written;” otherwise, $6 plus the difference between generic and brand name for up to 21-day supply. Out-of-network: 75% for up to 21-day supply. **TCU, ASWC, ARASA-OBS members**: In-network: $5 copay for generic, $10 copay for brand name; Out-of-network: 75% for up to 21 day supply.		
Mail order	$5 per prescription copay for 22- to 90-day supply. **TCU, ASWC, ARASA-OBS members:** $10 copay for generic, $15 copay for brand name for 22- to 90-day supply.		
MENTAL HEALTH AND SUBSTANCE ABUSE CARE[4]			
Inpatient mental health	In-network: 100%; Out-of-network: 75%, after deductible		
Outpatient mental health	In-network: $15 copay, then covered at 100%; Out-of-network: 75%, after deductible		
Inpatient substance abuse	In-network: 100%; Out-of-network: 75%, after deductible, up to 30 days per confinement, maximum of 2 confinements per lifetime		
Outpatient substance abuse	In-network: $15 copay, then covered at 100%; Out-of-network: 75%, after deductible, up to 30 visits per year*		

* Most care paid at 75%, subject to reasonable and customary (R&C) limits.

** Most care is subject to reasonable and customary (R&C) limits. However, the amount of coinsurance the Comprehensive Plan pays depends on if you live in an area that is within a Network Plan service area. Comprehensive Plan A–The Plan pays 85% of R&C for participants who live outside of a Network Plan service area. Comprehensive Plan B–The Plan pays 75% of R&C for participants who live in areas that are serviced by the Network Plan.

1 The out-of-pocket maximums shown do not include deductibles, copays, or any penalties you may pay for failure to contact Care Coordination.

2 Care Coordination rules may apply. Benefits will be reduced by 20% if required Care Coordination procedures are not followed.

3 Benefits for non-emergencies that are treated in an emergency room and are not true emergencies are paid at a lower level by UnitedHealthcare Choice Plus (Network Plan) – Plan pays 75%, after deductible; Comprehensive Plan – Plan pays 68%, after deductible.

4 Pre-authorization rules may apply. Benefits will be reduced by 50% if required pre-authorization is not obtained.

BENEFIT DESCRIPTIONS

The following describes covered services and supplies. For your convenience, they are listed in alphabetical order.

The Plan pays up to the R&C charge for these services and supplies.

Allergy Injections
Your medical benefits cover allergy injections. If you are in the Network Plan, you will not pay a copay for the shots unless you are billed for a doctor's office visit.

Ambulatory Surgical Center Services
Your medical benefits include services given in connection with a surgical procedure at an eligible ambulatory surgical center, as long as these services are provided within 72 hours before or after the surgical procedure.

An eligible ambulatory surgical center is:

- A specialized facility established, equipped, operated, and staffed primarily to perform surgical procedures; and
- Licensed as an ambulatory surgical center by the regulatory authority responsible for licensing under the laws of the jurisdiction in which it is located.

If licensing is not required, an eligible ambulatory surgical center:

- Is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.), and permits surgical procedures to be performed by a physician who is privileged to perform the procedure in at least one hospital in the area at the time the procedure is performed;
- Requires, in all cases (except those requiring only local infiltration anesthetics), that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and the anesthesiologist/anesthetist remains present during the entire procedure;
- Provides at least one operating room and at least one post-anesthesia recovery room;
- Is equipped to perform diagnostic X-ray and lab exams or has an arrangement to obtain these services;
- Has trained personnel and necessary equipment available to handle emergency situations;
- Has immediate access to a blood bank or blood supplies;
- Maintains an adequate medical record for each patient – with the record containing an admitting diagnosis, a preoperative examination report, medical history, lab tests or X-rays, an operative report, and a discharge summary (a record is not required for patients undergoing a procedure under local anesthesia); and
- Provides full-time services of one or more registered nurses for patient care in the operating rooms and post-anesthesia recovery rooms.

An ambulatory surgical center which is part of a hospital is also considered an ambulatory surgical center for the purposes of this Plan.

Anesthetics
The Plan covers anesthetics and their administration, as well as related doctor's charges.

Birthing Center Services
You may receive benefits for medical treatment provided at an eligible birthing center in connection with a birth, including the period following delivery. See the heading **Maternity Benefits** for additional information about benefits for childbirth.

An eligible birthing center is a specialized facility designed primarily as a place for delivery of children following a normal uncomplicated pregnancy. In addition, an eligible birthing center is licensed by the regulatory authority responsible for licensing under the laws of the jurisdiction in which it is located. Also, an eligible birthing center:

BENEFIT DESCRIPTIONS (CONTINUED)

- Is operated and equipped according to any applicable state law;
- Is equipped to perform routine diagnostic and lab exams;
- Has trained personnel and necessary equipment available to handle foreseeable emergencies;
- Is operated under the full-time supervision of a doctor of medicine (M.D.), doctor of osteopathy (D.O.), or a registered nurse (R.N.);
- Maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications; and
- Maintains an adequate medical record for each patient, with the record containing prenatal history, prenatal exam, any lab or diagnostic tests, and postpartum summary.

P You must call Member Services if your stay in a birthing center is longer than 48 hours following a vaginal delivery or 96 hours following a caesarean section. See the heading **Pre-Approval** for more information.

Chemotherapy
The Plan pays benefits for chemotherapy treatments received as an inpatient or as an outpatient.

Chiropractic Care
Your medical Plan pays benefits for medically necessary care provided by a chiropractor. UnitedHealthcare will review chiropractic services periodically for medical appropriateness and limits may apply. Tufts Health Plan has a 15-visit per year limit.

Diagnostic X-Ray and Lab Tests

The Plan covers diagnostic X-rays and lab tests, subject to any deductibles and co-insurance.

Emergency Care
UnitedHealthcare Select Plus POS Plan (Network Plan)
When you are experiencing a medical emergency, your focus is naturally on getting the help you need. To help ease your mind about your medical benefits during a medical emergency, the Network Plan provides in-network level of benefits for a true medical emergency, no matter where you receive care.

Important Note: Network Plan Participants Who Are Members Of TCU, ASWC, or ARASA-OBS: The in-network copay for emergency room care will be $50 per visit for members of TCU, ASWC, or ARASA-OBS. However, the copay will be waived if you are admitted to the hospital following the emergency room visit. This in-network copay applies to participants of the Network Plan administered by UnitedHealthcare, Tufts Health Plan, and Aetna. Out-of-network care is covered at 75%, after the deductible.

BENEFIT DESCRIPTIONS (CONTINUED)

The following chart shows how benefits for emergency care are paid under the UnitedHealthcare Choice Plus POS Plan.

UNITEDHEALTHCARE SELECT PLUS POS PLAN EMERGENCY CARE PROCEDURES

SITUATION	WHERE YOU GO FOR CARE	HOW BENEFITS ARE PAID
True medical emergency*	Nearest medical facility, including an Emergency Room or Urgent Care Center	Plan pays 100% after $15 copay (waived if admitted)
Not a medical emergency	Call your network doctor who will direct you where to go for care, including an Urgent Care Center	Plan pays benefits at in-network level
	Emergency Room	Plan pays 75%, after annual deductible

* Definition of True Medical Emergency: The sudden onset of a medical condition that has acute symptoms, including severe pain or bleeding, which are serious enough that the lack of immediate medical attention could reasonably be expected to:

- Be life-threatening;
- Place your health in serious jeopardy;
- Seriously impair a bodily function; or
- Cause serious dysfunction of a bodily organ or part.

Examples of a true medical emergency include apparent chest pain, appendicitis, severe bleeding, loss of consciousness, seizures, strokes, and apparent poisoning.

Examples of non-emergency conditions include routine colds, flu, sore throat, sprains, rashes, and muscular or lower back pain.

Helpful Hint: If your condition is serious, but not life-threatening, you may want to consider going to an Urgent Care Center for treatment. An urgent care center is a facility dedicated to the delivery of unscheduled, walk-in care outside of a hospital emergency department. In most cases, the amount of time you will wait to see a doctor is much less than in an Emergency Room.

Contact the Member Services number on your medical ID card or access the UnitedHealthcare, Tufts Health Plan, or Aetna website for a list of Urgent Care Centers near you.

Tufts Health Plan POS Plan Emergency Care Procedures (Network Plan)

If you participate in the Tufts Health Plan, emergency care benefits are administered a little differently from the UnitedHealthcare Choice Plus POS Plan. Tufts Health Plan encourages, but does not require you to call your PCP following emergency medical treatment.

This means that at the onset of a serious injury or condition, a reasonable person without medical training – using practical experience alone to evaluate medical symptoms – would make the decision to seek emergency medical treatment. The injury or condition should be serious enough that it prevents a person from being able to take the time to call their PCP or for pre-approval before receiving care.

If you are experiencing an emergency, you should seek care at the nearest emergency facility. Care for an emergency is covered as follows:

BENEFIT DESCRIPTIONS (CONTINUED)

- **Outpatient care:** If you receive outpatient care for a medical emergency in an emergency room, you will be covered at the in-network level of benefits. The Plan will pay 100%, after you pay a $15 copay (waived if you are admitted as an inpatient). You, a family member, or your representative should call your PCP within 48 hours after receiving care so he/she can provide or arrange for any follow-up care that you may need.
- **Inpatient care**: If you are admitted to the hospital following emergency room treatment, you, a family member, or your representative must notify your PCP by 5:00 pm the next business day to be covered at the in-network level of benefits. If you notify your PCP within the time limit, the Plan will pay 100% at the in-network level of benefits. Otherwise, coverage will be provided at the out-of-network level of benefits (75% of R&C after the annual deductible is met).

If you are admitted to a hospital that is not in the Tufts Health Plan network, your PCP may determine that a transfer to another facility is medically appropriate. If so, he/she may have you transferred to a network hospital, or another appropriate facility. If you choose to remain in the facility where you were originally admitted after your PCP has determined that a transfer is medically appropriate, coverage for your inpatient stay will be provided at the out-of-network level of benefits.

Aetna Emergency Care Procedures (Network Plan)

Aetna administers benefits for a true medical emergency, including coverage for ambulance service, medical care, surgical treatment, hospitalization, and related health care services required to treat an injury or sudden, unexpected onset of a serious sickness. Examples of a true medical emergency include conditions that:

- Produce loss of consciousness or excessive bleeding;
- Are life-threatening or may reasonably result in physical impairment; or
- Aetna may otherwise determine to be an acute condition requiring immediate medical attention.

To receive in-network benefits for additional care, you will need to comply with the requirements for obtaining in-network benefits.

UnitedHealthcare Managed Indemnity Plan (Comprehensive Plan)

Care in an emergency room for a true emergency is covered as any other eligible medical expense. If you are admitted to the hospital following emergency room treatment, you, a family member, or your representative must contact UnitedHealthcare Care Coordination within two business days of the admission.

Benefits for non-emergency care received in an emergency room will be reduced by 20%. For example, if you are charged $100 for emergency room treatment, for most participants, the Plan would normally pay 85%, or $85, after the deductible. If it was not a true emergency, the Plan would pay 20% less, for a total reimbursement amount of $68 [$85 – ($85 x 20%)].

Eye Surgery

You may receive benefits for non-laser radial keratotomy. Additionally, the Plan pays benefits for eye surgery when it is medically necessary due to an accident or illness.

BENEFIT DESCRIPTIONS (CONTINUED)

Home Health Care Agency Services

Your medical benefits cover the following home health care services provided from qualified home health care agencies:

- Part-time or intermittent care provided by a registered nurse or home health aide, or supervised by a registered nurse;
- Physical or occupational therapy;
- Speech therapy to restore speech lost or impaired due to the removal of vocal chords, cerebral thrombosis, or brain damage caused by injury or organic brain lesion;
- Prescription drugs;
- Medical supplies; and
- X-rays and lab tests.

Benefits for home health care are different between the Network Plan and the Comprehensive Plan, as shown in the following chart:

NETWORK PLAN	COMPREHENSIVE PLAN
■ In-network – the Plan pays 100% ■ Out-of-network – the Plan pays 75%, after the deductible, up to 40 visits per calendar year	The Plan pays 85%, after the deductible

P You must obtain pre-approval before you receive home health care. See the heading **Pre-Approval** for more information.

Hospice Care

Amtrak provides benefits for hospice care when a physician certifies that the patient is terminally ill. Services must be provided to the patient in an inpatient hospice facility or the patient's home.

The following charges are covered:

- Room and board;
- Other services and supplies;
- Part-time nursing care by or supervised by a registered nurse;
- Home health care services as shown under the sub-heading **Home Health Care Agency Services** under the heading **Benefit Descriptions;**
- Counseling for the patient and covered family members* up to $1,000; and
- Bereavement counseling, up to 15 visits per family or $1,000, for covered family members. However, counseling services must be provided within six months after the patient's death.*

*To be considered a covered expense, a licensed counselor must provide the counseling services. In addition, any counseling services provided in connection with a terminal illness will not be considered mental health treatment. Benefits for counseling will be paid for you, your spouse, child, brother, sister, or parent of you or your spouse.

To qualify for benefits, the hospice agency must:

- Be approved by Medicare as a hospice;
- Be licensed according to any applicable state laws;
- Provide care 24 hours a day, seven days a week;
- Be under the direct supervision of a physician;
- Have a nurse coordinator who is a registered nurse with clinical experience in caring for terminally ill patients;
- Provide hospice services as its main purpose;
- Have a full-time administrator;
- Maintain written records of services provided to the patient; and
- Maintain malpractice insurance coverage.

BENEFIT DESCRIPTIONS (CONTINUED)

A part of a hospital that meets the above criteria will be considered a hospice.

You will **not** receive benefits for services provided by a licensed pastoral counselor to a member of his or her congregation in the course of his/her normal duties as a pastor or minister.

> **P** You must obtain pre-approval before receiving hospice care. See the heading **Pre-Approval** for more information.

Hospital Services

You may receive benefits for both inpatient and outpatient services and supplies provided by a hospital. Charges for room and board will be covered up to the hospital's daily charge for a semi-private room. The Plan pays charges for a private room when it is medically appropriate; otherwise, the Plan pays up to the charge for a semi-private room.

Inpatient hospital benefits include care in an inpatient physical rehabilitation facility and an intensive care unit.

For your care to be eligible for benefits, the hospital must be accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations and be approved by Medicare. In addition, the hospital must:

- Maintain on the premises, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of qualified physicians;
- Continuously provide 24 hour a day nursing service on the premises by or under the supervision of registered nurses; and
- Be operated continuously with organized facilities for operative surgery on the premises.

The Plan also covers pre-admission tests before you enter a hospital. See the sub-heading **Pre-Admission Testing** under the heading **Benefit Descriptions** for more information.

> **P** You must call Member Services before a scheduled inpatient hospital stay. See the heading **Pre-Approval** for more information.

Jaw Joint Disorders

Your medical benefits will cover up to $1,250 per lifetime for the treatment of temporomandibular joint (TMJ) disorder. This includes treatment of the complex muscles, nerves, and other tissues related to that joint.

Covered services and supplies include:

- Fixed or removable appliances;
- Crowns and other restorations or alterations of the tooth structure; and
- Adjustments to the appliances, crowns, and other restorations or alterations.

Mastectomy

Federal law requires a group health plan to provide coverage to an individual receiving benefits in connection with a mastectomy. This includes reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to achieve symmetry between the breasts, prostheses, and physical complications resulting from a mastectomy, including lymphedema.

Maternity Care

Amtrak medical benefits provide coverage for pregnancy and the complications of pregnancy the same as any other sickness. These benefits apply only to you or your covered spouse, not your dependent children.

BENEFIT DESCRIPTIONS (CONTINUED)

Coverage includes prenatal and postnatal care. You should call Member Services during your first trimester, but no later than one month before your expected delivery date. This allows the claims administrator to tell you about any special maternity programs they offer and to help you manage a high-risk pregnancy, if applicable.

The Plan covers charges for pregnancy and childbirth as any other illness. Under federal law, the Plan pays benefits for a hospital stay in connection with childbirth for the mother or newborn for the first:

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

Your doctor, after consulting with you, may discharge you earlier than the above requirements, if medically appropriate.

> **P** You must call Member Services if an inpatient stay in a hospital or birthing center is longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery.
>
> In addition, you should contact Member Services during the first 12 weeks of pregnancy to enroll in a healthy pregnancy program. See the heading **Special Programs** for more details.

Medical Equipment

You may receive benefits for medically necessary durable medical equipment, including appliances which replace or supplement a lost body organ or limb, orthotic devices (such as braces), rental of a wheel chair or hospital-type bed, and oxygen and rental of the required equipment.

You will need to contact Member Services to authorize equipment over $1,000.

Medical Supplies

Your benefits cover the following medical supplies:

- Surgical supplies, such as bandages and dressings;
- An appliance, such as an artificial limb, that replaces a lost body organ or part or helps an impaired one to work;
- Oxygen, the charges for providing it, and the rental of the required equipment;
- Rental of a wheelchair, hospital-type bed, or other durable medical equipment;
- Rental of a device to help paralyzed patients with their breathing;
- Blood or blood plasma when not donated or replaced; and
- Insulin pumps.

Benefits are provided for the replacement of a type of durable medical equipment once every three calendar years.

Mental Health/Substance Abuse Benefits

MHN is the network administrator for non-work related mental health and substance abuse benefits. The Plan provides two levels of benefits. You'll receive the highest level of benefits when this care is provided by MHN network providers. Out-of-network care is covered, just at a lower level. To receive the maximum out-of-network benefit available, you must comply with MHN's certification or pre-treatment assessment requirements. These are explained in more detail later.

> **Important Note:** For the purposes of mental health and substance abuse benefits, the term "in-network" refers to providers in the MHN network only. The term "out-of-network" refers to providers who are not in the MHN network. To find out if a provider is part of the MHN network, call the MHN Member Services Hotline at 1-888-AMPLAN1 or 1-888-267-5261.

Important Note: Aetna Mental Health/Substance Abuse Benefits

If you participate in the Network Plan that is administered through Aetna, mental health and substance abuse benefits are administered by Aetna Behavioral Health. For information about these benefits, call 1-800-438-2602 or access the Aetna website: www.aetna.com.

Care Received From MHN Providers

MHN offers a network of qualified mental health and substance abuse providers. To receive the in-network level of benefits, an MHN provider must deliver the care. Here are the steps to obtain in-network care:

1. Call the MHN Member Services Hotline at 1-888-AMPLAN1 or 1-888-267-5261. The Hotline is open 24 hours a day, seven days a week.
2. A clinical case manager will discuss your problem with you and give you the name and number of a qualified counselor near you.
3. You will need to make an appointment with the counselor.

Benefits for care received from an in-network provider are as follows:

	INPATIENT	OUTPATIENT
MENTAL HEALTH AND SUBSTANCE ABUSE CARE	Plan pays 100%	Plan pays 100% Office visits: $15 copay

There are no deductibles, out-of-pocket maximums, or lifetime maximums when you receive care from a network provider.

Care Received From A Non-MHN Provider

You may receive care from a provider who is not part of the MHN network; however, the level of benefits the Plan provides will be less. For example, the Plan pays a portion of the R&C cost of care, after you satisfy an annual deductible. In addition, if you obtain care from an out-of-network provider, you must file claims directly to MHN for reimbursement. See your local Human Resources representative for a supply of claim forms or contact MHN at 1-888-AMPLAN1 or 1-888-267-5261.

When you receive care from an out-of-network provider, the Plan pays benefits as follows:

	INPATIENT	OUTPATIENT
MENTAL HEALTH	Plan pays 75% of R&C*	Plan pays 75% of R&C*
SUBSTANCE ABUSE	Plan pays 75% of R&C*, up to 30 days per confinement and 2 confinements per lifetime	Plan pays 75% of R&C*, up to 30 visits per year

* Subject to the same deductible and out-of-pocket limits as any other medical expense.

Covered charges include:

- Inpatient care in a hospital;
- Outpatient care (but not prescription drugs) provided by a doctor of medicine (M.D.) or licensed mental health provider;
- Outpatient care at an outpatient clinic or treatment center; and
- The R&C cost of transportation to and from a treatment center in connection with each eligible confinement, up to a maximum of $500 per confinement. The transportation must be to a treatment center that your attending physician or qualified counselor feels offers the most appropriate, effective, and economical treatment program.

P Out-of-network benefits will be reduced by 50% if care is not pre-authorized by MHN before it is received. See the sub-heading *Pre-Authorization Of Treatment* under the heading **Mental Health/ Substance Abuse Benefits** for more information.

Annual Deductible, Out-Of-Pocket Limit, And Lifetime Maximum

The annual deductible, out-of-pocket limit, and lifetime maximum are the same as under the Comprehensive Plan or out-of-network care under the Network Plan. In other words, expenses paid for mental health/substance abuse care will count toward the deductible, out-of-pocket limit, and lifetime maximum for out-of-network benefits under the Network Plan or the Comprehensive Plan.

Pre-Authorization Of Treatment

Before receiving out-of-network services, your care must be pre-authorized. To obtain a pre-treatment outpatient assessment or to pre-certify an inpatient stay, call MHN Member Services at 1-888-AMPLAN1 (1-888-267-5261). To receive the full benefit amount, you must pre-authorize all mental health and substance abuse care.

If you receive care from an in-network provider that is not pre-authorized, **no benefits will be paid**. If your out-of-network care is not pre-authorized, your benefits will be reduced by 50% of the R&C charges, provided MHN determines the services were medically necessary. The following chart shows how benefits will be paid if care is not pre-authorized.

	IN-NETWORK	OUT-OF-NETWORK	
		INPATIENT*	OUTPATIENT
MENTAL HEALTH	Plan pays $0	Plan pays 38% of R&C	Plan pays 38% of R&C
SUBSTANCE ABUSE	Plan pays $0	Plan pays 38% of R&C, up to 30 days per confinement and 2 confinements per lifetime	Plan pays 38% of R&C, up to 30 visits per year

* If you have reached the out-of-pocket limit, the Plan will pay 50% of the cost of inpatient care for the rest of the calendar year.

When your care is pre-authorized by MHN, your provider will submit claims directly to the claims administrator for payment. If your care is not pre-authorized, you must submit a claim form to MHN for benefits to be paid.

Important Note: If your benefits are reduced because care was not pre-authorized, these benefit reductions will not apply toward your annual out-of-pocket maximum.

Alcohol Treatment Center

The Plan pays benefits for inpatient room, board, and treatment for up to 30 days for each confinement, up to two confinements per lifetime. If you voluntarily leave an approved treatment program before it is completed, the Plan will only pay benefits up to $100 per day, up to 30 days of that confinement.

The Plan also pays benefits for services and supplies of a treatment center or outpatient clinic when a licensed counselor provides care. These benefits are limited to up to 30 episodes of treatment during each benefit period, with a maximum of two benefit periods per lifetime when care is received from a non-MHN provider.

BENEFIT DESCRIPTIONS (CONTINUED)

? **Definition:** An episode of treatment is a period in which service or treatment is provided as part of a treatment program. The treatment may involve just the patient, the patient and immediate family, or just the immediate family. The immediate family includes your spouse and children. If the care is for a dependent child, immediate family also includes the child's parents and brothers and sisters.

? **Definition:** A benefit period is a 12-month period that begins on the date you incur the first expense for covered outpatient treatment.

Emergency Care

If you have an emergency, contact MHN Member Services at 1-888-AMPLAN1 (1-888-267-5261). A clinical manager will direct you to the nearest emergency room. If you cannot call MHN Member Services first and you are admitted to the hospital for treatment, you (or someone acting on your behalf) must call MHN Member Services within two business days of the admission.

Submitting Claims

When you receive care through an MHN network provider, you do not have to submit a claim – it will be done for you. For out-of-network care that is pre-authorized, your provider will submit the claim for you. If you receive care from an out-of-network provider and the care is not pre-authorized, you will have to complete a claim form for benefits to be paid. Claim forms are available from the Amtrak Benefits Department, your local Human Resources Department, or MHN.

Attach a receipt to the claim form and mail it to the following address:

MHN
P. O. Box 14621
Lexington, KY 40512-4621
1-888-267-5261

Important Note: Do not submit claims for out-of-network mental health or substance abuse care to UnitedHealthcare or Tufts Health Plan for reimbursement. Send them directly to MHN.

Nursing Services

Your benefits include the services of a nurse or mid-wife. However, benefits are not paid for services provided by a trained nurse for outpatient mental health or substance abuse care when it is obtained out of the UnitedHealthcare or Tufts Health Plan network under the Network Plan. For additional information, see the heading **Mental Health/Substance Abuse Benefits**.

Occupational Therapy

Occupational therapy services are covered when your doctor recommends them as part of a medically necessary course of treatment for accidental bodily injury or disease.

Organ/Tissue Transplants

Amtrak provides benefits for medically necessary organ/tissue transplants for both the recipient and the donor, as long as certain requirements are met.

P You must call Member Services as soon as reasonably possible, but at least seven business days before the scheduled date of any of the following related to an organ transplant:

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant procedure.

See the heading **Pre-Approval** for more information.

Important Note: Benefits for eligible expenses are **paid at 100%** if provided at a facility that is part of the **United Resource Transplant Network** (for UnitedHealthcare participants) or **Tufts Health Plan Centers of Excellence** (for Tufts Health Plan participants). Otherwise, these benefits are subject to Plan copays, coinsurance, and deductibles.

Facilities in the United Resource Transplant Network or Tufts Health Plan Centers of Excellence have demonstrated clinical excellence in the field of transplants, including pediatric transplants.

For Aetna participants, the Aetna medical director must pre-certify the transplant, and the facility where the transplant is to be performed must be an Aetna-approved transplant facility.

Donor Charges For Organ/Tissue Transplants

In the case of an organ or tissue transplant, donor charges are considered covered expenses **only** if the recipient is a covered employee/dependent of Amtrak. If the recipient is not a covered employee/dependent, benefits are not payable for donor charges.

The search for bone marrow/stem cells from a donor who is not biologically related to the patient is not considered a covered service unless the search is made in connection with a transplant procedure arranged by a designated transplant facility. (**Exception:** Tufts Health Plan will cover up to 10 searches for a match that is not biologically related. Benefits may be paid for more than 10 searches if approved by a Tufts Health Plan authorized reviewer – call the Member Services number on your ID card for more information).

Qualified Procedures

The following are qualified procedures that are covered under your medical benefits:

- Heart transplants;
- Lung transplants;
- Heart/lung transplants;
- Liver transplants;
- Kidney transplants;
- Pancreas transplants;
- Kidney/pancreas transplants;
- Bone marrow/stem cell transplants; and
- Other transplant procedures when the claims administrator determines that it is medically appropriate to perform the procedure at an approved facility.

BENEFIT DESCRIPTIONS (CONTINUED)

Medical Care And Treatment

Your medical benefits cover the following services provided in connection with a transplant procedure:

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

* Benefits may be slightly different under Tufts Health Plan or Aetna. Contact Tufts Health Plan or Aetna Member Services for more information.

Transportation And Lodging

As part of the organ/tissue transplant benefits, charges for travel and lodging at an approved facility are paid by the Plan. These benefits are not paid when received at a facility that is not approved by the claims administrator.

The following requirements apply to these transportation and lodging benefits:

- The procedure is one of the qualified procedures outlined earlier;
- The procedure is medically necessary; and
- The procedure is performed at an approved facility.

If you meet these requirements, the claims administrator will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging, and meals for the transplant recipient and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up;
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people;
- Travel and lodging expenses are only available if the transplant recipient lives more than 50 miles (100 miles for Aetna) from the designated transplant facility;
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered, and lodging and meal expenses will be reimbursed up to the $100 per diem rate; and
- There is a combined overall lifetime maximum of $10,000 per covered person for all transportation, lodging, and meal expenses incurred by the transplant recipient and any approved companion(s).

Outpatient Rehabilitation Facility

The Plan pays benefits for care at a comprehensive outpatient rehabilitation facility, provided the facility's primary purpose is to provide diagnostic, therapeutic, and restorative services. These services are to rehabilitate you if you are sick or injured.

An eligible outpatient rehabilitation facility:

- Is approved by Medicare as a comprehensive outpatient rehabilitation facility;
- Provides the services of a doctor on a full-time or part-time basis;
- Provides physical therapy and social or psychological services;
- Requires that every patient be under the care of a doctor;

- Is established and operated according to applicable licensing and other laws; and
- Has policies established by a group of professional personnel associated with the facility. This group must include at least one doctor who governs the facility and is responsible for carrying out the policies.

Rehabilitation facilities must also be accredited by the Commission on Accreditation of Rehabilitation Facilities.

Physical Therapy

You will receive benefits for the services of a licensed physical therapist, provided that:

- Your PCP (if required) refers you to an in-network physical therapist (Tufts Network Plan participants only);
- The therapy is ordered and monitored by your physician;
- The therapy is provided according to a written treatment plan that has been approved by your physician; and
- The therapist submits progress reports to the physician at the intervals stated in the treatment plan.

The Plan also covers massage therapy.

Physician Service

Benefits will be paid for services provided by a doctor in connection with surgical procedures and other medical care. This includes a doctor's visit while you are in a hospital, as well as visits you make to a doctor's office or urgent care center.

> **Important Note:** If you are a Tufts Network Plan participant and you wish to see a doctor other than your PCP, you will need a referral from your PCP. Without a referral from your PCP, benefits will be paid at the out-of-network level.

Pre-Admission Testing

The Plan pays benefits for tests performed in a hospital before you are admitted as an inpatient. To be covered, these tests must be related to a scheduled surgery. In addition, your doctor must order the tests after he/she has diagnosed your condition and determined you require surgery. Your doctor must also request the hospital admission and have the hospital confirm this admission.

Benefits are paid when you are admitted to the hospital. However, if you are not admitted to the hospital for the following reasons, benefits will still be paid if:

- A hospital bed is not available; or
- Your condition changes which makes it necessary to postpone or cancel the surgery.

Prescription Drugs

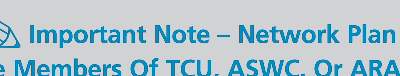
When you participate in any Amtrak medical option, Caremark administers your prescription drug benefits. Caremark offers you two choices when filling your prescriptions:

- A large network of over 44,000 retail pharmacies for short-term prescriptions for you and your dependents; and
- Mail-order pharmacy for maintenance or long-term prescriptions you or your dependents take on an ongoing basis.

Retail Pharmacy

When you use a pharmacy that participates in Caremark's CareSelect network, you pay only $2 per prescription for up to a 21-day supply of generic drugs. If no generic is available or your doctor prescribes "dispense as written," you pay a $6 copay for the brand name drugs. If generic is available and you choose a brand name drug instead, you pay the $6 **plus** the difference in cost between the brand name and its generic equivalent.

BENEFIT DESCRIPTIONS (CONTINUED)



Important Note – Network Plan Participants Who Are Members Of TCU, ASWC, Or ARASA-OBS:
The copay for up to a 21-day supply of prescription drugs filled at a retail pharmacy is $5 for a generic drug and $10 for a brand name drug.

You must use a Caremark CareSelect network pharmacy to receive these prescription drug benefits. If you choose to use a pharmacy that is not in the Caremark network, you will have to pay the full cost of the prescription. Then, when you submit a claim form, you will be reimbursed for up to 75% of the cost for up to a 21-day supply. You are responsible for the remaining cost.

Mail Order Program
When you use the Caremark mail order program, you pay only $5 per prescription for up to a 90-day supply. This feature offers a convenient and cost-effective way to get long-term or maintenance medications. For example, you may order refills by phone (1-800-378-0182), mail, or the Internet (www.rxrequest.com).

Important Note – Network Plan Participants Who Are Members Of TCU, ASWC, Or ARASA-OBS:
The copay for up to a 90-day supply of prescription drugs filled through the mail order program is $10 for a generic drug and $15 for a brand name drug.

Therapeutic Services Disease Management Program
There are certain medications for specific diseases that may not be available through regular retail pharmacies. Caremark's Therapeutic Services Disease Management Program is designed to help you receive the medications you need to control your condition. If you are taking medications for the following conditions:

- Multiple sclerosis;
- Growth deficiencies;
- Cystic fibrosis and genetic emphysema;
- Hemophilia;
- Rheumatoid arthritis;
- Hepatitis C; or
- Respiratory Syncytial Virus (RSV),

contact Caremark Therapeutic Services at 1-800-237-2767 for information on how to receive these medications. You will be assigned a CareTeam of professionals to help you manage your prescription drug needs.

Viagra
The Plan covers Viagra when it is medically necessary for male erectile dysfunction and is dispensed as follows:

- **At a retail pharmacy**: you may receive one prescription of up to six pills in a 21-day supply; and
- **Through the mail order program:** you may receive up to 24 pills in a 90-day supply.

Before filling a prescription for Viagra, your pharmacist will contact Caremark for pre-authorization. Pre-authorization may take up to three business days.

Drugs Covered Under Mail Order Only
In some cases, benefits are provided only when the prescription is filled through the mail order program. In some cases, an exception may be made for you to receive a "one-time only" fill of the initial prescription. However, all subsequent refills will be available through mail order only.

The medications covered through mail order only are as follows:

- Diabetic supplies and devices (such as insulin, lancets, test strips, syringes, needles, etc.);
- Medically necessary diet medications;
- Oral/injectable contraceptives, except for the first time a prescription is filled;
- Medically necessary fertility medications;

BENEFIT DESCRIPTIONS (CONTINUED)

- Retin A or Renova (limited to patients age 25 and under and if medically necessary for patients over age 25);
- Prescription smoking cessation products (up to two courses of treatment per lifetime);
- Prescription vitamins (including prenatal vitamins);
- Viagra (however, the first six pills can be received through a retail pharmacist, as explained earlier); and
- Non-insulin syringes.

If you receive any of the above drugs through a retail pharmacy, benefits will not be paid.

Drugs That Are Not Covered

Benefits are provided for all federally-approved and legend drugs, except as follows:

- Drugs that are not provided for the treatment of an injury, illness, or pregnancy;
- Drugs that are not medically necessary;
- Drugs that are available over the counter;
- Drugs used for weight control, unless they are medically necessary;
- Drugs to treat infertility and vitamin supplements, except when they are medically necessary and are filled through the mail order program;
- Prescription nicotine suppressants, except for two courses of treatment per lifetime, when they are ordered from the Caremark mail order pharmacy. Non-prescription nicotine suppressants are not covered by the Plan;
- Allergy serum, immunizations, vaccines, biologicals, and biological sera;
- Alcohol wipes;
- Hair loss products (such as Propecia);
- Blood plasma;
- Toxoids;
- Prescribed devices and supplies, of any type, including colostomy supplies (covered as durable medical equipment as part of your medical coverage), hypodermic needles, and syringes. However, the Plan covers needles and syringes prescribed for the administration of insulin and other needles and syringes prescribed by your doctor and ordered through the Caremark mail order feature;
- Drugs given by a doctor either in his/her office or as part of a home health care visit;
- Drugs, including take-home drugs, given by a hospital, skilled nursing facility, home health agency, or similar place that is not a pharmacy, but has its own drug dispensary;
- Injectables (other than insulin when it is ordered from the Caremark mail order pharmacy);
- Progesterone suppositories;
- Drugs received from a retail pharmacy that are covered through the mail order program only; and
- Viagra, except as described earlier.

Helpful Hint: You may be able to take advantage of tax-free reimbursement by a Health Care Spending Account for many drugs that are not covered by your medical benefits. See **Section 7: Spending Accounts** for more information.

BENEFIT DESCRIPTIONS (CONTINUED)

Preventive Care

In-Network Benefits

Your medical benefits cover the following preventive care services when obtained from a network provider:

- Routine physical exam (every 12 months) for you and your eligible spouse, including diagnostic tests and immunizations*;
- Routine well child care, including a physical exam and immunizations*; and
- One routine well-woman exam every calendar year. A well-woman exam may be given by your PCP or network gynecologist (this exam is not covered if you receive it out-of-network). You do not need a referral to see a network gynecologist for an annual well-woman exam. A well-woman exam includes a breast exam and/or mammogram, pelvic exam, and Pap smear. Tufts participants: additional treatment will require a referral from your PCP.

* includes Hepatitis B vaccine

> **Important Note:** Preventive care tests, screenings, and procedures that are not provided as part of a routine, preventive care exam will not be covered at the preventive care benefits level.

Out-of-Network And Comprehensive Plan Benefits

The following preventive care services are covered when obtained out-of-network or if you participate in the Comprehensive Plan:

- Routine childhood (age six and under) immunizations that are approved by the Center for Disease Control and Prevention and the American Academy of Pediatrics;
- One routine Pap smear each calendar year;
- Mammograms according to the following schedule:
  - One baseline mammogram for women from age 35 through 39;
  - One mammogram every two years for women from age 40 through 49 (can be more frequent if recommended by a doctor);
  - One mammogram every year for women age 50 and older;
- One annual digital rectal exam at age 40 or older;
- One annual stool blood slide test after age 49;
- One proctosigmoidoscopy every three years after age 49; and
- Prostate specific antigen (PSA) tests for men age 50 and older.

Covered services include the cost of the actual test as listed above, but not the cost of the office exam if the test is performed as part of an office exam.

In addition to the preventive care coverage outlined above, Amtrak also covers the cost of Lyme Disease vaccinations to members represented by the Brotherhood of Maintenance of Way Union. Claims for this benefit are processed differently than for other medical benefits. For information about filing claims for Lyme Disease vaccinations, contact the Amtrak Benefits Service Center at 1-800-481-4887.

> **Important Note – Network Plan Participants Who Are Members Of TCU, ASWC, Or ARASA-OBS:**
> The Plan will cover 100% of the reasonable and customary cost of one annual routine physical exam received out-of-network, up to $150. Any amounts over $150 will be paid at 75%.

BENEFIT DESCRIPTIONS (CONTINUED)

Private Duty Nursing

The Plan covers private duty nursing care when provided on an outpatient basis by a licensed nurse – RN, LPN, or LVN.

> **P** You should notify Member Services before receiving private duty nursing care. See the heading **Pre-Approval** for more information.

Psychological Services

See the sub-heading **Mental Health/Substance Abuse Benefits** under the heading **Benefit Descriptions** for information.

Radial Keratotomy

You may receive benefits for treatment of the eye by non-laser radial keratotomy (non-photorefractive keratectomy or laser assisted in situ karatomileusis (lasik) surgery). Benefits are paid for eye surgery when medically necessary due to an accident or sickness.

Radiation Therapy

Benefits are provided for radiation therapy treatment by X-ray, radium, or any other radioactive substance.

Skilled Nursing Facility

Your benefits include care in an approved skilled nursing facility. Covered services include room and board in an approved facility and other related services and supplies. Room charges are paid up to the facility's regular daily charge for a semi-private room. Benefits are paid for a private room when medically necessary.

> **P** You should contact Care Coordination before receiving care in a skilled nursing facility. See the heading **Pre-Approval** for more information.

The Network Plan provides benefits for up to 60 days per calendar year (combined in-network and out-of-network maximum). The Comprehensive Plan provides benefits for up to 31 days per confinement.

An approved skilled nursing facility is one that has been approved by Medicare and:

- Is operated under the applicable licensing and other laws of the state in which it operates;
- Is under the full-time supervision of a physician or registered nurse;
- Is regularly engaged in providing room and board and 24-hour-a-day skilled nursing care of sick or injured persons at the patient's expense during a convalescent state of an illness or injury;
- Maintains a daily record of each patient who is under the care of a licensed doctor; and
- Is authorized to administer medications to patients on the order of a physician.

In addition, the facility cannot be:

- A home for the aged, blind, or deaf;
- A hotel;
- A domiciliary care home;
- A maternity home; or
- A home for alcoholics, drug addicts, or the mentally ill.

A part of a hospital that meets the above criteria is also considered an approved skilled nursing facility.

Speech Therapy

Benefits are provided for services provided by a licensed speech therapist to restore speech that has been lost or impaired due to:

- Removal of vocal chords;
- Cerebral thrombosis (cerebral vascular accident);
- Brain damage due to injury, including brain damage at birth or organic brain lesion (aphasia);
- Surgery, radiation, or other treatment which affects the vocal chords; or
- Accidental injury.

BENEFIT DESCRIPTIONS (CONTINUED)

Important Note – Members Of TCU, ASWC, Or ARASA-OBS:
The Plan will cover speech therapy for children under age three to treat infantile autism, developmental delay, cerebral palsy, hearing impairment, and major congenital anomalies as follows:

Network Plan
In-network: 100%
Out-of-Network: 75%

Comprehensive Plan
85%, after deductible (75%, after deductible, if you live in a network service area)

Substance Abuse

See the sub-heading **Mental Health/Substance Abuse Benefits** under the heading **Benefit Descriptions** for information.

Surgery

You may receive benefits for inpatient and outpatient surgery. Benefit payments may differ if more than one procedure is performed during the same operation.

P You need to contact Member Services before inpatient or outpatient surgery. If more than one surgical procedure is to be performed, your Case Manager can let you know how benefits will be paid. See the heading **Pre-Approval** for more information.

Transportation Services

When it is medically necessary, you may receive benefits for transportation to and from a medical facility in your area. If there is no local facility equipped to provide the care you need, your benefits cover transportation to and from the nearest facility outside your local area that is qualified to provide the treatment you need.

If the transportation is needed to provide treatment for mental health or substance abuse care, benefits are paid up to $500 per confinement.

Urgent Care Facility

Charges for care in an urgent care facility are covered.

ELIGIBLE PROVIDERS

The Plan pays benefits when care is provided by a licensed provider who meets the following requirements:

- **Licensed Counselor:** a person who specializes in mental disorder treatment and is licensed as a Licensed Professional Counselor (L.P.C.) or Licensed Clinical Social Worker (L.C.S.W.).
- **Nurse-Midwife**: a person who is licensed or certified to practice as a nurse-midwife and who is licensed by a board of nursing as a registered nurse and has completed a program approved by the state for the preparation of nurse-midwives.
- **Nurse-Practitioner:** a person who is licensed or certified to practice as a nurse-practitioner and who is licensed by a board of nursing as a registered nurse and has completed a program approved by the state for the preparation of nurse-practitioners.
- **Physician:** a legally qualified:
  - – Doctor of Medicine (M.D.) (includes psychiatrists);
  - – Doctor of Chiropody (D.P.M. or D.S.C.);
  - – Doctor of Dental Surgery (D.D.S.);
  - – Doctor of Medical Dentistry (D.M.D.);
  - – Doctor of Osteopathy (D.O.); and
  - – Doctor of Podiatry (D.P.M.).
- **Primary Care Physician (PCP) – Tufts Only:** a physician in general practice or who specializes in pediatrics, family practice, or internal medicine. This doctor has agreed with the claims administrator to act as the entry point to the health care delivery system. A PCP will coordinate his/her patient's care. A PCP is not an agent or employee of the claims administrator.

ELIGIBLE PROVIDERS (CONTINUED)

- **Psychologist:** a person who specializes in clinical psychology and is licensed or certified as a psychologist or is a member or fellow of the American Psychological Association.

The Plan also covers services of a provider, if those services are:

- Listed as covered services; and
- Within the scope of the provider's license.

Examples may include physical, occupational, and speech therapists.

WHAT IS NOT COVERED

The following charges, services, or supplies are not covered under the Amtrak medical options.

Abortions
Abortions are not covered for dependent children unless the pregnancy is a result of rape or incest, as defined by the state in which the child lives.

Cosmetic/Reconstructive Surgery
You will not receive benefits for cosmetic or reconstructive surgery or treatment except when needed to correct a deformity caused by:

- A birth defect;
- A mastectomy; or
- Surgery to restore a bodily function.

Benefits are not paid for:

- Cosmetic or reconstructive surgery performed for psychological or emotional reasons;
- Liposuction, abdominoplasty, or rhytidectomy;
- Non-medically necessary surgical treatment of obesity, breast augmentation/reduction, eyelid blepharoplasty; and
- Gastric bypass, except when medically necessary.

Custodial Care
You will not receive benefits for care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment. Benefits are not paid if this care can safely and adequately be provided by someone who does not have the technical skills of a qualified health care professional.

Care that meets this definition is custodial care, regardless of:

- Who recommends, provides, or directs the care;
- Where the care is provided; or
- Whether or not the patient can be or is being trained to care for him/herself.

Dental Services
The Medical Plan does not cover care and treatment of the teeth and gums, except:

- Hospital, radiology, and pathology services while you are confined as an inpatient in a hospital for dental surgery or within 72 hours of dental surgery;
- Full or partial dentures, fixed bridgework, or to repair natural teeth if needed because of an injury to natural teeth that happens while you are covered under this Plan; and
- Charges for treatment of jaw joint disorders unless specifically outlined in this section of the handbook (see the sub-heading **Jaw Joint Disorders** under the heading **Benefit Descriptions**).

Helpful Hint: See **Section 5: Dental Benefits** for information about dental care benefits.

WHAT IS NOT COVERED (CONTINUED)

Dependent Expenses

The Plan provides benefits for your covered dependent spouse and children, except in the following cases:

- A dependent child's pregnancy or the resulting childbirth, abortion, or miscarriage (except when the pregnancy is the result of rape or incest as defined in the state where the child lives);
- If your dependent child is covered under the Plan as an employee; and
- Services or supplies for which your dependent child or spouse is entitled to receive benefits under any workers' compensation or similar law.

Donor Expenses

The Plan does not cover expenses incurred by an organ donor except as described under the sub-heading **Organ/Tissue Transplant** under the heading **Benefit Descriptions**.

Ecological Or Environmental Medicine

You will not receive benefits for the following ecological or environmental medicine, diagnosis, and/or treatment:

- Chelation therapy, except to treat metal poisoning;
- Chemical analysis of hair or nails;
- Gastrogram;
- Heidelberg capsule;
- Cytotoxic, sublingual, or wrinkle allergy testing; and
- Environmental chemical screening for toxins and allergens.

Educational Or Developmental Services

The Plan does not cover examinations, evaluations, or services for educational or developmental purposes, except as may be provided, as described under the heading **Speech Therapy**.

Experimental Or Investigational Treatments

The Plan does not pay benefits for medical care, surgical care, diagnostic care, psychiatric care, substance abuse care, other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that are considered experimental or investigational.

The above are considered experimental or investigational when they are not approved by the appropriate government or medical oversight organizations (such as the U.S. Food and Drug Administration, American Medical Association, National Institutes of Health, etc.) and do not meet the criteria established by the claims administrator. In addition, the claims administrator has the final say about what is considered experimental or investigational and how benefits may be applied.

Facility Charges

The Plan does not cover facility charges or related services if the procedure being performed is not a covered service.

Family Members

Treatment given by a member of your family is not covered. Family members include your spouse, children, siblings, and parents of either you or your spouse.

Foot Conditions

Benefits will not be paid for services to treat:

- A weak, strained, flat, unstable, or imbalanced foot, or for a metatarsalgia or bunion (this does not apply to charges for an open cutting operation); or
- One or more corns, calluses, or toenails (this does not apply to charges for the removal of all or part of one or more nail roots or services in connection with treatment of a metabolic or peripheral vascular disease).

Foot orthotics are considered a covered expense.

Government Hospital

The Plan does not pay benefits for treatment in a U.S. government or agency hospital, unless the federal or state government or one of its agencies is authorized by law to charge the Plan for the services provided.

Hearing Care

This Plan does not cover ear examinations, hearing aids, or cochlear implants, or diagnosis or treatment of hearing loss. However, these services and supplies are covered if they are needed to repair hearing damages caused by a bodily injury that occurred while you are covered under the Plan.

Hospital Special Care Areas

You will not receive benefits for services and supplies received in a hospital **during a confinement** in an area of the hospital that is used as a special care area. These areas include (but are not limited to) the following:

- Adult or child day care center;
- Halfway house;
- Vocational rehabilitation center;
- Ambulatory surgical center;
- Birth center; and
- Any other area of a hospital that provides care on an inpatient basis for other than acute care of the sick, injured, or pregnant persons.

Benefits may be available with respect to the above facilities if care is received through covered facilities other than hospitals.

Infertility Treatment

This Plan does not pay benefits for procedures which facilitate pregnancy, such as in vitro fertilization, embryo transfer procedure, artificial insemination, or immunotherapy for treatment of infertility.

Medicare

If Medicare is your primary medical insurance, amounts that are payable under Medicare will not be paid under the Amtrak medical options. However, this Plan will pay the difference between the amount payable under Medicare and the amount this Plan would pay if Medicare coverage was not available. For example, if Amtrak paid 80% of a claim amount and Medicare covers this amount at 70%, Amtrak medical benefits will pay up to 10%, for a combined total of 80%.

This exclusion does not apply to employees affected by the Medicare Working Age Provision. See the heading **When You Become Eligible For Medicare** in **Section 12: Administrative Information** of this handbook for more information.

No Legal Obligation

The Plan will not pay benefits for services and supplies you are not legally required to pay. In addition, you will not receive benefits for services and supplies for which you would not have been charged if you did not have this coverage. The only exception is if the U.S. government or one of its agencies is authorized by law to charge this Plan for the services provided.

Nutritional Counseling

You will not receive benefits for nutritional counseling under this Plan.

In addition, enteral feedings are not covered unless they are the sole source of nutrition and/or when a certain nutritional formula treats a specific inborn error of metabolism.

On-Duty-Injury Claims

You will not receive benefits from this Plan for medical, mental health/substance abuse, and prescription drug services and supplies for treatment of an injury that occurred while on duty at Amtrak. **See Section 10: On-Duty Injury Coverage** of this handbook for information about how these services and supplies are covered.

WHAT IS NOT COVERED (CONTINUED)

Personal Items
Costs for personal comfort or convenience items, such as telephones and televisions are not covered under the Plan.

Preventive Care
Except as outlined earlier, the Plan does not cover preventive care out-of-network under the Network Plan or under the Comprehensive Plan. See the sub-heading **Preventive Care** under the heading **Benefit Descriptions** for more information.

Radial Keratotomy
Benefits are not paid for non-photorefractive keratectomy or laser assisted in situ karatomileusis (lasik) surgery. However, non-laser surgery is covered when medically necessary.

Sex-Change Surgery
This Plan does not cover sex-change surgery.

Speech Therapy
Except for those services outlined under the sub-heading **Speech Therapy** under **Benefit Descriptions**, this treatment is not covered.

Sterilization (And Reversal)
You will not receive benefits for sterilization (except to avoid a life-threatening condition) or reversal of sterilization.

Vision Care
Medical benefits are not paid for eye examinations, glasses, or contact lenses, or diagnosis or treatment of refractive errors unless these procedures are needed to repair damages caused by bodily injury that you incurred while covered under this Plan.

> **Helpful Hint:** See **Section 6: Vision Benefits** for information about vision care benefits.

Weight Control
This Plan does not cover a weight reduction or control program. It also does not cover prescription drugs for weight control unless medically necessary.

PRE-APPROVAL

If you receive care that is not coordinated by a network provider (Tufts Plan: a PCP must coordinate care) under the Network Plan or if you are enrolled in the Comprehensive Plan, your benefits are subject to pre-approval guidelines. If your doctor recommends certain kinds of care, you will need to contact Member Services by calling the toll-free number on your ID card.

When you call Member Services, the doctors and nurses at this service will help you:

- Understand your medical care choices and options;
- Confirm how benefits will be paid for the procedure or treatment;
- Avoid unneeded hospital stays and surgery; and
- Find network providers.

(See the sub-heading **Mental Health/Substance Abuse Benefits** under the heading **Benefit Descriptions** in this handbook section for information about pre-authorizing mental health and substance abuse care.)

Important Note: There may be some differences in the way UnitedHealthcare, Tufts Health Plan, and Aetna pre-approve care. UnitedHealthcare, Tufts Health Plan, and Aetna have different pre-approval requirements. It's always a good idea to contact Member Services (the phone number on your ID card) if you are not sure if you should call before a treatment or procedure.

You and your doctor are the ultimate decision-makers when it comes to your medical care. Your case manager will determine if a service or supply is covered under the Plan.

No benefits are payable if your case manager determines a service or supply is not a covered expense. However, approval by your case manager does not guarantee that benefits are payable under this Plan. Benefits are based on:

- If the service or supply is covered under the Plan;
- Your eligibility (or your dependent's eligibility) under this Plan on the date the service or supply is provided; and
- The copays, coinsurance, deductibles, maximum limits, and other terms of this Plan.

Admissions And Procedures That Require Pre-Approval
To get maximum benefits, you must request pre-approval before you receive the following care:

- Non-emergency hospitalization – admission to a hospital or skilled nursing facility;
- Non-emergency procedures – procedures that cannot be performed in the doctor's office on the same day;

If you participate in the Tufts Health Plan, you do not need to call the Tufts Case Management before these procedures. However, you do need to call Tufts Case Management for inpatient procedures or if the treatment is considered experimental.

- Pregnancy – call to enroll in the Healthy Pregnancy Program if you are a UnitedHealthcare participant or the Healthy Birthday[sm] Program if you are a Tufts Health Plan participant (explained in more detail under the heading **Special Programs**). You (or your spouse) should call to enroll within the first 12 weeks of pregnancy to get the full benefit of the program;
- Private duty nursing and home health care;
- Hospice care;
- Organ transplant; and
- Inpatient or outpatient surgery.

How To Begin The Pre-Approval Process
If you are enrolled in the Comprehensive Plan or seek medical care out of the network under the Network Plan, you are responsible for notifying Member Services.

You begin the pre-approval process by calling the Member Services number on your ID card.

Your case manager will confirm whether or not your care is covered under the Plan and what possible treatment options are available to you.

PRE-APPROVAL (CONTINUED)

When To Request Pre-Approval

You should notify Member Services as far in advance of the procedure as you can. The following is a list of procedures or inpatient stays that require you to obtain pre-approval:

- Scheduled inpatient stay;
- Emergency inpatient admission;
- Pregnancy and childbirth;
- Organ and/or tissue transplant;
- Hospice care;
- Durable medical equipment (if the cost is more than $1,000);
- Reconstructive procedures; and
- Dental service needed due to an accident.

The information that follows provides additional details about when to obtain pre-approval.

Inpatient Stay

If you are scheduled to be admitted to a hospital, hospice, birthing center (only if a stay following delivery is longer than 48 hours following a vaginal delivery or 96 hours following a cesarean section), or skilled nursing facility, you need to obtain pre-approval at least five business days (14 days for Aetna participants) before the date of your admission. In some cases, the date of your inpatient stay may not have been determined when you first contacted Member Services. If so, you must call Member Services again as soon as the admission date is set.

Emergency Admissions

If you are admitted to the hospital because of a medical emergency, you, a family member, or your representative need to call Member Services within two business days of your admission (by 5:00 pm the next business day if you are a Tufts Health Plan participant or within 48 hours if an Aetna participant). If it is not possible to call within the required time, you, a family member, or your representative need to call as soon as reasonably possible.

Pregnancy And Childbirth

You should call Member Services during the first 12 weeks (trimester) of pregnancy. This early notification makes it easier for you or your spouse to participate in prenatal programs.

You must contact Member Services about the delivery of your child only if the hospital/birthing center stay is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section. If the stay goes beyond the 48/96-hour limits, you must contact Member Services before the end of the 48/96-hour limit.

Organ/Tissue Transplants

You must obtain pre-approval as soon as possible and at least seven business days (14 days for Aetna participants) before the scheduled date of the following:

- Evaluation;
- Donor search;
- Organ procurement/tissue harvest; and
- Transplant.

If it is not possible to obtain pre-approval within seven days, you must do so as soon as reasonably possible.

PRE-APPROVAL (CONTINUED)

Penalty If You Don't Obtain Pre-Approval

If you do not obtain pre-approval before a treatment, procedure, or admission when it is required, your benefits for that procedure will be reduced by 20%. For example, after the annual deductible, out-of-network care will be paid at 60% and benefits under the Comprehensive Plan will be paid at 68%.

The reduction in benefits will not be included in your annual out-of-pocket limit.

You may appeal a decision by calling the Member Services number on your ID card.

Appealing A Decision

If you or your doctor don't agree with a pre-approval decision, you may appeal the decision.

For complete details about appealing a medical decision, see the heading **Claims Processing** in **Section 12: Administrative Information.**

Personal Health Support

UnitedHealthcare Participants

If you or a covered family member experience a serious illness or injury that could result in a long-term inpatient stay, you may be assigned a case manager. Your case manager will help you determine the best course of treatment, and he or she will advise you of alternative treatments that may be appropriate. Your case manager will also help you work through any notification requirements.

Tufts Health Plan Participants

Tufts Health Plan may develop an individual case management (ICM) plan designed especially for you or a covered family member who has a severe illness or injury. Tufts Health Plan Case Management will determine the need for an ICM plan.

The ICM plan authorizes services and supplies that may not otherwise be covered by the Plan. However, the ICM plan does not change the benefits covered under the Plan, except where specified in the ICM plan.

Case Management may develop an ICM plan if:

- The ICM plan services and supplies are medically necessary;
- The ICM plan services and supplies will sustain or improve your condition and are reasonably expected to be cost-effective;
- You and your doctor agree to the ICM plan; and
- You have no other coverage which pays for the services and supplies outlined in the ICM plan.

Tufts Health Plan will monitor the ICM plan to ensure it is appropriate. Tufts Health Plan may change or end coverage for ICM plan services or supplies if it feels:

- Your medical condition has changed; or
- The ICM plan no longer meets the conditions outlined above.

INFORMATION THAT APPLIES TO ALL MEDICAL BENEFITS

The information that follows applies to all Amtrak medical benefits, including those administered by UnitedHealthcare, Tufts Health Plan, Aetna, Caremark, and MHN, unless stated otherwise.

FILING CLAIMS FOR BENEFITS

If a network provider coordinates your care under the Network Plan, you do not have to file a claim. Show your ID card and pay any required copays when you receive care. The provider will file the necessary claims for you.

If you participate in the Comprehensive Plan or receive out-of-network care under the Network Plan, you will pay the full cost of the care at the time you receive it. Then, you need to complete a claim form, attach a receipt, and submit it to the claims administrator.

See **Section 12: Administrative Information** for details about filing claims and the appeals process for denied claims.

COORDINATION OF BENEFITS

If both you and your spouse work, members of your family could be covered under other group medical plans in addition to your Amtrak medical benefit option. The coordination of benefits (COB) provision is designed to eliminate any duplicate payments for the same expenses.

Under a COB provision, the plan that pays first is called the primary plan. When the Amtrak medical option is primary, the Plan pays the benefits outlined in this section of your handbook. The additional benefits to which you may be entitled under another medical plan (such as your spouse's employer's plan) will be determined under the COB provisions of the other plan.

When the Amtrak medical option is secondary, the combined benefit under the primary plan and the Amtrak medical option will not be more than 100% of the benefit that would have been payable under the Amtrak medical option if the primary plan did not exist. This Amtrak secondary benefit is calculated as follows:

Step 1: The benefit that would have been payable under the Amtrak medical option for the medical services received is determined first.

Step 2: Then, the benefits paid under the primary plan are subtracted from the amount determined in Step 1.

Step 3: The Amtrak medical option pays the difference, if any.

If you are also covered under another plan as a laid-off or retired employee, then your Amtrak coverage will be considered primary to your other coverage.

When both plans have a COB provision, the following chart shows you how the primary plan is determined for your husband or wife. Separate rules apply to determining which plan is primary for children, as explained later.

IF YOU ARE:	AND THE OTHER PLAN IS SPONSORED BY:	AND EXPENSES ARE FOR:	THEN AMTRAK IS:
Husband	Wife's employer	Husband	Primary
		Wife	Secondary
Wife	Husband's employer	Wife	Primary
		Husband	Secondary

Coordination Of Benefits For Dependent Children

In coordinating benefits for children's coverage, the parent whose birthday falls earlier in the calendar year will have the primary plan for the children.

When parents are divorced or separated, the plan in which the parent with custody of the children participates is usually the primary plan, unless the non-custodial parent has been assigned financial responsibility for the children's health care.

If there is no court order and the parent with custody has remarried, the order of payment is as follows:

1. The plan of the parent with custody pays first;
2. The plan of the stepparent with custody pays second; and
3. The plan of the parent without custody pays last.

If none of these rules apply, the Amtrak Benefits Service Center can help you determine which plan is primary or secondary in your situation.

Please note that if your other plan is primary, you must first file a claim with that plan before the Amtrak claims administrator will process your claim.

COORDINATION OF BENEFITS (CONTINUED)

If You And Your Spouse Are Amtrak Employees

If both you and your spouse are Amtrak agreement-covered employees, each of you is covered under your own coverage and as a dependent spouse under the other's coverage. For the purposes of COB, your coverage and your spouse's coverage will be treated as separate plans. The rules determining which plan is primary for you, your spouse, and your children are those explained earlier. The plan that is primary pays the benefits outlined in this section of your handbook. The additional benefits the secondary plan will pay will be calculated as follows:

Step 1: First the reasonable cost of the eligible medical expense is determined.

Step 2: Benefits paid under the primary plan are subtracted from the amount in Step 1.

Step 3: The secondary plan will pay the difference between the amounts in Step 1 and Step 2. For example, if the amount in Step 1 is $100 and the benefit paid in Step 2 is 80% or $80; the secondary plan will pay the remaining 20% or $20.

If you and your spouse are participating in the Network Plan and pay a copay for in-network care, you will be reimbursed the amount of the copay.

These provisions also apply if your spouse is covered under the Amtrak Early Retirement Major Medical Benefit Plan.

COB For Prescription Drug Expenses

If you or your dependent has primary coverage for prescription drugs under another employer-sponsored group medical plan, the following COB procedures will apply:

1. You pay the full cost of the prescription at the pharmacy, even if it is a participating Caremark CareSelect pharmacy. Keep a receipt of the amount you paid.
2. Submit a claim for reimbursement to the primary plan (the other employer-sponsored medical plan).
3. You will receive an explanation of benefits (EOB) form from the primary plan. Attach the EOB and a copy of your receipt to a Caremark claim form and send them to Caremark at the address on the claim form. If you need a Caremark claim form, call the Amtrak Benefits Service Center at 1-800-481-4887 or Caremark at 1-800-378-0182. Or, you may download a claim form from the Caremark Internet site: www.rxrequest.com.

You will be reimbursed for the difference between what the primary plan pays and what Caremark pays.

This COB provision does not apply when:

- You receive prescription drugs through the Caremark mail order pharmacy;
- You and your spouse are both Amtrak agreement-covered employees; or
- Your spouse is covered by the Amtrak Early Retirement Major Medical Benefit Plan.

WHEN MEDICAL COVERAGE ENDS

Medical coverage for you or your covered dependents may end for a variety of reasons, such as:

- You end employment with Amtrak;
- Your death;
- Your divorce;
- Your dependent reaches the maximum age for eligibility; or
- You or your covered dependent become entitled to Medicare.

Important Note: Once your divorce becomes official, you **must** remove your former spouse from your Amtrak benefits coverage by calling the Amtrak Benefits Service Center at 1-800-481-4887 or by logging onto www.amtrakbenefits.com. This applies even if you are required by a court order to continue coverage for your former spouse. Following a divorce, your former spouse and/or your dependent children are eligible for continued coverage through COBRA.

See **Section 2: Life Events That Affect Your Benefits** for more information about how a divorce could affect your benefits.

See **Section 3: Eligibility And Participation** for more information about when coverage ends.

If coverage ends, you may be able to continue coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA). If you meet the requirements of COBRA coverage, you may be able to continue your coverage for 18, 29, or 36 months. For complete details about COBRA coverage, please see **Section 12: Administrative Information**.

Life Event Reminder: See Section 2: Life Events That Affect Your Benefits for more information about steps you should take if a life event affects your coverage.

If you are a Tufts Health Plan participant, you may apply for coverage under the Tufts Health Plan Massachusetts Non-Group Plan. Call the Tufts Health Plan Member Services number on your ID card for help arranging the conversion.

FAMILY AND MEDICAL LEAVE

During Family and Medical Leave, medical coverage for you and your eligible dependents will continue. Your coverage will remain the same as it did before the Family and Medical Leave occurred.

See **Section 3: Eligibility And Participation** for information about your benefits if you do not return to work following a Family and Medical Leave.

Life Event Reminder: See Section 2: Life Events That Affect Your Benefits for more information about steps you should take if a life event causes you to take a leave of absence or if you need to add a dependent to your coverage.

CERTIFICATE OF COVERAGE

If you or a covered dependent lose your medical coverage (including COBRA coverage), Amtrak is required to provide, at no cost to you, a certificate of coverage (also known as a HIPAA notice – Health Insurance Portability and Accountability Act of 1996). At a minimum, this certificate will state the length of time you (or your dependent) had uninterrupted coverage, up to 18 months. It will also show the date the coverage ended.

CERTIFICATE OF COVERAGE (CONTINUED)

If you or a covered dependent lose medical coverage, be sure to notify the Amtrak Benefits Service Center to request a certificate of coverage. Certificates are not automatically provided until Amtrak is aware that coverage is lost (for example, when a dependent no longer qualifies for coverage because of age). The certificate of coverage may allow you to reduce any pre-existing condition limits that apply to future coverage.

You may request a certificate of coverage for up to 24 months from the date your coverage ended.

RIGHT OF REIMBURSEMENT

If you or your covered dependent receives medical benefits and you or your dependent are entitled to recover some or all of the benefits from a party other than Amtrak, then Amtrak will have a lien on the proceeds of any such recovery from that party, whether the recovery is by judgment, settlement, or otherwise. The lien will not exceed the lesser of the total amount of benefits or the amount actually recovered, less the proportionate amount of legal fees and expenses incurred in pursuing the recovery.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Plan provides coverage at any time to your child if it is required under the terms of a Qualified Medical Child Support Order (QMCSO) that results from your divorce or legal separation. A QMCSO is any judgment, decree, or order issued by a court of law or qualified state agency requiring you to provide support or health care coverage for your child. If the child is not in your custody, the Plan will:

- Provide the non-custodial parent with information about health benefits under the Plan;
- Permit the custodial parent to submit claims; and
- Pay claims directly to the custodial parent.

QMCSOs should be sent to the Plan Administrator. The information included here provides an overview of the procedures for a Qualified Medical Child Support Order (QMCSO). For the details about these procedures, contact the Amtrak Benefits Department and a copy will be provided free of charge.

> ✓ **Life Event Reminder:** **See Section 2: Life Events That Affect Your Benefits** for more information about steps you should take if you become divorced.

RETIREE MEDICAL BENEFITS

If you:

- Are at least age 60; **and**
- Have at least 360 credited months of total railroad service as determined by the Railroad Retirement Board; **and**
- Meet the requirements of an age annuitant under the Railroad Retirement and Survivors' Improvement Act of 2001; **and**
- Retire from Amtrak before age 65,

you will be eligible for Amtrak early retirement medical benefits.

The lifetime maximum of benefits provided under this Plan is $92,400 (subject to change).

Retiree medical benefits also offer a Preferred Provider Organization (PPO) feature. Seeing a doctor in the PPO network is voluntary. However, when you see a provider who is part of the PPO network, the doctor or provider will charge you less for medical care. So, you pay less out of your pocket. In addition, when you see a PPO network doctor or provider, you do not have to file claim forms – it will be done for you.

RETIREE MEDICAL BENEFITS (CONTINUED)

To locate a PPO doctor or check to see if your doctor is in the PPO network:

- Call the Amtrak Benefits Service Center at 1-800-481-4887; or
- Call UnitedHealthcare Member Services at 1-888-675-RAIL (7245); or
- Visit the UnitedHealthcare Internet site at www.provider.uhc.com/Amtrak.

> **Helpful Hint:** Once you reach age 65, you may be eligible for medical coverage through Medicare (1-800-MEDICARE) and through a Medicare Supplemental Plan (1-800-809-0453).

ADMINISTRATIVE INFORMATION

For additional information about how your Amtrak medical options are administered, please refer to **Section 12: Administrative Information** of this handbook.

YOUR DENTAL BENEFITS

Another way to keep your health on track is by taking care of your teeth, gums, and mouth. To help you pay the cost of dental care, Amtrak provides you and your covered dependents with dental benefits through the Railroad Employees National Dental Plan, insured through Aetna (Delta Dental for police). While these benefits are not a part of your AmPlan benefits, they are available to eligible agreement-covered employees.

The level of dental benefits you may receive depends on your union, as shown in this chart:

PLAN FEATURE	OUT-OF-POCKET COSTS	
	BRS EMPLOYEES AND UTU ZONE 1 CONDUCTORS	ALL OTHER AGREEMENT-COVERED EMPLOYEES
Annual deductible	$50 per person/$100 per family	$50 per person/$100 per family
Annual maximum benefit (except orthodontia)	$1,000 per person	$1,500 per person
SERVICES	**PLAN PAYS***	**PLAN PAYS***
Type A – Preventive (such as exams, X-rays, and sealants for children under age 14)	100% after deductible (does not include sealants)	100% after deductible
Type B – Basic (such as fillings)	75%	80%
Type C – Restorative (such as dentures and implants)	50% (does not include implants)	50%
Orthodontia (children only) Lifetime maximum benefit per child	50%, no deductible $750	50%, no deductible $1,000

* *Plan pays a percentage of the prevailing reasonable and customary charges for the geographic area in which you receive care.*

FOR MORE INFORMATION

This is a very brief overview of your dental benefits. For more detailed information, please contact the Railroad Employees National Dental Plan at 1-877-277-3368 (administered by Aetna) or the Amtrak Benefits Service Center Helpline at 1-800-481-4887. Police employees should contact Delta Dental at 1-800-932-0783 or the Amtrak Benefits Service Center Helpline.

VISION BENEFITS

In addition to your medical and dental benefits, Amtrak also offers vision care benefits to eligible employees and their dependents. However, see the heading **Eligibility And Effective Date** in this section for specific information about who is eligible for these benefits.

Vision Service Plan (VSP) administers your vision care benefits. Highlights of this coverage include:

- Routine eye exams performed by highly-skilled and professionally-certified optometrists and ophthalmologists;
- Eyeglass lenses and frames or contact lenses;
- The option to see any provider you wish for eye care;
- Receiving the maximum level of benefits when you receive care from a VSP Select Network doctor; and
- No annual deductible before the Plan pays vision benefits.

Your vision benefits are described in more detail throughout this section.

ELIGIBILITY AND EFFECTIVE DATE

Most Amtrak agreement-covered employees and their dependents are eligible to participate in the vision care benefit on the first of the month after one year of service with Amtrak. Once you become eligible for coverage, to continue your participation, you must have a certain amount of active, compensated service in the previous calendar month. Please refer to **Section 3: Eligibility and Participation** for more information about maintaining your eligibility for coverage.

Other eligibility requirements depend on your union status and if you are an Amtrak employee or dependent, as shown in the following chart:

TYPE OF EMPLOYEE	EMPLOYEE ELIGIBLE?	DEPENDENTS ELIGIBLE?
Members of Brotherhood of Railroad Signalmen	No	No
UTU Zone 1 Conductors	No	No
UTU Stewards	Yes	Yes
All other full-time agreement-covered employees	Yes	Yes
Part-time Transportation Communication Union (TCU) clerks	Yes	No

YOUR BENEFITS-AT-A-GLANCE

This chart shows how services and supplies are covered under the Plan, and the difference in benefits, depending on whether your care is received from a VSP doctor or a non-VSP provider.

FEATURE	SEE A VSP SELECT NETWORK PROVIDER	SEE A NON-VSP PROVIDER
Eye exam (every calendar year)	Covered in full	Reimbursed up to $35
Lenses (one set every other calendar year)		Reimbursed up to:
■ Single	■ Covered in full[1]	■ $25
■ Bifocal	■ Covered in full[1]	■ $40
■ Trifocal	■ Covered in full[1]	■ $55
■ Lenticular	■ Covered in full[1]	■ $80
Frames (one pair every other calendar year)	Covered up to $75	Reimbursed up to $35
Contact lenses (every other calendar year)[2]		
Medically necessary contacts[3]	■ Covered in full	■ Reimbursed up to $210
Elective contacts[4]	■ Covered up to $105	■ Reimbursed up to $105

[1]Basic lenses are covered in full. Cosmetic options, such as tints (except Pink # 1 and Pink # 2) or coatings, are your responsibility.

[2] Contact lenses are in lieu of your frame and lenses benefit.

[3] Medically necessary contact lenses are covered in full, if required for certain medical conditions that prevent you from wearing eyeglasses. Medically necessary contacts must be approved by VSP.

[4] Your allowance is applied to both the contact lens exam (fitting and evaluation) and the contact lenses. The contact lens exam is a special exam for ensuring proper fit of your contacts and evaluating your vision with the contacts.

Helpful Hint: VSP also offers discounts on other types of vision care, such as laser vision correction surgery. These are not benefits negotiated under the Plan – they are offered through VSP and may change in the future. For more information about discounts VSP offers, call 1-800-877-7195.

PLAN LIMITS

The Plan pays benefits for the following:

- An eye exam once every calendar year; and
- A pair of eyeglass lenses and one set of frames every other calendar year; or
- One pair of contact lenses every other calendar year (You may choose contact lenses in lieu of eyeglasses. You will not receive coverage for both contact lenses and eyeglasses during the 24-month period).

If you see a non-VSP provider for care, the following dollar limits apply to the amount the Plan will reimburse you:

- $35 for the cost of a routine eye exam;
- $25 for single lenses;
- $40 for bifocal lenses;
- $55 for trifocal lenses;
- $80 for lenticular lenses;
- $35 for eyeglass frames;
- $210 for medically necessary contact lenses; and
- $105 for elective contacts.

USING A VSP SELECT NETWORK DOCTOR

VSP maintains a nationwide network of highly-skilled and professionally-certified optometrists and ophthalmologists. You can locate a VSP Select Network doctor in your area by:

- Calling VSP at 1-800-877-7195;
- Accessing the VSP website at **www.vsp.com**; or
- Calling the Amtrak Benefits Service Center at 1-800-481-4887.

When you use a VSP Select Network doctor, you will enjoy the following advantages:

- You will receive the maximum benefits; and
- Your doctor will file your claims for you.

When you wish to receive vision care, set up an appointment with your VSP Select Network doctor and provide the following information:

- Your name and indicate that you're a VSP member;
- Your employer's name (Amtrak);
- Your Social Security number; and
- Your date of birth.

If you are making an appointment for a dependent, you will need to provide their name, date of birth, and relationship to you.

Your doctor will contact VSP to verify your eligibility, check your coverage, and obtain authorization. If you are not eligible for benefits from this Plan, your doctor will let you know.

Make sure your doctor obtains authorization for your benefits. If your benefits are not authorized, any services you receive will be covered at the non-VSP provider level.

There are no deductibles or claim forms.

USING A NON-VSP PROVIDER

If you see a provider outside of the VSP Select Network, you will still receive benefits; however, at a lower level. At the time you receive care, pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the service or supply. Send a copy of the itemized bill(s) to VSP within 12 months of the date you received the treatment. You may use any standard claim form available from your vision care provider. Or, if a claim form is not available, you may file a claim by sending the following information with your receipt to VSP:

- Your name and mailing address;
- Your employer's name (Amtrak);
- The last four digits of your Social Security number; and
- Patient's date of birth and relationship to you.

Send your claim form and receipt (or your receipt and the above information if a claim form is not available) to:

Vision Service Plan
Attn: Out-of-Network Provider Claims
P.O. Box 997105
Sacramento, CA 95899-7105

You will be reimbursed according to the level of benefits outlined under the heading **Your Benefits-At-A-Glance**.

WHAT IS NOT COVERED

This Plan is designed to cover visual needs, not cosmetic materials. If you select extra features, the Plan will pay the cost for basic lenses and frames, and you will be responsible for any additional costs. Extra features include:

- Blended lenses;
- Oversize lenses (over 56mm eye size);
- Photochromic lenses;
- Tinted lenses (except Pink #1 and Pink #2);
- Progressives J, K, L, and M (except CR-39 plastic and glass) and progressive flat top (smart seg);
- Scratch coating;
- Anti-reflective coating;
- UV coating;
- Laminating of the lens or lenses;
- A frame that costs more than the Plan allowance;
- Certain limitations on low vision care;
- Cosmetic lenses; and
- Optional cosmetic processes.

The following services and materials are **not** covered:

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses (less than +/-.50 diopter power);
- Two pairs of glasses in lieu of bifocals;
- Replacement of lenses or frames that are lost or broken, unless the appropriate time interval has passed since they were purchased;
- Medical or surgical treatment of the eyes (however, VSP may offer discounts on laser eye surgery – contact VSP at 1-800-877-7195 for more information);
- Corrective vision treatment of an experimental nature;
- Costs for services or materials above Plan benefit limits; and
- All other services or materials not specifically described in the Plan contract.

At its discretion, VSP may waive any of the Plan limitations if, in the opinion of VSP's optometric consultants, such action is necessary for the member's visual welfare.

FILING CLAIMS

If you use a VSP doctor, you have no claims to file. You pay the doctor any costs for cosmetic options or non-covered services at the time you receive care. Your doctor will file your claim for you.

If you use a provider outside of the VSP network, you must pay the full amount for all services. Then, submit your claim for reimbursement within 12 months of the date services were received. See the heading **Using A Non-VSP Provider** for information about filing an out-of-network claim.

If your claim is denied and you wish to appeal the denial, refer to **Section 12: Administrative Information** for an outline of the procedures to follow.

COORDINATION OF BENEFITS

If both you and your spouse have vision benefits, the coordination of benefits (COB) provision will eliminate any duplicate payments for the same expenses.

Under a COB provision, the plan that pays first is called the primary plan. When Amtrak vision benefits are primary, the Plan pays the benefits outlined in this handbook section. The additional benefits to which you may be entitled under another vision plan (such as through your spouse's employer) will be determined under the COB provisions of the other plan.

COORDINATION OF BENEFITS (CONTINUED)

When the Amtrak vision plan is secondary, the combined benefit under the primary plan and the Amtrak vision plan will not be more than 100% of the benefit that would have been payable under the Amtrak vision plan if the primary plan did not exist. This Amtrak secondary benefit is calculated as follows:

Step 1. The benefit that would have been payable under the Amtrak vision plan option for the vision services received is determined first.

Step 2. Then, the benefits paid under the primary plan are subtracted from the amount determined in Step 1.

Step 3. The Amtrak vision plan pays the difference, if any (not to exceed the actual plan benefit amount).

If you are also covered under another plan as a laid-off or retired employee and are still covered under an Amtrak plan, your Amtrak coverage will be considered primary to your other coverage.

When both plans have a COB provision, the following chart shows you how the primary plan is determined for your husband or wife. Separate rules apply to determining which plan is primary for children, as explained later.

Determining Primary And Secondary Plans

IF YOU ARE:	AND THE OTHER PLAN IS SPONSORED BY:	AND EXPENSES ARE FOR:	THEN AMTRAK IS:
Husband	Wife's employer	Husband Wife	Primary Secondary
Wife	Husband's employer	Wife Husband	Primary Secondary

Coordination Of Benefits For Dependent Children

In coordinating benefits for children's coverage, the parent whose birthday falls earlier in the calendar year will have the primary plan for the children.

When parents are divorced or separated, the plan in which the parent with custody of the children participates is usually the primary plan, unless the non-custodial parent has been assigned financial responsibility for the children's health care.

If there is no court order and the parent with custody has remarried, the order of payment is as follows:

1. The plan of the parent with custody pays first;

2. The plan of the stepparent with custody pays second; and

3. The plan of the parent without custody pays last.

If none of these rules apply, the Amtrak Benefits Service Center can help you determine which plan is primary or secondary in your situation.

Please note that if your other plan is primary, you must first file a claim with that plan before the Amtrak claims administrator will process your claim.

WHEN COVERAGE ENDS

Please refer to handbook **Section 3: Eligibility and Participation** for information about when coverage ends. For information about COBRA coverage after this coverage ends, see handbook **Section 12: Administrative Information**.

FOR ADDITIONAL INFORMATION

For additional information about how your vision benefits are administered, please refer to **Section 12: Administrative Information.**

OVERVIEW OF YOUR SPENDING ACCOUNTS

Health care and dependent care expenses can take quite a bite out of your family's budget. That's why Amtrak offers you a way to pay these expenses on a tax-free basis.

You can set aside tax-free money in two types of accounts that reimburse you for eligible health care and dependent care expenses. These accounts are:

- Health Care Spending Account; and
- Dependent Day Care Spending Account.

Spending account claims are processed by SHPS Inc. For more information about SHPS, call 1-888-421-SHPS (7477) or access their website at: **www.myshps.com**.

HOW TO USE THESE ACCOUNTS

The Health Care Spending Account provides you with a tax-free method of paying for health care expenses that are not covered by a medical or dental plan. When you have an eligible health care expense, you submit a claim to the spending accounts administrator and are reimbursed from your Health Care Spending Account.

The Dependent Day Care Spending Account works the same way for dependent care expenses, such as day care for a child or an elderly parent. When you have an eligible dependent care expense, you submit a claim and are reimbursed from your Dependent Day Care Spending Account.

> **Important Note:** The two accounts are separate. You cannot be reimbursed for health care expenses from your Dependent Day Care Spending Account, or vice versa.

> **Important Note:** You must enroll in these accounts each year if you wish to continue using these accounts.

Contributions Are Tax-Free

The advantage of these accounts is that your contributions are deducted from your pay before federal, state, or Railroad Retirement taxes are calculated.* So, when you use these accounts to pay for health or dependent care expenses, you're paying with tax-free money.

*If you live in Pennsylvania, contributions to your Dependent Day Care Spending Account are subject to Pennsylvania State tax.

> **Helpful Hint:** Check the SHPS website for an interactive worksheet that can help you calculate your tax savings: **www.myshps.com**.

HEALTH CARE SPENDING ACCOUNT

A Health Care Spending Account allows you to put aside money to pay for certain out-of-pocket health care expenses that are not covered by health insurance. The advantage of this account is that you are reimbursed from your account with tax-free dollars.

Eligible Expenses

Some examples of eligible health care expenses are medical plan deductibles, copays, and coinsurance. Other eligible expenses include, but are not limited to:

- Eyeglasses, including exam;
- Contact lenses and supplies;
- Over-the-counter medicines needed to treat or alleviate a medical condition (such as cough medicine, antacids, allergy relief medicine, aspirin, etc.);
- Chiropractic treatment;
- Dental and orthodontia fees;
- Hearing aids;
- Acupuncture;
- Birth control pills;
- Therapy treatment;
- Special items, such as guide dogs for the blind;
- Transportation for medical service or treatment; and
- Any other unreimbursed out-of-pocket medical, dental, and vision expenses allowed as deductions by the IRS on your Federal tax return (except insurance premiums).

Expenses Not Covered

The following are examples of expenses not eligible for reimbursement from the Health Care Spending Account:

- Cosmetics and toiletries;
- Health club dues;*
- Premiums for other health insurance coverage;
- Weight reduction programs;*
- Non-medical expenses, such as electronic air filters and hot tubs;*
- Marriage counseling; and
- Payments for domestic help, a companion, or a baby sitter, who primarily provides services of a non-medical nature. (Such services may be eligible under the Dependent Day Care Spending Account.)

* Unless prescribed by a doctor for a specific medical condition.

> **Important Note:** Expenses reimbursed from your Health Care Spending Account cannot be claimed as itemized deductions on your federal income tax return.

> **Helpful Hint:** For more information about eligible and ineligible expenses:
>
> - Refer to the chart on page 91 of this handbook:
> - Check the SHPS website: **www.myshps.com**;
> - Call the Amtrak Benefits Service Center at 1-800-481-4887;
> - See IRS Publications 969 and 502, available on the IRS website: www.irs.gov/forms-pubs/; or
> - Call your local IRS office.

HEALTH CARE SPENDING ACCOUNT (CONTINUED)

Contribution Maximum

If you choose to participate in the Health Care Spending Account, you will need to determine how much to have deducted from your paycheck and deposited into your account. The **maximum** amount you can contribute to this account is $1,300 per year, or $25 per paycheck.

Please remember that you cannot claim expenses as itemized deductions on your federal income tax return if you are reimbursed for them from your Health Care Spending Account.

Calculating Your Contributions

To get the most from your Health Care Spending Account, you need to think carefully about your out-of-pocket health care expenses. First, review the health care expenses you had last year. Then, take a look at any planned health care expenses for the upcoming year that will not be covered by your health care plan.

DEPENDENT DAY CARE SPENDING ACCOUNT

Day care for young children has become a major expense for many families. And, for some families, children are not the only ones who need dependent care. Often, elderly parents need care while you work.

If you're paying for day care for your child or elderly parent, you can probably estimate what those costs will be from year to year. To help offset some of these costs, you can take advantage of the tax-savings benefit of a Dependent Day Care Spending Account.

The Dependent Day Care Spending Account is designed to help you pay the cost of caring for your dependents while you work. However, it is not designed to reimburse you for your dependents' health care expenses. For those expenses, you may use the Health Care Spending Account.

Important Note: The Dependent Day Care Spending Account is for dependent care expenses only.

Contribution Maximums

If you're single, or married and filing a joint income tax return, the maximum amount you can contribute to the Dependent Day Care Spending Account is $5,000 per year, or $96.15 per paycheck. If you're married, but filing a separate income tax return from your spouse, the maximum amount you can contribute is $2,500 per year, or $48.07 per paycheck.

In addition, you may not contribute an amount that is more than your spouse's earned income. If your spouse is a full-time student, looking for work, or disabled, you may set aside:

- $200 per month for one qualified dependent; or
- $400 per month for two or more qualified dependents.

Who May Use The Dependent Day Care Spending Account

You are eligible to use the Dependent Day Care Spending Account if you have:

- Children under age 13 for whom you claim as a tax deduction; or
- Children, a spouse, or other dependents of any age who cannot care for themselves due to a mental or physical disability.

To be eligible, you must also be:

- A single parent; or
- Married to a spouse who cannot provide care because he or she is:
  - – Working or looking for work;
  - – Attending school full-time; or
  - – Physically or mentally disabled.

Eligible Dependent Day Care Expenses

You can use a Dependent Day Care Spending Account to pay for the following expenses:

- Day care centers for children or the elderly;
- Day camp;
- Nursery school;
- Before- and after-school care (as long as these expenses can be separated from tuition payments);
- In-home day care; and
- Other eligible expenses that are listed in IRS Publication 503.

Under IRS regulations, you can use this account to pay for a dependent adult's day care expenses only if that adult regularly spends at least eight hours a day in your home. This means that you cannot use this account to cover costs for a dependent adult who is confined in a nursing home or who lives away from you. Also, you cannot use this account to pay someone to watch your dependents while you are otherwise engaged at home. You must be at work, looking for work, a full-time student, or disabled.

Eligible Providers

You may be reimbursed for dependent day care services provided by any person or organization **except**:

- Your own child under age 19; or
- Someone you or your spouse claims as a tax deduction.

When you submit a dependent day care claim for reimbursement, you must include the Social Security number or the tax identification number of the person/organization providing the care.

Dependent Care Tax Credit

As you decide whether to use a Dependent Day Care Spending Account, you should keep in mind that current tax law allows you to take a tax credit for some of your dependent care expenses. However, the law does not allow you to use both the tax credit and a Dependent Day Care Spending Account for the same dependent care expenses. You can claim a tax credit on eligible expenses up to $3,000 a year for one dependent, or $6,000 a year for two or more dependents.

If you pay for dependent care with a combination of tax dollars and spending account dollars, your tax credit will be reduced, dollar for dollar, by the amount you put into a Dependent Day Care Spending Account.

Helpful Hint: For the complete list of expenses that can be reimbursed from a Dependent Day Care Spending Account:

- Check the SHPS website: **www.myshps.com**;
- Call the Amtrak Benefits Service Center at 1-800-481-4887;
- Refer to IRS Publication 503, which is available on the IRS website at www.irs.gov/forms_pubs/; or
- Call your local IRS office.

Important Note: School tuition and fees for overnight camp are **not eligible** for reimbursement. However, before- and after-school day care expenses are eligible for reimbursement.

IRS REGULATIONS

Please be aware of the following important IRS regulations governing spending accounts.

The Use-It-Or-Lose-It Rule

The IRS requires you to use all of the money in your account by the end of the plan year. Any money left in your account is forfeited and can't be returned to you or carried over into the next plan year. Therefore, it is very important that you carefully estimate your expected health and/or dependent care expenses for the coming year when you decide how much to contribute to either account.

Accounts are **not** interchangeable. You cannot use money from your health care account to pay dependent care expenses, or vice versa. This applies even if it looks as though you won't use all the money in one of your accounts.

Must Enroll For Full Plan Year

Once you have made your enrollment decision, you can't change your election during a plan year, unless you have an IRS-qualified change in family status (for example, if you have a baby).

If You Leave Amtrak

If you end your employment with Amtrak, you may be reimbursed for expenses you incurred before your termination date. Also, under a federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA), you (or a qualified beneficiary) may be able to continue participating in a Health Care Spending Account if you end your employment with Amtrak. (The Dependent Day Care Spending Account is not covered under COBRA.)

Under COBRA regulations, you (or your qualified beneficiary) may continue your participation until the end of the calendar year. However, your contributions will be taxable, and you'll be charged a 2% administration fee.

If you end your employment with Amtrak (or experience some other qualifying event) and wish to continue your Health Care Spending Account participation, please contact the Amtrak COBRA Service Center at 1-866-381-2859 for additional information. Also, please see **Section 12: Administrative Information** of your handbook for more information about COBRA coverage.

> ✓ **Life Event Reminder:** **See Section 2: Life Events That Affect Your Benefits** for information about how a life event (such as leaving Amtrak) may affect your benefits.

Spending Account Grace Period

While the plan year for the Spending Accounts runs from January 1 through December 31, you have an additional 2.5 months to incur claims that can be reimbursed from the previous plan year's account. In other words, you may use money left in your account after December 31 to reimburse yourself for eligible expenses you incur up to March 15 of the following year.

For example, at the end of 2006 Carlos has $200 remaining in his Health Care Spending Account and elects to contribute $1,500 to this account in 2007. Carlos incurs $300 in out-of-pocket medical expenses before March 15, 2007. The first $200 will be deducted from the 2005 balance, which will "close out" Carlos' 2006 Health Care Spending Account. The remaining $100 will be reimbursed from his 2007 Health Care Spending Account balance.

IRS-Qualified Change In Family Status

When you enroll for Spending Accounts, your elections will remain in place until the end of the plan year (December 31). However, you may make a change to your benefit elections during the year if you have an IRS-qualified change in family status. You must make any changes to your benefits within 31 days of the family status change. Otherwise, you will have to wait until the next Open Enrollment Period to make a change.

IRS REGULATIONS (CONTINUED)

Any changes you make to your Spending Accounts because of a qualified status change must be consistent with the change in status. For example, if you have a baby, you can change your contributions to a Dependent Day Care Spending Account, but you cannot stop your contributions to a Health Care Spending Account.

> ✓ **Life Event Reminder:** **Refer to Section 2: Life Events That Affect Your Benefits** for information on the steps to take if you have a family status change.

Examples of IRS-qualified family status changes include, but are not limited to:

- Your marriage, divorce, or annulment;
- The birth, adoption, placement for adoption, or appointment of legal guardianship of your child;
- Your death;
- The death of your dependent;
- A gain or loss of your or your dependent's employment;
- A change in your (or your dependent's) employment status due to a switch between full-time and part-time, an unpaid leave of absence, strikeout, or lockout;
- A change in your or your dependent's eligibility;
- A change in your (or your dependent's) place of residence or work;
- Your requirement to cover your dependent according to a judgment, decree, or order resulting from your divorce, annulment, or change in legal custody;
- Your (or your dependent's) eligibility for COBRA;
- Your or your dependent's loss of other health coverage resulting in your enrolling in Amtrak medical coverage; and
- Your (or your dependent's) eligibility for Medicare or Medicaid (you may change the current election for the eligible person only).

Effect On Railroad Retirement Benefits

Tax-free contributions you make to one or both Spending Accounts will reduce the amount of salary on which your eventual Railroad Retirement benefits will be based. This may result in a reduction in the amount of Railroad Retirement benefits you may receive. However, in most cases, the amount of taxes you save using a Spending Account is more than any reduction in Railroad Retirement benefits. For additional information, consult with a tax advisor.

HOW TO FILE A CLAIM

To be reimbursed for an eligible health care or dependent care expense, you must complete a claim form and submit it to the claims administrator in one of these ways:

By mailing your information to:

SHPS Inc.
FSA Processing Center
P.O. Box 34700
Louisville, KY 40232-4700

By faxing your information to this number:
1-866-643-2219.

See your local Human Resources representative or contact the Amtrak Benefits Service Center at 1-800-481-4887 for a supply of claim forms. Or, if you prefer, you may download a claim form from the SHPS website: **www.myshps.com** or **www.amtrakbenefits.com**.

When you submit a claim form, it must be accompanied by proof of the expense, such as an itemized receipt or an "Explanation of Benefits" statement from your health insurance company.

HOW TO FILE A CLAIM (CONTINUED)

Make sure that your proof of expense (e.g., receipt or "Explanation of Benefits" statement) includes the following information:

For Health Care Spending Account

- The name of the provider;
- Your name and Social Security number;
- The date of service; and
- The amount charged.

For Dependent Day Care Spending Account

- The name, address, and Social Security or tax ID number of the care provider;
- The name of the person receiving the care;
- The type of service provided (such as day care) and the date it was provided; and
- The amount paid for the service.

With a Health Care Spending Account, you may be reimbursed for more than the amount in your account, but not more than your annual contribution amount.

With a Dependent Day Care Spending Account, you will only be reimbursed up to the amount you have contributed to your account. As you make contributions, the remainder of your claim will be automatically reimbursed. You do not have to resubmit a claim for these expenses.

If, because of an IRS-qualified family status change, you enroll in a Spending Account after the start of the plan year, you can only submit expenses for services provided during the time you're enrolled in the Spending Account.

✓ **Life Event Reminder:** If you have a family status change, refer to **Section 2: Life Events That Affect Your Benefits** for information on how the family status change may affect your benefits.

How You Are Reimbursed

Once the claims administrator (SHPS) receives your claim form and your receipts and processes your claim, a check will be mailed to your home.

If you would like to reduce the amount of time it takes to be reimbursed, you may have your reimbursement deposited directly into your bank account. To set up electronic fund transfer, you will need to complete a special form and attach a voided check or deposit slip. For a copy of the form, call the Amtrak Benefits Department or download the claim form from the SHPS website: **www.myshps.com**.

Last Day To File

You have until April 15 of the next plan year to file a claim for expenses you incurred during the previous plan year. For instance, you will have until April 15, 2007 to file a claim for eligible expenses you incurred during the year 2006.

FOR MORE INFORMATION

For additional information about Spending Accounts, please see **Section 12: Administrative Information** of your handbook.

Examples Of **Eligible** Health Care FSA Expenses

- Acupuncture
- Birth control pills
- Braces
- Braille books and magazines
- Capital expenses for medical equipment
- Care for a mentally handicapped child
- Chiropractors
- Coinsurance amounts you pay
- Contact lenses and materials
- Crutches
- Deductible amounts you pay
- Dental care
- Drug and medicines
- Eyeglasses, including examination fees
- Eye surgery, including laser eye surgery and radial keratotomy
- Fertility enhancement
- Guide dog for visually impaired/hearing impaired
- Hearing devices and batteries
- Lead-based paint removal
- Learning disability expenses
- Legal fees to authorize treatment of mental illness
- Lodging at a hospital necessary to receive medical care
- Nursing home
- Optometrist
- Osteopath
- Over-the-counter medicines
- Oxygen
- Prosthesis, artificial limbs
- Psychiatric care, psychoanalysis, psychologists' fees
- Smoking cessation programs (when prescribed by a doctor)
- Special education for mentally impaired or physically disabled child
- Special home for the mentally disabled
- Sterilization fees, including vasectomy
- Surgery
- Telephone equipment for the hearing impaired
- Television closed-captioned equipment for the deaf
- Therapy treatments
- Transplants
- Weight loss program to treat a specific disease diagnosis
- Wheelchairs
- Wig to replace hair lost due to disease

Examples Of **Non-Eligible** Health Care FSA Expenses

- Baby-sitting, child care, or nursing services for normal healthy children
- Controlled substances
- Cosmetics
- Cosmetic surgery
- Dancing lessons, swimming lessons
- Diaper service
- Dietary supplements
- Electrolysis or hair removal
- Hair transplant
- Health club dues unless medically necessary
- Health insurance credit
- Health or Long-Term Care insurance premiums
- Illegal operations and treatments
- Maternity clothes
- Personal use items
- Toiletries
- Vitamins, nutritional supplements
- Weight-loss program unless needed to treat a specific ailment or disease

For complete information, see the IRS Publications, available at www.irs.gov:
– Publication 502: Medical and Dental Expenses
– Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans

SECTION 8:
Commuter Reimbursement Benefits

TAX-FREE COMMUTER EXPENSES

One of the benefits Amtrak provides is the ability to pay for certain commuter expenses on a tax-free basis.

TWO COMMUTER REIMBURSEMENT ACCOUNTS

You may use one or both Commuter Reimbursement Accounts:

- **Transportation Reimbursement Account** – helps you pay for qualified mass transit or van pooling expenses; and
- **Parking Reimbursement Account** – helps you pay for qualified parking expenses.

Commuter Reimbursement Accounts work in much the same way as Spending Accounts. You agree to set aside a certain amount of money in one or both of these accounts. This money is deducted from your paycheck before federal income, state income (except New Jersey and Pennsylvania), and Railroad Retirement taxes are calculated. Then, when you have an eligible expense, you are reimbursed with tax-free dollars from your account.

Important Note: Unlike Spending Accounts, there is no "use it or lose it" rule with Commuter Reimbursement Accounts. If you don't use the money in your account, you may roll it over to the next month.

HOW TO ENROLL FOR BENEFITS

You may enroll for these benefits at any time, with your payroll deductions starting on the first or second payroll after you submit an enrollment form. The actual date your payroll deductions begin depends on when you are paid.

Contact the Amtrak Benefits Service Center at 1-800-481-4887 for enrollment information and/or an enrollment form or you can enroll via the benefits website: www.amtrakbenefits.com.

CONTRIBUTION LIMITS

There are limits on the amounts that may be reimbursed each month from the accounts. The Internal Revenue Service has set the following limits for 2007*:

- $110 per month for qualified mass transit and vanpooling expenses; and
- $215 per month for qualified parking expenses.

**The IRS may increase this amount in the future.*

In any given month, you will be reimbursed for any expenses up to the above limits. For example, if your monthly mass transit expenses are $115, you'll be reimbursed with tax-free dollars from your account for up to $110. You will have to pay the remaining $5 with taxable dollars.

However, any money remaining in your account at the end of the month will roll over – still tax-free – to the following month to pay eligible expenses.

ELIGIBLE EXPENSES

The following are examples of eligible expenses:

TYPE OF ACCOUNT	ELIGIBLE EXPENSES
Transportation Reimbursement Account	■ Transit passes, tokens, fare cards, vouchers, or similar items that allow you to travel on mass transit or in a commuter highway vehicle ■ Vanpooling or similar transportation between your home and where you work in a commuter highway vehicle
Parking Reimbursement Account	■ Parking at or near Amtrak work locations ■ Parking near a location from where you carpool, vanpool, or take mass transit (such as a bus, train, or subway)

HOW REIMBURSEMENT ACCOUNTS WORK

You'll find that using your Commuter Reimbursement Accounts is an easy and effective way to save valuable tax dollars. Here's how the accounts work:

Step 1. Figure out how much you spend per month on commuting and/or parking expenses. You may choose to set up one or both accounts, depending on how you get to work.

> **Important Note:** If you work at Union Station in Washington, D.C. or Kansas City, and have parking expenses automatically deducted from your paycheck, you do not have to do anything different. You will continue to have payroll deduction for parking – ***but your deductions will be made on a tax-free basis***.

Step 2. Based on your monthly transportation costs, decide the amount of money you want deducted each pay period. Your deductions will be placed into an account in your name.

Step 3. Your contributions will be deducted from the first and third paycheck of the month on a tax-free basis and placed into an account in your name. This means the money you set aside will not be taxed – so you will enjoy immediate savings.

Step 4. When you have eligible expenses, submit a claim form and receipts for those expenses to the claims administrator, SHPS Inc., for reimbursement from your tax-free account (explained later in this section).

If, at the end of the plan year, you still have money left in either account, it will be rolled over into your account for the next year.

> **Important Note:** If you are an Amtrak employee who currently receives monthly vouchers to ride SEPTA, you are not eligible to participate in a Transportation Reimbursement Account. However, you may participate in a Parking Reimbursement Account.

HOW TO CHANGE DEDUCTION AMOUNTS

When you set up your account, you choose the amount you want to set aside for each type of account. Because your transportation expenses may vary throughout the year, you may change your paycheck deduction amount for each account as often as you need to make changes.

You can conveniently change your deduction amounts by:

- Calling the Amtrak Benefits Service Center at 1-800-481-4887 and following the prompts; or
- Accessing the benefits website: **www.amtrakbenefits.com** and following the instructions after you logon.

The change will become effective no later than the second paycheck after you call the Amtrak Benefits Service Center or make the change on the benefits website.

Keep in mind, you may only deduct up to the monthly account reimbursement limits.

HOW TO GET REIMBURSED

First, pay your transportation and/or parking expenses as usual and get a receipt for your expenses. To receive reimbursement, submit your receipt, including the amount paid, and the date it was paid, to the address on the claim form.

Send the receipt and the claim form to the claims administrator, SHPS, at this address:

SHPS Inc.
Commuter Reimbursement
P.O. Box 34700
Louisville, KY 40232-4700

You may download a claim form from the SHPS website: www.shps.net. Or, contact your local Human Resources representative or Department Administrator for a copy of the claim form.

If you are unable to get a receipt for your commuting or parking expenses, you can still be reimbursed for your expenses from your account. There is a section on the claim form called **Affidavit of Transportation and/or Parking Expenses**. You will need to complete this section of the claim form with information about your expenses.

You can choose to receive your reimbursement either through electronic fund transfer to your bank account or by check. If you would like to have your reimbursement deposited directly into your bank account, provide the number of your bank account to SHPS. Please call SHPS at 1-800-678-6684 or the Amtrak Benefits Service Center at 1-800-481-4887 for a copy of the appropriate form.

APPEALING A DENIED CLAIM

If you file a claim for benefits, Amtrak has 90 days after receiving your initial claim to notify you if your claim is denied. If Amtrak needs an extension for special circumstances and provides you with a notice of the extension during the initial 90-day period, Amtrak may take an additional 90 days (for a total 180 days).

If your claim is denied, you have 60 days after receiving the claim denial to appeal Amtrak's decision. Amtrak has 60 days following your appeal to notify you of the appeal decision. If Amtrak needs more time, it has 120 days after receiving the appeal to notify you of the appeal decision.

WHEN COVERAGE ENDS

Your participation in these accounts will continue as long as you are:

- Actively employed by Amtrak; and
- Making required contributions.

If your employment with Amtrak ends, you may file a claim to be reimbursed for eligible expenses you incurred before your termination date.

You may voluntarily end your participation at any time by contacting the Amtrak Benefits Service Center at 1-800-481-4887 or accessing the benefits website: www.amtrakbenefits.com.

FOR ADDITIONAL INFORMATION

For additional information about how your Commuter Reimbursement benefits are administered, please refer to **Section 12 – Administrative Information**.

OVERVIEW OF YOUR SURVIVOR BENEFITS

Occasionally life isn't as smooth as we would like. However, if you are prepared for life's unexpected bumps, they can be easier to handle. This is especially true when it comes to protecting your family's financial security if something should happen to you.

As part of your Amtrak benefits, you receive two types of survivor coverage:

- Life Insurance; and
- Accidental Death & Dismemberment (AD&D) Insurance.

These coverages are insured through and administered by Metropolitan Life Insurance Company. This section of your handbook explains these coverages in more detail.

YOUR LIFE INSURANCE COVERAGE

Eligible employees and retirees receive Life Insurance coverage in the following amounts:

- $10,000 for active employees; and
- $2,000 for retired employees.

See **Section 3: Eligibility And Participation** for information about who is eligible for coverage.

Your beneficiary will receive your benefit if you die while covered under Amtrak benefits.

BENEFITS IF YOU BECOME DISABLED

If you become disabled while an Amtrak employee, your Life Insurance benefit will be paid as follows:

- From your date of disability until the end of the calendar year following the year in which you last rendered compensated service or received vacation pay – coverage amount: $10,000
- After the end of the calendar year following the year in which you last rendered compensated service or received vacation pay – coverage amount: $2,000

YOUR AD&D COVERAGE

In addition to the Life Insurance coverage described above, eligible employees receive AD&D Insurance coverage. This coverage provides you or your beneficiary with a benefit if you are injured or killed as the result of an accident.

The following chart shows how AD&D benefits are paid.

TYPE OF LOSS	BENEFIT AMOUNT
Your life	$8,000 paid to your beneficiary
Both hands or both feet or sight of both eyes	$8,000 paid to you
Combination of any two losses – hand, foot, or sight of one eye	$8,000 paid to you
One hand, one foot, or sight of one eye	$4,000 paid to you

? **Definition:** Loss of a hand means removal at or above the wrist joint. Loss of a foot means removal at or above the ankle joint. Loss of an eye means the total loss of sight that cannot be recovered.

The Fine Print

If you suffer more than one loss in an accident, only one benefit will be paid – the highest amount. To receive a benefit, the loss must occur within 90 days of the accident and be as a direct result of the accident.

What Is Not Covered Under AD&D Insurance

Your AD&D coverage does not cover losses caused by:

- Sickness, including mental illness, or medical or surgical treatment for disease, whether the loss results directly or indirectly from the disease;
- Infections, except pus-producing infections resulting from an accidental cut or wound;
- Suicide or any attempt at suicide, while sane or insane;

- War or any act of war, declared or undeclared, including resistance to armed aggression; or
- Travel or other movement by means of an aircraft, if you have any duties aboard the aircraft that relate in any way to that aircraft or its operation, equipment, passengers, or crew. This includes giving or receiving training for any of the duties aboard that aircraft.

> **Definition:** "Aircraft" means any kind of vehicle or device designed for travel or other movement beyond the earth's atmosphere.

YOUR BENEFICIARY

Your beneficiary is the person or persons you designate to receive your Life Insurance and/or AD&D Insurance benefit in the event of your death.

When you first become eligible for Amtrak benefits, you will be asked to complete a *Beneficiary Designation* Form. Fill out this form and return it to:

Amtrak Benefits Service Center
P.O. Box 9183
Des Moines, IA 50306-9183

You may get a copy of the *Beneficiary Designation* Form by:

- Downloading it from the benefits website: **www.amtrakbenefits.com**; or
- Calling the Amtrak Benefits Service Center at 1-800-481-4887 and having it mailed to you.

Complete this form and return it to the Amtrak Benefits Service Center at the address above.

Your beneficiary change will become effective on the date you sign the form, provided the Amtrak Benefits Service Center has received it. However, if you die and the insurance company pays your benefit before the Amtrak Benefits Service Center receives the new *Beneficiary Designation Form*, the insurance company may not be able to make payment to the new beneficiary.

If you name more than one person as your beneficiary, be sure to indicate the percentage of your benefit you would like each to receive. The total of all benefit amounts cannot be more than 100% of your benefit. For example, suppose you want to name three people as your beneficiary, you may want to designate your benefit as follows:

- Person A – 50% of your benefit
- Person B – 30% of your benefit
- Person C – 20% of your benefit

Your beneficiary(ies) will be the same for both Life Insurance and AD&D Insurance.

If you do not name a beneficiary or your beneficiary dies before you, your benefit will be paid to:

- Your surviving spouse, if any;
- Your surviving children, equally, if there is no surviving spouse; or
- Your estate, if there are no surviving children.

> **Important Note:** Please keep your beneficiary information as up to date as possible.

Naming A Minor As Your Beneficiary

If you name a minor as your beneficiary, you should appoint a legal guardian since minors cannot directly receive insurance payments.

Primary And Contingent Beneficiaries

You may want to name a primary and a contingent beneficiary. A primary beneficiary will be the person who receives a benefit at your death. A contingent beneficiary will receive a benefit only if your primary beneficiary dies before or at the same time you die.

> **Life Event Reminder:** See **Section 2: Life Events That Affect Your Benefits** for information about benefits your beneficiary or covered family members should consider if you die while an Amtrak employee.

ASSIGNING BENEFITS

You may assign your Life Insurance coverage only as a gift assignment. However, payments to a funeral home may be assigned by the beneficiary.

WHEN YOUR COVERAGE ENDS

See **Section 3: Eligibility And Participation** for information about when coverage ends.

CONVERTING TO AN INDIVIDUAL POLICY

If your Amtrak Life Insurance coverage ends, you may buy an individual life insurance policy from the Aetna Life Insurance Company.

You will not have to provide proof of good health to get this policy. The new policy will not offer disability benefits or any other extra benefits.

To be able to convert to an individual policy, you must apply for this policy within 31 days after your Amtrak Life Insurance coverage ends.

If you are a furloughed, suspended, dismissed, or pregnant employee, and your dependent health benefits are being continued after your Amtrak Life Insurance ends, you may buy an individual policy at any time – as long as your dependent health benefit coverage is still in effect.

If you die within the conversion period, the insurance company will pay your beneficiary the amount of life insurance you could have bought under the individual policy.

The benefit amount from the individual policy will be limited to the amount of your Amtrak Life Insurance benefit. However, you may choose to buy a lower benefit amount.

The benefit amount you can buy will be limited, as follows:

- If you are a retiree, the benefit amount you may buy will be reduced by the amount you are eligible to receive as a retired employee ($2,000); and
- If the Amtrak Life Insurance benefit ends or is changed so that you are no longer an eligible employee, the benefit amount you can buy will be reduced by any other group life insurance benefit amounts for which you are eligible. The individual policy cannot be more than $2,000.

NEW YORK EMPLOYEES

If you live in the state of New York, the following features apply:

- This policy provides accident insurance only. It does not provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department.
- This policy does not provide coverage for sickness.

ADMINISTRATIVE INFORMATION

The Basic Group Term Life and Accidental Death and Dismemberment coverages are underwritten by the Aetna Life Insurance Company. This handbook section is intended to be a summary of your benefits and does not include the full text of all contract provisions. If there is a discrepancy between this document and the Group Contract/Booklet-Certificate issued by the Aetna Life Insurance Company, the terms of the Group Contract will govern.

For additional information about your Amtrak Life Insurance and AD&D benefits, please see **Section 12: Administrative Information**.

ON THE JOB PROTECTION

Amtrak provides medical benefits for you in the event you are injured on the job or suffer from an occupational illness. Claims for these benefits are administered by MCMC.

COVERAGE AMOUNT

Your On-Duty Injury (ODI) coverage provides the same level of benefits as what you receive through your Amtrak medical option (Network or Comprehensive Plan). At Amtrak's discretion, up to 100% of the usual and customary fees may be paid for services that are determined medically necessary and are directly related to the on-the-job injury or illness. In such cases, you may be reimbursed for any deductibles, copayments, or coinsurance.

STEPS IF YOU INCUR AN ON-DUTY INJURY OR OCCUPATIONAL ILLNESS

The following outlines the steps you should take if you incur an occupational illness or injury while on duty:

Step 1: Contact your supervisor immediately. Your supervisor will assist you in getting the medical care you need.

Step 2: You and your supervisor must complete a *First Report of Injury* form (NRPC Form 260), including a *Personal Statement* from you. Your supervisor must report your injury by calling the Injury Reporting Hotline at 1-800-505-5549. Your supervisor, in conjunction with your medical provider, will complete an *Amtrak Medical Information* form (NRPC Form 488). This will begin your on-duty injury/illness coverage documentation.

Step 3: You may receive medical care from any provider you wish. This includes your primary care physician (if you are enrolled in the Network Plan). If you don't have a doctor, your supervisor or a representative from the claims administrator (MCMC) can help you find one. Your supervisor or MCMC may recommend a network provider who has been selected because of his/her expertise in treating occupational injuries and illnesses. You are not required to get pre-authorization for health care services related to an on-duty injury (see **Section 4: Medical Benefits** for more information about pre-authorization and care coordination).

Step 4: Tell your provider(s) that all medical bills related to your on-duty injury/illness must be sent to the ODI claims administrator at the following address:

MCMC
Attn: ABR Department
15 River Road, Suite 100
Wilton, CT 06897
1-800-219-8184

Step 5: In those instances when you are required to pay for some or all of your on-duty injury medical expenses, send all bills and receipts to MCMC at the above address. In some cases, you may be reimbursed for these amounts. Please remember to keep copies of all bills and receipts for your records.

✓ **Life Event Reminder:** Please see **Section 2: Life Events That Affect Your Benefits** for information about how a disability may affect your Amtrak employee benefits.

APPEALING A DENIED CLAIM

If your claim is not paid, or if you and your provider disagree with the payments made, you or your provider should contact MCMC at 1-800-219-8184. The MCMC Bill Review Department will review your claim. If additional information is needed as part of the review process, MCMC will contact your provider for this information. Once the Bill Review Department has made a decision about your claim, they will notify your provider.

If you are not satisfied with the decision about your claim, you may appeal this decision.

First Level Of Appeal

The following outlines the steps for the first level of appeal:

Step 1: You or your provider should notify the MCMC Service Reviewer that you are not satisfied with the Bill Review Department decision.

Step 2: The MCMC Service Reviewer will review your information and prepare a file. If there is any information missing that could affect the appeal, the MCMC Service Reviewer will contact you or your provider to request this information.

Step 3: All information given by you and your provider, along with the MCMC Service Reviewer's written explanation of the original denial, will be forwarded to the MCMC Review Physician.

Step 4: Together, the MCMC Service Reviewer and the Review Physician will discuss your claim and review your information. The MCMC Review Physician will let your provider know of his/her decision in writing.

Final Level Of Appeal

If you and your provider are not satisfied with the decision of the MCMC Review Physician, you will have 30 days to request (in writing) another appeal.

The following are the steps involved in this appeal:

Step 1: MCMC will forward your written request for appeal to the MCMC Medical Director and the Network Advisory Committee. In addition, the MCMC Service Reviewer will provide the Medical Director with your file of information.

Step 2: If necessary, the Medical Director will clarify any outstanding medical necessity issues.

Step 3: If your provider requests a hearing, MCMC will arrange the hearing and notify your provider.

Step 4: The MCMC Medical Director will issue a final decision within 30 days of the date you requested an appeal or the date the hearing ends, whichever is later.

The decision of the Medical Director is final and binding.

If your medical claim is denied by MCMC, you may submit your claim for reimbursement through your Amtrak medical plan. See **Section 4: Medical Benefits** for more information.

RIGHT CARE...DAY ONE

To help you recover as quickly as possible from a work-related illness or injury, Amtrak provides most employees with interim work opportunities until you can return to full-time work. If you are in an on-duty injury status, check with your Amtrak claims representative to see if you are eligible for this program. This voluntary program, called ***Right Care…Day One***, offers the following advantages:

- You will have access to a network of doctors and Occupational Health Facilities that specialize in work-related illnesses and injuries; and
- You will be assigned a case manager who can:
  - Answer your questions;
  - Help you receive the most appropriate care for your condition; and
  - Help coordinate your return-to-work program – including modified or alternative work.

You may be eligible for this program if you are injured in an on-duty accident — check with your claims representative. For additional information about ***Right Care…Day One*** or to speak with a case manager, call MCMC at 1-800-505-5549.

AMTRAK'S LIMITS

In accordance with the 1990 arbitration award issued by Nicolas Zumas, which recognized the unilateral right of Amtrak to create its own health plan provided that the benefits under such a plan are equivalent to those provided by the Railroad Employees National Health and Welfare Plan (National Plan), AmPlan will be considered as if it were the National Plan on December 31, 1996 for the purpose of applying the collateral source rule to ODI payments. Accordingly, the history of ODI payments under the National Plan is deemed to be the history of ODI payments under AmPlan and the legal status of ODI payments under the National Plan as of December 31, 1996 as determined by the courts is deemed to be the same as that of ODI payments under AmPlan. In light of this understanding, the following language excerpted from the October 22, 1975 Health and Welfare Agreement which appeared in the National Plan 1995 Summary Plan Description is also applicable to AmPlan:

"In case of an injury or sickness for which an employee who is eligible for employee benefits and may have a right of recovery against the employing railroad benefits will be provided under the Policy Contract, subject to the provisions hereinafter set forth. The parties hereto do not intend that benefits provided under the Policy Contract will duplicate, in whole or in part, any amount recovered from the employing railroad for hospital, surgical, medical, or related expenses of any kind specified in the Policy Contract, and they intend that benefits provided under the Policy Contract will satisfy any right of recovery against the employing railroad for such benefits to the extent of the benefits so provided. Accordingly, benefits provided under the Policy Contract will be offset against any right of recovery the employee may have against the employing railroad for hospital, surgical, medical, or related expenses of any kind specified in the Policy Contract. (Art. III, Sec.A.)"

FOR MORE INFORMATION

For additional information about ODI coverage, refer to **Section 12: Administrative Information**.

SAVING FOR YOUR FUTURE

In addition to the health and welfare benefits described in this handbook, Amtrak provides you with a 401(k) savings plan that can make it easier for you to save money for the future. The Retirement 401(k) Savings Plan allows you to put money aside on a tax-deferred basis to help provide you with an income at retirement. You may also use your savings for other long-term goals, such as paying for college tuition.

This section of your handbook describes the provisions of the Retirement 401(k) Savings Plan and the steps you should take to participate.

The Retirement 401(k) Savings Plan is administered by the Vanguard Group.

WHO IS ELIGIBLE TO PARTICIPATE

You may participate in this Plan if you:

- Are an eligible employee as described in **Section 3: Eligibility And Participation** of this handbook; and
- Have worked at Amtrak for at least one year.

HOW TO ENROLL

When you become eligible to participate in this Plan, you will receive a letter notifying you of your eligibility. At that time, you can enroll in this Plan through Vanguard's automated VOICE™ Network at 1-800-523-1188. You will need a personal identification number (PIN) that Vanguard will mail to you shortly after you receive your eligibility letter.

If you don't enroll when you are first eligible, you may enroll at any time by calling the automated VOICE™ Network at 1-800-523-1188. The VOICE™ Network is available 24 hours a day, seven days a week.

You will also need to complete and return a *Beneficiary form* to the Vanguard Group. You may obtain a *Beneficiary form* through www.amtrakbenefits.com or call the Vanguard Group at 1-800-523-1188.

If You Leave Amtrak

If you end your employment with Amtrak and are later rehired, you may rejoin the Plan when you are rehired. To rejoin, you must complete the enrollment process as outlined earlier.

✓ **Life Event Reminder:** Refer to **Section 2: Life Events That Affect Your Benefits** for information about how your benefits may be affected if you leave Amtrak.

WHEN PARTICIPATION BEGINS

Your participation begins with the first or second paycheck following the date you enroll.

HOW THE PLAN WORKS

The Retirement 401(k) Savings Plan is designed to help you save money for your retirement. These savings, in addition to Railroad Retirement benefits and your personal savings, will make up your income when you retire.

When you enroll, an account will be set up in your name. You will make contributions from your paycheck into your account on a tax-deferred basis. In other words, your contributions are deducted from your paycheck before Federal (and sometimes State) income taxes are calculated. This means you don't pay Federal income taxes on your contributions until you withdraw the contributions from your account.

Any gains your account earns are also tax-deferred – so you don't pay taxes on the earnings until you withdraw them.

Important Note: When you save on a tax-deferred basis, it will reduce the amount of salary used in determining your Railroad Retirement Tax Act (RRTA) earnings, and eventual Railroad Retirement benefits. In most cases, the income tax savings will more than offset the reduction in your eventual Railroad Retirement benefits.

HOW MUCH YOU CAN SAVE

You may contribute from 1% to 40% of your salary (in whole percentages) on a tax-deferred basis. Your salary includes your total compensation, including any pre-tax contributions you may make for benefits, such as Spending Accounts.

Because of the tax advantages of this Plan, the IRS places limits on the amount of salary that can be considered for tax-deferred contributions. Similarly, the IRS limits the amount you may contribute each year. These amounts are subject to change by the IRS annually.

For 2007, these limits are:

- Maximum salary to be considered: $225,000; and
- Maximum contribution amount: $15,500.

You may change or stop your contributions at any time by calling Vanguard at 1-800-523-1188. You may restart your contributions by calling this same number.

VESTING

Vesting is your right to the money in your account. You are always 100% vested in the money you contribute to your account.

CATCH-UP CONTRIBUTIONS

Employees who are at least age 50 by December 31 may make an extra tax-deferred contribution to their Retirement 401(k) Savings Plan account. If you are eligible, you may set aside up to $5,000 in additional contributions each year.

> **Important Note:** You can start making a catch-up contribution before you reach age 50, as long as you will reach age 50 by December 31 of that year.
>
> Some states may not allow you to defer state income taxes from catch-up contributions. Contact Vanguard at 1-800-523-1188 or your state's Treasury Department for more information.

PARTICIPANT DIRECTED ACCOUNT

This Plan is intended to constitute an employee-directed, individual account plan described in section 404(c) of the Employee Retirement Income Security Act of 1974 (ERISA) and its regulations. The fiduciaries of the Retirement 401(k) Savings Plan may be relieved of liability for any losses that are the direct and necessary result of investment instructions given by you or your beneficiary(ies).

The Retirement 401(k) Savings Plan is responsible for providing, at the request of you and/or your beneficiary(ies), a wide range of information about investment elections, etc.

The following information will be provided to you if you request it:

- A description of the annual operating expenses of each fund;
- The percentage of net assets of each fund that those expenses represent; and
- Any materials about the funds that have been given to the Retirement 401(k) Savings Plan, but that you have not received.

HOW TO INVEST YOUR SAVINGS

You have several fund options from which to choose. You may invest in one or more of these funds, in 1% increments. Your investment mix must add up to 100% of your contributions. The fund options and types are as follows:

- Prime Money Market Fund – Money Market Fund
- Total Bond Market Index Fund – Bond Fund
- Wellington Fund – Balanced Fund of Stocks and Bonds
- 500 Index Fund – Growth and Income Stock Fund
- Growth Index Fund – Growth and Income Stock Fund
- Windsor Fund – Growth and Income Stock Fund
- U.S. Growth Fund – Growth Stock Fund

HOW TO INVEST YOUR SAVINGS (CONTINUED)

- Explorer Fund – Aggressive Growth Stock Fund
- International Growth Fund – International Stock Fund
- LifeStrategy™ Income Fund – Balanced Fund of Stocks and Bonds
- LifeStrategy™ Conservative Growth Fund – Balanced Fund of Stocks and Bonds
- LifeStrategy™ Moderate Growth Fund – Balanced Fund of Stocks and Bonds
- LifeStrategy™ Growth Fund – Balanced Fund of Stocks and Bonds

For more information about the objectives and underlying investments of these funds, please review the fund prospectus, as well as other materials provided by the Vanguard Group.

Changing Your Investment Choices
Most investment experts don't recommend that you change your investment mix too often. However, if you want to change your investment choices, you may do so daily by calling Vanguard at 1-800-523-1188 or accessing the Vanguard website at **www.vanguard.com.**

ACCOUNT STATEMENTS

Each calendar quarter, Vanguard will send you a statement showing your account balance and any gains or losses to your account. It will also show account activity that occurred during the last quarter (for example, if you changed your contributions or investment mix).

ACCESS TO THE MONEY IN YOUR ACCOUNT

While this Plan is designed to help you save for retirement, you may access money from your account under certain circumstances. However, in some cases, a penalty and income taxes may apply.

There are three ways to access the money in your account:

- Taking out a loan;
- Taking a hardship withdrawal; or
- Receiving a distribution from the Plan.

These are explained in more detail next.

Loans
If you have participated in the Plan for at least one year, you may borrow from your account balance. You may borrow:

- A minimum of $1,000; and
- A maximum of 50% of your account balance, up to $50,000 minus the highest outstanding loan balance in the last 12 months.

To apply for a loan, access the Vanguard website: www.vanguard.com, the Voice® Network, or call Vanguard at 1-800-523-1188 and speak with a Participant Services Associate who will mail an application to you. If you meet certain requirements, an "express" loan may be available. A Vanguard representative will help you to determine the terms of your loan. Once your application is confirmed, Vanguard will mail the loan check within three to five business days to your address of record. When you endorse the check, you are indicating your acceptance of the loan provisions, including your certification that the loan will be used to purchase your principal residence, if applicable. A non-refundable loan fee will be deducted from the loan check.

You may only have one loan outstanding at a time.

Repaying A Loan
You will repay the loan, plus interest, to your Plan account, through payroll deductions. Loan repayments are invested in the same manner as your current contributions.

The interest rate you pay will be based on the prime rate received by Vanguard from Reuters on the first working day of the month in which Vanguard processes your loan. The interest rate will be set for the term of your loan and is not tax deductible.

ACCESS TO THE MONEY IN YOUR ACCOUNT (CONTINUED)

If You Leave Amtrak

If you leave employment with Amtrak, you will be required to repay any outstanding loans in full within 90 days. If you do not repay the loan, it will be considered a distribution and will be taxed accordingly (see the heading **Distributions** later in this section of your handbook for more information).

✓ **Life Event Reminder:** Refer to **Section 2: Life Events That Affect Your Benefits** for information about how your benefits may be affected if you leave Amtrak.

Hardship Withdrawals

The Internal Revenue Service (IRS) gives tax-deferred status to your savings to encourage retirement savings. Because of this tax advantage, the IRS places restrictions on withdrawals from your account.

However, if you are experiencing a severe financial hardship that cannot be met through any other means, you may make a withdrawal from your account. You may qualify for a hardship withdrawal if you have been a Plan participant for at least one year.

The amount you withdraw may be limited to the amount needed to meet the financial hardship. The minimum amount you may withdraw is $500.

Investment earnings made to your account after December 31, 1988 may not be withdrawn. In addition, any outstanding loan balance will be subtracted from the amount you may withdraw.

To request an application for a hardship withdrawal, contact Vanguard at 1-800-523-1188.

Financial Hardship Expenses

Examples of expenses that qualify as a financial hardship include:

- Necessary medical expenses for you, your spouse, or your dependent children;
- College tuition for you, your spouse, or your dependent children for a 12-month period;
- The purchase of a primary home (not including mortgage payments);
- Payment for burial or funeral expenses for your parent, spouse, children, or other dependents;
- Expenses for payments to repair damages to your principal residence that would qualify as a casualty deduction under IRS Code Section 165; and
- To prevent eviction or foreclosure of your principal residence.

If you take a hardship withdrawal, you will not be able to contribute to your account for six months. Contributions after this six-month period may be limited, according to IRS regulations. For example, the maximum amount you may contribute to your account during the taxable year following the year in which you take a hardship withdrawal will be reduced by the amount of contributions you made in the taxable year in which you take a hardship withdrawal.

The hardship withdrawal will be subject to income taxes and any penalty taxes required (explained in more detail later in this handbook section).

Distributions

You are eligible to receive the full amount of your account balance if you leave Amtrak. At that time, you may:

- Receive payment in a lump sum;
- Roll over the money into an IRA or another qualified plan; or
- Leave your account balance in the Plan and withdraw it at a future day (but no later than age 70½).

ACCESS TO THE MONEY IN YOUR ACCOUNT (CONTINUED)

Small Account Balances

If your account value is less than or equal to $5,000, you may elect to roll your Plan balance over into another qualified 401(k) plan or to an Individual Retirement Account (IRA). If you do not roll over your balance into another plan, the Plan Administrator will distribute your balance as follows: .

IF YOUR ACCOUNT BALANCE IS...	WHEN YOU LEAVE AMTRAK
$1,000.00 or less	Your Plan balance will be paid to you automatically as a lump-sum payment*, unless you elect to roll over your balance to another qualified plan or IRA.
Between $1,000.01 and $5,000.00	Your Plan balance will be automatically rolled over into a Vanguard traditional IRA on your behalf, unless you elect to roll over your balance to another qualified plan or IRA or request a distribution.* Your funds will be invested in the Vanguard® Prime Money Market Fund.**
$5,000.01 or more	Your Plan balance may remain in the Plan in the investment funds you have chosen, until you request that your funds be distributed to you or rolled over into another qualified plan or IRA.

* *Please note that any distribution you receive from the Plan is subject to income taxes, and a 10% penalty tax for early withdrawal (unless you are 59fi or older).*

** *Vanguard's Prime Money Market Fund invests in short-term, high-quality money market instruments issued by financial institutions, non-financial corporations, the U.S. government, and federal agencies. Its holdings may include certificates of deposit, bank-guaranteed securities, corporate IOUs, and other money market instruments, as well as U.S. Treasury and government agency securities and repurchase agreements on such securities. The average maturity of the fund's holdings will be 90 days or less.*

If your Plan account balance is between $1,000.01 and $5,000.00 when you leave Amtrak, Vanguard will send you a notice that outlines your distribution options. If you do not contact Vanguard within 90 days of the date your employment ends, Vanguard will automatically distribute your plan account balance as outlined in the chart above.

If your Plan balance is $5,000.01 or more, you may leave your balance in the Plan until a later date. The investment elections you have made will remain in effect until you notify Vanguard that you wish to roll over your balance to another qualified plan, or that you want to receive a distribution.

Income And Penalty Taxes

Any distribution you receive from the Plan will be taxed at your income tax rate at the time of the distribution.

In addition, if you are under age 59½ when you receive a distribution, you will be subject to an additional 10% penalty tax. However, this 10% penalty tax will not apply if the distribution is paid:

- Because of your death or total disability;
- After you reach age 59½;
- To an alternate payee directed by a Qualified Domestic Relations Order (explained later in this section);
- As a lump sum and you roll it over into an Individual Retirement Account (IRA) or another qualified plan within 60 days of receipt;

ACCESS TO THE MONEY IN YOUR ACCOUNT (CONTINUED)

- To cover medical expenses that are tax deductible;
- On separation from service after age 55; or
- In a series of equal periodic payments over your life.

More About Income Taxes

According to federal law, when you take a distribution from your account, the Plan Administrator will withhold 20% of your distribution for federal income taxes. You may be eligible to receive a reimbursement of some or all of this amount once you file an income tax return.

The 20% is not withheld if you transfer your distribution directly into an IRA or another qualified plan. If you personally receive a distribution and you roll that amount into an IRA or another qualified plan within 60 days of the date of your receipt, your distribution will not be subject to the 20% tax withholding.

IRS Form 1099-R

When you receive a distribution from the Plan, you will receive an IRS form 1099-R. This form is sent to you in January following your distribution. The information is also filed with the IRS. You'll need this form when filing your income taxes.

Check With The Experts

This information is meant to help guide you. Please consult with a tax expert or financial advisor for information about your particular situation.

> ✓ **Life Event Reminder:** Refer to **Section 2: Life Events That Affect Your Benefits** for information about how a life event, such as retirement, may affect your other Amtrak employee benefits.

ROLLOVERS

If you participated in a similar qualified plan with a former employer, you may deposit any tax-deferred contributions into the Amtrak Retirement 401(k) Savings Plan, as long as the contributions remain in a tax-deferred status. You may make a rollover contribution before you become an active participant in the Amtrak Retirement 401(k) Savings Plan.

To request a rollover, submit the following to the Amtrak Benefits Department:

- A copy of your previous plan's description; and
- A final statement indicating taxable and non-taxable contributions.

If your rollover qualifies, the Amtrak Benefits Department will let you know how to process the rollover.

MILITARY LEAVE

If you are away from work due to military leave, special rules apply to your Retirement 401(k) Savings Plan account. You may make up your contributions for the period you were on military leave. The amount of time you have to make-up contributions begins when you become re-employed, and cannot be more than three times the period of military service, or if less, five years.

No investment gains or losses on make-up contributions will be applied.

> ✓ **Life Event Reminder:** Refer to **Section 2: Life Events That Affect Your Benefits** for information about how a military leave of absence may affect your other Amtrak benefits.

BENEFITS AT YOUR DEATH

If you are married and die before retirement, your spouse (or other beneficiary, if your spouse provides written, notarized consent or consent is witnessed by the Plan Administrator) will receive a benefit from the Plan. Your spouse (or other beneficiary) should contact your Department Administrator or your local Human Resources Representative for information on how to receive these benefits.

If you have not designated a beneficiary or your beneficiary dies before you do, the value of your account at the time of your death will be paid to your personal representative.

> ✓ **Life Event Reminder:** Refer to **Section 2: Life Events That Affect Your Benefits** for information about how your death may affect your other Amtrak benefits.

ASSIGNMENT OF BENEFITS

Your value in this Plan may not be assigned, sold, transferred, garnished, or pledged as collateral. In addition, a creditor may not attach your value in the Plan as a means of collecting a debt owed to you.

However, your account may be attached to satisfy a federal tax levy or a Qualified Domestic Relations Order (QDRO) issued by a state court. A QDRO requires that all or a portion of your benefits be paid to someone other than you or your named beneficiary in connection with child support, alimony payment, or marital property rights.

In the case of a QDRO, the Plan Administrator will review all court orders to determine if the order is qualified. To make the process as easy as possible, the Plan Administrator may provide you and your former spouse (at no charge) with a copy of the Retirement 401(k) Savings Plan QDRO procedures and a model domestic relations order.

Once the Plan Administrator has determined that the order is qualified, your account will be distributed as soon as administratively possible, according to the terms of the QDRO.

The above information is an overview of the procedures for a QDRO. You may receive a copy of the precise procedures free of charge from the Amtrak Benefits Department.

> ✓ **Life Event Reminder:** Refer to **Section 2: Life Events That Affect Your Benefits** for information about how a divorce may affect your other Amtrak benefits.

TOP HEAVY

Federal law states that in the event the Plan pays benefits to certain "key" employees disproportionately, the Plan may be declared "top heavy." If this occurs, the Plan will become subject to special rules. If the Plan is determined to be top heavy, you will receive information about the effect, if any, on your benefits.

PLAN INSURANCE

Because there are no definite benefit amounts that can be insured under a defined contribution plan, the benefits under this Plan are not covered by the plan termination insurance of the Pension Benefit Guaranty Corporation (PBGC).

PLAN TRUSTEE

The trustee of the Retirement 401(k) Plan is: The Vanguard Group, P.O. Box 2900, Valley Forge, PA 19482-2900, Phone: 1-800-523-1188.

OTHER ADMINISTRATIVE INFORMATION

For additional information about the Retirement 401(k) Savings Plan and your rights, please refer to **Section 12: Administrative Information** of your handbook.

INFORMATION THAT IS COMMON TO ALL BENEFITS

While each employee benefit plan is different, there are certain aspects that are the same for several, if not all of the Plans. This section describes these similarities and your rights as an employee.

The Employee Retirement Income Security Act of 1974 (ERISA) requires Amtrak to provide summary plan descriptions that explain the features of your benefits as simply, understandably, and accurately as possible. This handbook constitutes a summary plan description for the following benefits:

- Medical;
- Spending Accounts;
- Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance;
- On-Duty Injury; and
- Retirement 401(k) Savings Plan.

For a summary plan description of your dental benefits, contact the Railroad National Dental Plan at 1-877-277-3368. Amtrak Police should contact Delta Dental at 1-800-932-0783.

There may be changes to your benefits as dictated by Federal and State laws. You will be notified if this happens. If anything described here needs further clarification, contact your local Human Resources representative or the Amtrak Benefits Service Center at 1-800-481-4887.

PLAN SPONSOR

The National Railroad Passenger Corporation (Amtrak) is the sponsor of the plans outlined in this summary plan description. The official name, address, phone number, and Employer Identification Number (EIN) are as follows:

National Railroad Passenger Corporation (Amtrak)
60 Massachusetts Avenue, NE
Washington, DC 20002
1-202-906-3000
EIN: 52-0910053

PLAN ADMINISTRATOR

The Plan Administrator is the person or group who manages the plan and answers questions about plan details. If you want to take legal action for any reason related to the Plan, you can contact the Plan Administrator or Plan Trustee for actions against the Retirement 401(k) Plan. The name, address, and telephone number of the Plan Administrator is:

National Railroad Passenger Corporation
60 Massachusetts Avenue, NE
Washington, DC 20002
1-202-906-3000

The Plan Administrator is responsible for the proper administration of the plans according to the terms of ERISA, any plan documents or insurance contracts, or other instruments. The Plan Administrator generally supervises the operation of the Plan, including having discretionary authority to interpret its provisions and arrange for benefit payments.

COLLECTIVELY-BARGAINED PLANS

Your Medical benefits, Dental benefits, Vision benefits, Life Insurance and AD&D Insurance, and On-Duty Injury Benefits are collectively bargained. You, your dependents, and/or your beneficiary(ies) may request, in writing, a copy of the collective bargaining agreements relating to these benefits. Or, you may ask to review these agreements in person.

If you would like a list of all employee organizations sponsoring the benefits, you may do so by sending a written request to the Amtrak Benefits Department. You may also request, in writing, information on whether a particular union or employer is a plan sponsor.

TERMINATING THESE PLANS

Amtrak expects to continue its benefit plans indefinitely, but reserves the right to modify, suspend, terminate, or collectively bargain any plan at any time for any reason. If such steps are taken, you will be notified. You will also be informed of the effect that any material changes in the plans will have on your rights to benefits.

TERMINATING THESE PLANS (CONTINUED)

Some possible reasons why a plan could end would be the installation of a revised successor plan; merger, transfer, or consolidation with another plan; or a change in economic conditions or corporate structure that would make the plan no longer feasible as it currently exists.

If a plan or any part of a plan should end, you would receive the benefits due you to the extent funded or provided contractually under the terms defined in the plans' legal documents.

NOT A CONTRACT OF EMPLOYMENT

Nothing in this handbook is intended or should be construed as a contract of employment, express or implied.

ADMINISTRATIVE INFORMATION

If you have a question about a benefit, wish to appeal a denied claim, or take legal action against the Plan, you may need the following information:

EMPLOYER IDENTIFICATION NUMBER:	52-0910053
PLAN YEAR:	January 1 through December 31
BENEFITS ADMINISTRATIVE AGENT:	Amtrak Benefits Service Center P.O. Box 9183 Des Moines, IA 50306-9183 1-800-481-4887

To exercise your rights under ERISA, you will need the following information about your benefits:

- The official plan name and number;
- How benefits are funded; and
- How and where claims are paid.

OFFICIAL PLAN NAMES AND NUMBERS

The official plan names and numbers are as follows:

- AmPlan, the Amtrak Union Benefits Plan, 555 – includes Medical, Prescription Drug, Vision, Mental Health and Substance Abuse, Life and AD&D Insurance, and On-Duty Injury benefits.
- The Railroad Employees National Dental Plan, 505 – includes dental benefits for non-police employees. Delta Dental Plan, 501 – includes dental benefits for police employees.
- Spending Accounts, 507 – includes Health Care and Dependent Day Care Spending Accounts.
- Commuter Reimbursement Account – includes Transportation and Parking Reimbursement Accounts.
- Amtrak Retirement 401(k) Savings Plan for Agreement Employees, 003 – includes the Retirement Savings Plan (401(k) Plan).

FUNDING OF THE PLANS

Your AmPlan benefits (Medical, Prescription Drug, Mental Health and Substance Abuse, Life and AD&D Insurance, and On-Duty Injury benefits) are funded entirely by Amtrak through contracts with the following organizations:

UnitedHealthcare
450 Columbus Boulevard
Hartford, CT 06115
1-888-675-RAIL (7245)

Tufts Health Plan
(Massachusetts)
333 Wyman Street
Waltham, MA 02454
1-800-462-0224

Aetna (Central PA and WV only)
P.O. Box 26012
Greensboro, NC 27402-6102
1-800-438-2602

Caremark Inc.
Prescription Service
2211 Sanders Road
Northbrook, IL 60002
1-800-378-0182

Matria Healthcare
Disease Management
1850 Parkway Place
Marietta, GA 30067
1-888-779-1316

MHN
P. O. Box 14621
Lexington, KY 40512
1-888-267-5261

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105
1-800-877-7195

FUNDING OF THE PLANS (CONTINUED)

Aetna Life Insurance Company
P.O. Box 14549
Lexington, KY 40512-4540
1-800-523-5065

MCMC, LLC
ATTN: ABR Department
15 River Road, Suite 200
Wilton, CT 06897
1-800-219-8184

Benefits under the Spending Accounts, Commuter Reimbursement Accounts, and the Retirement 401(k) Savings Plan are funded entirely by employee contributions through contracts with the following:

SHPS Inc.
P.O. Box 34700
Louisville, KY 40232-4700
1-800-678-6684

The Vanguard Group
P.O. Box 2900
Valley Forge, PA 19482-2900
1-800-523-1188

Dental benefits are funded by Amtrak through insurance contracts with:

Aetna
P.O. Box 120
Grand Rapids, MI 49501-0120
1-877-277-3368

Delta Dental (Police Only)
One Delta Drive
Mechanicsburg, PA 17055-6999
1-800-932-0783

CLAIMS ADMINISTRATORS

The following chart provides information about the organizations that pay claims.

NAME, ADDRESS, PHONE NUMBER OF CLAIMS PAYOR	TYPE OF BENEFITS
UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-888-675-RAIL (7245) www.myuhc.com	Medical (Network and Comprehensive Plans)
Tufts Health Plan 333 Wyman Street Waltham, MA 02454 1-800-462-0224 www.tufts-healthplan.com	Medical (Network Plan in Massachusetts only)
Aetna (Central PA only) P.O. Box 26102 Greensboro, NC 27402-6102 1-800-438-2602 www.aetna.com	Medical (Network Plan in Central PA only)
Caremark Inc. Prescription Service 2211 Sanders Road Northbrook, IL 60002 1-800-378-0182 www.caremark.com	Prescription Drug
Matria Healthcare, Inc. 1850 Parkway Place Marietta, GA 30067 1-888-779-1316 www.matria.com	Disease Management (SmartCare)
MHN P. O. Box 14621 Lexington, KY 40512-4621 1-888-267-5261 www.mhn.com	Mental Health and Substance Abuse
Aetna Life Insurance Company P.O. Box 14549 Lexington, KY 40512-4540 1-800-523-5065	Life Insurance and AD&D Insurance

CLAIMS ADMINISTRATORS (CONTINUED)

NAME, ADDRESS, PHONE NUMBER OF CLAIMS PAYOR	TYPE OF BENEFITS
Aetna P.O. Box 14091 Lexington, KY 40512-4091 1-877-277-3368 www.aetna.com	Dental
Delta Dental One Delta Drive Mechanicsburg, PA 17055-6999 1-800-932-0783 www.deltadental.com	Dental (Police only)
Vision Service Plan P.O. Box 997105 Sacramento, CA 95899-7105 1-800-877-7195 www.vsp.com	Vision
MCMC, LLC ATTN: ABR Department 15 River Road, Suite 200 Wilton, CT 06897 1-800-219-8184	On-Duty Injury
SHPS Inc. P.O. Box 34700 Louisville, KY 40232-4700 1-800-678-6684 www.myshps.com	Spending Accounts, Commuter Reimbursement Accounts
The Vanguard Group P.O. Box 2900 Valley Forge, PA 19482-2900 1-800-523-1188 www.vanguard.com	Retirement 401(k) Savings Plan

YOUR BASIC ERISA RIGHTS

As a participant in Amtrak employee benefits for agreement-covered employees, 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 their plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

Receive Information About Your Plan and Benefits
You are entitled to:

- Examine, without charge, all documents governing the plan. These include insurance contracts, 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. The Form 5500 may also be obtained from the Public Disclosure Room of the Employee Benefits Security Administration. You are entitled to examine these documents at the Plan Administrator's office and at other agreed upon locations, such as worksites and union halls.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan. These include insurance contracts, collective bargaining agreements, the latest annual report (Form 5500), and the 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
You are entitled to:

- Continue medical, dental, and vision care coverage for yourself, your spouse, or your 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. It is important to review this summary plan description and the documents governing the plan regarding the rules for exercising your COBRA continuation coverage rights.

YOUR BASIC ERISA RIGHTS (CONTINUED)

- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan provided that you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group medical, dental, or vision plan or 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
  - When you request it anytime up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for up to 12 months (18 months for late enrollees) after the date you enroll in the plan.

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 are called "fiduciaries," and they 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 which prevents you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

You are entitled to:

- Enforce your rights if your claim for a benefit (either pension or welfare) is denied or ignored, either in whole or in part;
- Know why this was done; and
- Obtain copies of documents relating to the decision without charge, and to appeal any denial within certain time schedules.

Under ERISA, there are steps that you can take to enforce your rights. For example, you may file suit in Federal court if:

- You request a copy of plan documents or the latest annual report (Form 5500) and do not receive them within 30 days. 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 they were not sent for reasons beyond the control of the administrator.
- You have a claim for benefits which is denied or ignored, in whole or in part. You may also file suit in state court.
- 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.
- The plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay court costs and legal fees. For example, 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. This could occur if the court finds your claim frivolous.

The address of the person designated as agent for the service of legal process for your benefit plans is:

National Railroad Passenger Corporation (Amtrak)
60 Massachusetts Avenue, NE
Washington, DC 20002
1-202-906-3000

You may also serve legal process to the Plan Administrator.

YOUR BASIC ERISA RIGHTS (CONTINUED)

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 your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, which is listed in your telephone directory. You may also contact:

Division of Technical Assistance and Inquiries
Employee Benefit Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210
1-866-444-EBSA
www.askebsa.dol.gov

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIMS PROCESSING

In most cases, you, a health care provider, or a family member must file claims to receive benefits. Instructions for filing claims vary by plan, and are included in earlier sections of this handbook.

The following outlines the claims approval/denial process for medical, dental, vision, and Health Care Spending Account claims.

Urgent Health Care Claims:

- Conditions that could jeopardize life, health, or ability to regain maximum function, or would subject you to severe pain.
- Conditions that a physician determines is urgent.

Step 1 The Plan has **72 hours** after receiving your initial claim to notify you if your claim is approved or denied.

Step 2 If denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.

Step 3 The Plan has **72 hours** after receiving your appeal to notify you of its appeal decision.

If the urgent health care claim is improper or incomplete, the following rules apply:

- The Plan has 24 hours after receiving your initial claim to notify you that your claim is improper or incomplete.
- You have 48 hours after receiving notice from the Plan to correct or complete your claim.
- The Plan has 48 hours to notify you if your claim is approved or denied. The Plan must do so within the earlier of 48 hours of:
  – Receiving your completed claim, or
  – Your deadline to complete the claim.
- If denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.

Pre-Service Health Claim:

- Where treatment must be pre-certified before it is performed.

Step 1 The Plan has **15 days** after receiving your initial claim to notify you if your claim is approved or denied.

Step 2 If denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.

Step 3 The Plan has **30 days** after receiving your appeal to notify you of the appeal decision. If the Plan allows two levels of appeal, it has **15 days** after receiving your appeal to notify you of its decision. Both levels of appeal must be completed within the 30-day deadline.

CLAIMS PROCESSING (CONTINUED)

If a pre-service claim is improper or incomplete, the following rules apply:

- The Plan has **5 days** after receiving your initial claim to notify you that your claim is improper or incomplete.
- The Plan has **15 days** after receiving your claim to notify you of its decision to approve or deny the claim. If the Plan needs more information and provides an extension notice during the initial 15-day period, the Plan has 30 days after receiving the claim to notify you of its decision. (The time the Plan waits for information from you is not counted in totals.)
- You have **45 days** after receiving the extension notice to provide additional information or complete the claim.
- If denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.
- The Plan has **30 days** after receiving your appeal (**15 days** if the Plan allows two levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 30-day deadline.

Post-Service Health Claim:

- Where you request reimbursement after treatment has been performed.

Step 1 The Plan has **30 days** after receiving your initial claim to notify you if your claim is approved or denied.

Step 2 If denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.

Step 3 The Plan has **60 days** after receiving your appeal (**30 days** if the Plan allows two levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 60-day deadline.

If the Plan needs further information or an extension, the following rules apply:

- The Plan has **30 days** after receiving the initial claim to notify you if your claim is denied. If the Plan needs more information and provides an extension notice during the initial 30-day period, the Plan has **45 days** after receiving the claim to notify you if your claim is denied. (The time the Plan waits for information from you is not counted in totals.)
- You have **45 days** after receiving the extension notice to provide additional information or complete your claim.
- If denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.
- The Plan has **60 days** after receiving your appeal (**30 days** if the Plan allows two levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 60-day deadline.

Written Notice Requirements

The following applies to claims for medical, dental, and vision benefits, as well as claims for a Health Care Spending Account.

If your initial claim for benefits is denied (in whole or in part), you will receive a written explanation of the denial that will include the following:

- The specific reason why your claim was denied;
- Reference to the specific Plan provisions on which the decision is based;
- A description of any additional material or information necessary for you to complete the claim (if you elect to appeal the denial) and an explanation of why such material and information is necessary;
- A description of the Plan's review procedures and time limits for appealing the decision, including a statement of your right to obtain information about those procedures and the right to sue in federal court;

CLAIMS PROCESSING (CONTINUED)

- In the case of a claim denial, a statement that a copy of any internal rules, guidelines, or other similar criterion relied upon in denying the claim, will be provided to you free of charge upon request;
- If a denial is based on a medical necessity, experimental treatment, or other similar exclusion or limit, a statement notifying you that an explanation of the scientific or clinical judgment for the denial that applies the terms of the Plan to your medical circumstances will be provided to you free of charge upon request; and
- In the case of a denial involving a claim for urgent care, a description of the expedited review process applicable to urgent care claims. This denial may be given orally, provided that a written or electronic notification is provided to you no later than three days after you are notified orally.

You may submit written comments, documents, or other information in support of your appeal. You may also have access, upon your request, to all relevant documents free of charge. The review of the claim denial will take into account all new information, whether or not presented or available at the initial claim review. The second claim review will not be influenced by the initial claim decision.

A different person than the one who made the initial claim determination will conduct the appeal review. The second reviewer will not work under the original decision maker's authority. If your claim was denied on the grounds of a medical judgment, the Plan will consult with a health care professional with appropriate training and experience. This health care professional will not be the individual who was consulted during the initial determine or work under their authority. If the advice of a medical or vocational expert was obtained by the plan in connection with the denial of your claim, we will provide you with the names of each expert, regardless of whether their advice was used.

If your appeal is denied, the denial notice will contain the following:

- The specific reason why your claim was denied;
- Reference to the specific Plan provisions on which the decision is based;
- Statements that:
  - Tell you that you are entitled to receive – upon request and without charge – reasonable access to or copies of any documents, records, or other relevant information;
  - Describe any voluntary appeal procedures offered by the Plan Administrator and your right to get information about these procedures;
  - Describe your right to bring a civil lawsuit under federal law;
  - Outline any internal rules, guidelines, protocols, or other similar criterion relied on when denying the claim (will be provided to you free of charge upon request);
  - Explain how the scientific or clinical judgment for the denial that applies to the terms of the Plan and your medical criteria will be provided to you free of charge upon request, if the denial is based on a medical necessity, experimental treatment; and
  - Describe how you or the claims administrator may have other voluntary alternative dispute resolution options, such as mediation. To find out what may be available to you, contact your local U.S. Department of Labor Office or your state insurance regulatory agency. The appeal determination notice may be provided in written or electronic form. Electronic notices must be provided in a form that complies with any applicable legal requirements.

CLAIMS PROCESSING (CONTINUED)

All Other Claims

The following applies to claims under Life and AD&D Insurance, Retirement 401(k) Savings Plan, Dependent Day Care Spending Account, and Commuter Reimbursement Accounts.

Once your claim has been documented and you've filled out all the necessary forms, the claims administrator must process your claim within 90 days after they receive it. However, in some cases, the claims administrator might need more time. If this happens, you'll be notified that an additional 90-day processing period is required. You should file your claim as soon as possible. However, the maximum claim-filing deadline is two years from the date of service. Claims filed after that date are not eligible for reimbursement.

If your claim is denied, or if you do not hear anything within 90 days after you send it in, you can appeal the denial and have your claim reviewed. You have at least 60 days to appeal from the time you're notified of the denial, or at least 60 days from the end of the processing period, if you've heard nothing by that time.

If your claim is denied, you'll be notified in writing. This written notice will tell you why the claim was denied. It will also point out what additional information is needed, if any, which could change the decision to deny the claim. Finally, the notice will tell you how you can file an appeal to have the decision reviewed.

To help you prepare your appeal, you or your authorized representative can examine any plan documents related to your claim. Your appeal must state, in writing, the reasons why you think the claim should not be denied.

As fiduciaries, the claims payers have the authority to determine eligibility for benefits and to interpret and construe the terms of the appropriate plan, including, without limitation, those terms that are disputed or ambiguous. A fiduciary is accorded the broadest discretion permitted by federal law when making any such decisions. The fiduciary must act within 60 days of receiving your appeal. However, in special cases, they may be allowed 120 days. The final decision will be sent to you in writing, together with an explanation of how the decision was made.

You cannot take any legal action against the Plan for benefits until you follow and complete the entire claims and appeals process as explained above. Also, you cannot begin any legal action more than 12 months after the Plan has made a final review decision regarding your claim.

CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

As a participant in the Amtrak health plans for Agreement-Covered employees and the Health Care Flexible Spending Account, the information that follows describes your right to COBRA continuation coverage.

COBRA, or the Consolidated Omnibus Budget Reconciliation Act of 1985, is a federal law affecting most employers who offer group health coverage to their employees. Under this law, you and other members of your family may have the right to temporarily continue the group health benefits when you would ordinarily lose coverage. This section describes your right to this **COBRA continuation coverage**, when it may become available to you and your family and what you must do to protect your right to receive it.

CONTINUATION OF COVERAGE RIGHTS UNDER COBRA (CONTINUED)

Qualifying Events

COBRA continuation coverage extends your health plan coverage when it would otherwise end because of a life change (known here as a **qualifying event**). After a qualifying event, COBRA continuation coverage must be offered to each person who is a **qualified beneficiary**. You, your spouse and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage are required to pay for it.

As an employee covered by the plan, you will become a qualified beneficiary if you lose your plan coverage because:

- Your hours of employment are reduced below the number required for eligibility; or
- Your employment ends for any reason except for gross misconduct on your part.

As the spouse of a covered employee, you will become a qualified beneficiary if you lose your plan coverage for any of the following reasons:

- Your spouse dies;
- Your spouse's hours of employment are reduced below the number required for eligibility;
- Your spouse's employment ends for any reason other than gross misconduct;
- Your spouse becomes entitled to Medicare benefits; or
- You become divorced or legally separated from your spouse.

As a dependent child of a covered employee, you will become a qualified beneficiary if you lose your plan coverage for any of the following reasons:

- Your employee-parent dies;
- Your employee-parent's hours of employment are reduced below the number required for eligibility;
- Your employee-parent's employment ends for any reason other than gross misconduct;
- Your employee-parent becomes entitled to Medicare benefits; or
- You cease to be a "dependent child" under the terms of the plan.

You are eligible for COBRA continuation coverage only after the Plan Administrator has been notified that a qualifying event has occurred.

Amtrak is responsible for notifying the Plan Administrator if the qualifying event is one of these:

- Your termination or a reduction in your hours of employment below the number required for eligibility;
- Your death; or
- Your becoming entitled to Medicare.

Filing for bankruptcy under Title 11 of the United States Code can also be a qualifying event. If Amtrak were to file for bankruptcy and that bankruptcy resulted in the loss of coverage for a retired person under the plan, the retired employee would become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children would also become qualified beneficiaries if this bankruptcy were to result in the loss of their coverage under the plan.

CONTINUATION OF COVERAGE RIGHTS UNDER COBRA (CONTINUED)

You are responsible for notifying the Plan Administrator that a qualifying event has occurred when the event is one of these:

- You become divorced or legally separated from your spouse; or
- Your dependent child ceases to be eligible under the plan.

You must notify the Plan Administrator within 60 days after the qualifying event has occurred. Provide this notice in writing to:

Amtrak COBRA Service Center
c/o ADP Benefit Services
P.O. Box 9280
Des Moines, IA 50306-9280

Once the Plan Administrator has received notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each person will have an independent right to elect or decline the coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouse, and parents may elect the coverage on behalf of their children.

Length Of Coverage

COBRA continuation coverage is temporary coverage. Generally, it lasts only up to 18 months, when the qualifying event is a reduction in your hours of employment or your employment ends.

COBRA continuation coverage can last up to 36 months when the qualifying event is one of the following:

- You die;
- You become entitled to Medicare benefits;
- You and your spouse become divorced or legally separated; or
- Your dependent child ceases to be eligible under the plan.

An 18-month coverage period can be extended in two ways: through 1) disability or 2) a second qualifying event.

If the Social Security Administration determines that you or another covered individual in your family are disabled and you notify the Plan Administrator within 60 days of the Social Security Administration's determination, you and your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started sometime before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second Qualifying Event

If your family experiences a second qualifying event during its 18-month period of COBRA continuation coverage, your covered spouse and dependent children in your family can obtain an additional 18 months of coverage, for a maximum of 36 months, if the Plan Administrator is notified timely of one of these second events:

- You die;
- You become entitled to Medicare benefits;
- You become divorced or legally separated from your spouse; or
- Your dependent child ceases to be an eligible dependent under the plan.

A second qualifying event extension may be available to your spouse and dependent children only if the event would have caused them to lose coverage under the plan had the first qualifying event not occurred.

Important Note: Divorced spouses of Amtrak employees are not eligible for Amtrak benefits. However, a divorced spouse may continue medical, dental, or vision coverage, according to the COBRA rules as outlined in this section.

CONTINUATION OF COVERAGE RIGHTS UNDER COBRA (CONTINUED)

To help protect your COBRA rights:

- Always keep the Plan Administrator informed of any address change for any family member.
- Whenever you correspond with the Plan Administrator, keep a copy for your records.
- For answers to your questions about your group health plan, contact the Plan Administrator:

  Amtrak COBRA Service Center
  c/o ADP Benefit Services
  P.O. Box 9280
  Des Moines, IA 50306-9280
  1-866-381-2859

- For answers to your questions concerning your rights under COBRA, ERISA, HIPAA and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration or visit the EBSA Website at www.dol.gov/ebsa.

Important Note: COBRA Coverage Concurrent With Amtrak Benefits – In many cases, Amtrak-sponsored benefits will continue when a qualifying event occurs. See **Section 3: Eligibility And Participation** for a description of how long benefits could continue, depending on the event. If your Amtrak-sponsored benefits continue, COBRA coverage will be offered to you at the same time as Amtrak-sponsored coverage.

In other instances (such as if you become furloughed), your Amtrak-sponsored coverage will end before COBRA coverage ends.

When a qualifying event occurs, contact the Amtrak Benefits Service Center at 1-800-481-4887 to confirm how long you will have extended coverage – whether it is through COBRA or is Amtrak-sponsored coverage.

COBRA Election Period

You will receive a notice of your ability to elect COBRA coverage once a qualifying event occurs (or, in the event of divorce, legal separation, or dependent losing eligibility, you notify Amtrak that a qualifying event has occurred). When Amtrak-sponsored benefits run concurrently with COBRA, the COBRA election period will not begin until your Amtrak-sponsored benefits end. For example, if you are furloughed as of February 15, your Amtrak-sponsored benefits will continue until June 30. The 60-day period to elect COBRA coverage will not begin until June 30. However, any Amtrak-sponsored benefits you receive will be deducted from the amount of time you are eligible for COBRA coverage. For example, if the COBRA coverage period for a particular qualifying event is 18 months and you received Amtrak-sponsored benefits for 4 months, you may elect COBRA coverage for 14 months (18 months minus 4 months).

If there is no continuation of Amtrak-sponsored benefits, you will have 60 days from the date you receive your COBRA notice to elect COBRA coverage.

If there is a continuation of Amtrak-sponsored benefits and COBRA coverage runs at the same time, you do not have to begin to pay COBRA premiums until your Amtrak-sponsored benefits end. However, your first premium will be due within 45 days of the deadline to apply for COBRA coverage.

CONTINUATION OF COVERAGE RIGHTS UNDER COBRA (CONTINUED)

Terminating COBRA Coverage

COBRA coverage can be terminated before the end of the maximum coverage period for any of the following reasons:

- Payment for coverage is not received on a timely basis;
- After the COBRA election date, you become covered under another employer's group health plan that does not limit or exclude coverage for a pre-existing condition;
- After the COBRA election date, you become covered under Medicare; and
- Amtrak stops providing group health coverage for all active employees.

Individuals Eligible For Federal Trade Adjustment Assistance

Workers whose employment is adversely affected by international trade, such as increased imports or a shift in production to another country, may become eligible for federal trade adjustment assistance (TAA). Part of this assistance is a 65% tax credit toward the purchase of COBRA coverage if loss of health coverage is trade-related.

To be eligible for the tax credit, you must currently be receiving or be eligible for trade adjustment assistance or considered an "eligible PBGC pension recipient;" and not in prison. If you become eligible for TAA after a termination of employment or reduction of hours and did not elect COBRA coverage during your initial 60-day election period, you will be eligible for a second COBRA election period.

This second election period begins on the first day of the month in which you are determined to be a TAA-eligible individual provided this second election is made within six months after the date health coverage was originally lost. If you elect COBRA coverage during this second election period, it is effective on the first day of the second election period and not on the date coverage was originally lost. However, the maximum COBRA coverage period is still measured from the date coverage was originally lost.

More information is available at www.cobralaw.com/trade-act.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides for continuation of medical care coverage for employees and covered dependents if you or a covered dependent is called for active duty military service.

If your military leave is not more than 30 days, you and your eligible dependents will not be required to pay more than your share of the premium toward the extended coverage. (Currently, all premiums for AmPlan medical benefits are paid by Amtrak.) If the leave is more than 30 days, then Amtrak may require you to pay the full premium cost, plus an additional 2% administration fee.

Important Note: If the military service qualifies as Emergency Military Leave and you are a member of a certain union (Amtrak Service Workers Council, Brotherhood of Maintenance of Way Employees, Brotherhood of Locomotive Engineers, Transportation Communications Union, International Brotherhood of Electrical Workers, and United Transportation Union Stewards), medical, dental, and vision coverage will continue until the end of the fourth month following the month you last rendered compensated service or received vacation pay.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (CONTINUED)

The maximum length of extended coverage under USERRA is the lesser of:

- 24 months beginning on the date that the military leave begins; or
- A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If you (or your covered dependent) return to covered employment after your military leave has ended, your medical care coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the Veterans Administration) incurred or aggravated as a result of the military service.

✓ **Life Event Reminder:** Refer to **Section 2: Life Events That Affect Your Benefits** for information about how a leave of absence could affect your benefits.

RETIREMENT 401(K) SAVINGS PLAN

If you are away from work due to military leave, special rules apply to your Retirement 401(k) Savings Plan account. You may make up your contributions for the period you were on military leave. The amount of time you have to make-up contributions begins when you become re-employed, and cannot be more than three times the period of military service, or if less, five years.

No investment gains or losses on make-up contributions will be applied. Your time during a military leave will not count as a break in service for vesting purposes, as long as you are re-employed within the time frames set by law for release from military service.

If you borrowed from your account balance, you may suspend loan repayment until you return from a military leave.

OFFICIAL PLAN DOCUMENTS

We have made every effort to make the information in this handbook as accurate and as easy for you to understand as possible. However, this handbook and any oral statements are not a substitute for the official plan documents and insurance policies. If there is a difference between what is in this handbook, told to you orally, and the official plan documents and insurance policies, the official plan documents and insurance policies will govern.

Nothing in this handbook is a guarantee or contract of employment. In addition, this handbook supercedes all prior handbooks and summary plan descriptions.

FOR ADDITIONAL INFORMATION

If you have questions about your benefits that are not addressed in this handbook, please call the Amtrak Benefits Service Center at 1-800-481-4887. Customer Service Representatives are available from 8:00 am to 8:00 pm, Eastern Time, Monday through Friday.

SECTION 13:
Who To Call

WHO TO CALL

One of the best ways to stay on track with your employee benefits is to make sure you have the information you need. This section of your handbook provides a list of telephone numbers and websites you can use to get information.

THE AMTRAK BENEFITS SERVICE CENTER 1-800-481-4887

Call the Amtrak Benefits Service Center:

- To enroll for your benefits;
- To obtain information about enrolling; or
- If you have any questions about your Amtrak benefits.

Customer Service Representatives (CSRs) are available Monday through Friday from 8:00 am to 8:00 pm Eastern Time. At other times, you can leave a message and a CSR will return your call by the end of the next business day.

ADMINISTRATION COMPANIES' NUMBERS

The phone numbers and websites of the companies that administer Amtrak benefits are provided below, in case you need to contact them directly.

TUFTS HEALTH PLAN
(NETWORK MEDICAL PLAN – MASSACHUSETTS ONLY)

1-800-462-0224
www.tufts-healthplan.com

AETNA
(NETWORK MEDICAL PLAN – CENTRAL PENNSYLVANIA AND WEST VIRGINIA ONLY)

1-800-438-2602
www.aetna.com

UNITEDHEALTHCARE
(NETWORK AND COMPREHENSIVE MEDICAL PLANS – ALL OTHER LOCATIONS)

1-888-675-RAIL (7245)
www.provider.uhc.com/Amtrak
www.myuhc.com

CAREMARK
(PRESCRIPTION DRUG BENEFITS)

1-800-378-0182
www.caremark.com

MATRIA HEALTHCARE, INC.
(SMARTCARE PROGRAM)

1-888-779-1316
www.matria.com

MHN
(MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS)

1-888-267-5261 (1-888-AMPLAN1)
www.mhn.com

AETNA DENTAL
(RAILROAD EMPLOYEES NATIONAL DENTAL PLAN)

1-877-277-3368

DELTA DENTAL
(FOR POLICE ONLY)

1-800-932-0783
www.deltadental.com

VISION SERVICE PLAN
(VISION BENEFITS)

1-800-877-7195
www.vsp.com

SHPS
(SPENDING ACCOUNTS AND COMMUTER REIMBURSEMENT ACCOUNTS)

1-800-678-6684
www.myshps.com

AETNA
(LIFE INSURANCE PLANS)

1-800-523-5065