THE LONG ISLAND RAIL ROAD COMPANY
2019 BENEFITS PACKAGE OVERVIEW
FOR RETIRED MANAGEMENT EMPLOYEES

Minimum of 10 years of service required to qualify for Retiree Health & Welfare Benefits

Note that all benefits described herein are benefits that are currently in effect. These benefits are all subject to change, including termination thereof, at any time in the sole discretion of the MTA. The summary of benefits is for information purposes only and may be modified at any time. Some benefit programs, such as public retirement plans, are administered and interpreted outside of the MTA. If information conflicts with the provisions of any benefit program, the program's policies control.

The Empire Plan (New York State Health Insurance Program)

The Empire Plan is a comprehensive health insurance program, consisting of four main parts:

- **Hospital Program (administered by Empire BlueCross BlueShield)**
- **Medical Surgical Program (administered by UnitedHealthcare)**
- **Mental Health & Substance Abuse Program (administered by Beacon Health Options, Inc.)**
- **Prescription Drug Program (administered by CVS Caremark)**

See following pages for more detailed information on the Plan.

Empire Plan Out-Of-Pocket Costs

In-Network Out of Pocket Limit: The amount you pay for network services/supplies is capped at the out-of-pocket limit, and includes copayments you make to providers, facilities, and pharmacies. Once the out-of-pocket is reached, network benefits are paid in full. For 2019, the maximum out-of-pocket limit for covered in-network services under the Empire Plan is $7,900 for Individual coverage and $5,800 for Family coverage, split between all four lines of coverage listed above.

Out-of-Network Combined Annual Deductible: The combined annual deductible is $1,250 for the enrollee, $1,250 for enrolled spouse/domestic partner, and $1,250 for all dependent children combined. This annual deductible applies to services received out-of-network, combined across the Basic Medical Program, the Home Care Advocacy Program, and the Mental Health and Substance Abuse Program.

Combined Annual Coinsurance Maximum: The combined annual coinsurance maximum is $3,750 for the enrollee, $3,750 for the enrolled spouse/domestic partner, $3,750 for all dependent children combined. Coinsurance amounts incurred for non-network Hospital coverage, Basic Medical Program coverage and non-network Mental Health and Substance Abuse coverage count toward the combined annual coinsurance maximum.

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Hospital Program (Empire Blue Cross Blue Shield) **1-877-769-7447** **Call for Pre-Admission/MRI/CT/PET: 1-877-769-7447** **Please Note: Pre-admission certification is required before a maternity or scheduled hospital admission, within 48 hours after an emergency or urgent hospital admission or for admission or transfer to a skilled nursing facility.**	**Network Benefits**: You pay only applicable copayments for services/supplies provided by a facility that is part of the network. **Hospital Inpatient:** Paid in full benefits for inpatient hospital, hospice or skilled nursing facility care at a network facility. Services provided by an anesthesiologist, radiologist or pathologist that are related to your hospital service but billed separately are paid in full. **Emergency Department:** $100 copayment for emergency medical care. Includes use of facility for emergency care, emergency room physician, providers who administer or interpret radiological exams, electrocardiograms and pathology services. (co-pay waived if patient is admitted). **Outpatient Department:** $95 copayment for outpatient surgery. $50 copayment for outpatient diagnostic radiology, diagnostic lab tests, and/or, administration of Desferal for Cooley's Anemia. No copayment for outpatient radiation therapy, hemodialysis or chemotherapy. **Non-network Benefits** Non-network hospital inpatient stays and outpatient services: You will be responsible for a coinsurance amount of 10% of billed charges for inpatient services, and the greater of 10% coinsurance or $75 for outpatient services until you meet the combined annual coinsurance maximum.	Coverage for life upon retirement from the LIRR for eligible retiree & eligible dependents. Upon death of retiree, coverage continues for surviving eligible dependents as long as they remain eligible.	LIRR pays the entire premium cost. Co-payments & deductibles are your responsibility. .
Medical/Surgical Program (UnitedHealthcare) 1-877-769-7447	**NON-PARTICIPATING PROVIDERS** Deductible of $1250 enrollee; $1250 enrolled spouse/domestic partner; $1250 all dependent children combined. Coinsurance - 80% of R&C after deductible is satisfied. The Plan has a combined annual coinsurance maximum of $3,750 per enrollee, $3,750 spouse/ domestic partner, and $3,750 per all dependent children, After you reach the combined annual maximum, reimbursement will be up to 100% of the usual and customary charge.		Co-payments & deductibles are your responsibility.

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Medical/Surgical Program (Continued)	**PARTICIPATING PROVIDERS** **Doctor's Office Visit/Office Surgery/Laboratory/Radiology** Each covered service is subject to $25 copayment per visit to a Participating Provider. Maximum of 2 copayments per visit. Urgent care center visit - $30 copayment. **Routine Physical** Paid-in-full benefits for preventive care services as defined in the Patient Protection and Affordable Care Act. Other covered services subject to $25 co-payment per visit to Participating Provider. For Non-Participating Providers, routine exams are covered once every calendar year for employees age 50 or older, and for covered spouse/domestic partner 50 or older. **Routine Pediatric Care – Up to Age 19** Routine well-child care is a paid-in-full benefit. This includes examinations, immunizations and cost of injectable substances when administered according to guidelines. **Hearing Aids** Hearing aid evaluation, fitting & purchase of hearing aids covered up to a max. reimbursement of $1,500, per hearing aid, once every 4 yrs; children 12 yrs. and under covered up to $1,500, per hearing aid, every 2 yrs. if existing hearing aid can no longer compensate for child's hearing per ear loss. This benefit is not subject to deductible or co-insurance. **Outpatient Surgical Locations** $50 co-payment covers facility, the same-day on-site testing & anesthesiology charges for covered services at participating surgical centers. **Diabetes Education Centers** Visits subject to $25 copayment for participating centers.		Co-payments & deductibles are your responsibility.

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Medical/Surgical Program (Continued)	**Ambulance Service** Local, professional/commercial ambulance covered under basic medical, subject to a $70 co-payment. Volunteer Ambulance Service: Reimbursed for donation up to $50 for services under 50 miles; $75 for services over 50 miles. Not subject to deductible and co-insurance.		Co-payments & deductibles are your responsibility.
Home Care Services, Skilled Nursing Services & Medical Equipment/ Supplies	**Home Care Advocacy Program (HCAP)** Home care services, nursing services and durable medical equipment & supplies call HCAP at 1-877-769-7447. Covered services & supplies are covered in full when HCAP pre-certifies & makes or helps make arrangements.		You must call for prior authorization to receive paid-in-full benefit.
Mental Health/Substance Abuse (MHSA) Program **Beacon Health Options** **Call 1-877-769-7447 and choose the Mental Health & Substance Abuse Program (menu item 3).** **The Clinical Referral Line is available 24 hours a day every day of the year.**	The Mental Health and Substance Abuse Program offers two levels of benefits. If you call the MHSA Program before receiving services, and follow their recommendations, you will receive in-network benefits as follows: **Network Coverage** **Inpatient:** Mental Health and Substance Abuse: Approved Facilities and Practitioner Treatment or Consultation are paid-in-full **Outpatient:** Mental Health: $25 copay per visit with up to three visits per crisis paid in full Substance Abuse: $25 copay per visit. **Non-Network Coverage** **Inpatient:** Plan pays up to 90% of usual and customary charges for covered services and up to 100% after coinsurance maximum per enrollee, spouse/domestic partner, dependent child(ren). **Outpatient:** Plan pays up to 80% of usual & customary charges for covered services after $1250 annual deductible is met. After maximum coinsurance of $3,750 is met for enrollee, $3,750 spouse/domestic partner, or $3,750 dependent child(ren), benefits are paid at 100% of usual & customary charges for covered service.	To ensure highest level of benefits, you must call Beacon Health **before** beginning any treatment including substance abuse or alcoholism. Call 1-877-769-7447 and press or say "3" to reach the MHSA program.	Co-payments & deductibles are your responsibility.

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Empire Plan NurseLine (Available 24/7)	Call the Empire Plan toll-free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Empire Plan NurseLine for health information and support.		N/A
Centers of Excellence **Preauthorization Required** **1-877-769-7447** **Please see The Empire Plan "Choices for 2019" booklet" for more information, on The LIRR Benefits page, or** **www.cs.state.ny.us**	**Centers of Excellence for Cancer Program** Includes paid-in-full coverage for cancer-related expenses received through Cancer Resource Services (CRS), which is a nationwide network including many leading cancer centers. Contact CRS at 1-866-936-6002 (or through NYSHIP) If you do not use a Center of Excellence, benefits will be provided in accordance with The Empire Plan Hospital Program coverage and/or Medical/Surgical Program coverage. **Centers of Excellence for Transplants Program** Paid-in-full benefits are available for certain transplant services when authorized by Empire BlueCross BlueShield and received at a designated Center of Excellence. When calling NYSHIP, select the Hospital Program for prior authorization. **Infertility Centers of Excellence** Paid-in-Full benefit is available subject to the lifetime maximum of $50,000 per covered person. To request a list of qualified procedures, or for preauthorization of infertility benefits, call the Medical/Surgical Program.		Paid-in-full benefits are available through the Centers of Excellence Program. If you do not enroll, benefits will be provided in accordance with the Hospital Program, and/or Medical/Surgical Program coverage. Prior Authorization for services is required whether or not you choose a Centers of Excellence Program.

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Chiropractor/ Physical Therapist United Health Care **1-877-769-7447**	**Managed Physical Network (MPN) Provider** $20 co-pay per visit for medically necessary chiropractic treatment or physical therapy. **Non-Network Provider** $250 Managed Physical Medicine Program deductible per participant. 50% co-insurance after meeting the annual deductible(s).		Co-payments & deductibles are your responsibility.
HMO (Health Maintenance Organizations) Various	In addition to the Empire Plan, NYSHIP offers several HMOs. HMO's are a pre-paid medical plan that provides a pre-determined medical care package. **Participating HMOs include:** **Blue Choice, Community Blue, HMO Blue, Empire BlueCross BlueShield HMO, and HIP Health Plan of New York.** **Contact NYSHIP for additional information (1-877-769-7447).**		Employee contribution varies based on the HMO premium cost. Co-payments & deductibles are your responsibility.
Prescription Drug Program CVS-Caremark / Empire Plan **Retail Pharmacy or through Mail Order Service**	**Prescription Drug Co-payment Chart** Supply Dispensed — Generic — Preferred Brand-name — Non Preferred Brand-name Up to 30 day supply from a participating pharmacy — $5 — $25 — $45 31-90 day supply from participating retail pharmacy — $10 — $50 — $90 31-90 day supply from Mail Service pharmacy — $5 — $50 — $90 Certain covered drugs do not require a copayment when using a network pharmacy, including oral chemotherapy drugs, Tamoxifen and Raloxifene when prescribed for the primary prevention of breast cancer.		If you choose to purchase a brand-name drug, which has a generic equivalent, you pay the non-preferred brand-name co-payment plus the difference in cost between the brand-name drug and the generic.
Medicare Parts A&B **Medicare Reimbursement**	NYSHIP regulations require that all retirees and eligible dependents must elect Medicare if offered in retirement. If dependent was eligible for Medicare Part A due to a SSA disability or age 65 when employee was active, they must now apply for Medicare Part B when you retire.	Effective the first day of your retirement from the LIRR. Retiree must notify the MTA BSC and show proof of Medicare eligibility.	Retiree is reimbursed applicable Medicare B premium from NYSHIP.

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Dental Plan **MetLife** ***Group Plan # 94074***	The Dental Plan allows you to choose from MetLife Network (Participating Dental Providers – PDPs) or Non-Network Dentists each time you and/or your eligible dependents receive care. **For PDP Providers Call: 1-800-474-7371** **Dental Customer Service No.: 1-800-942-0854** When you and/or your eligible dependents receive care from Network Dentists (PDP's), the plan will reimburse you at a higher percentage as shown below. (Deductible below applies to Type B&C Services. There is a separate $50.00 deductible on Orthodontic Care or Out-of-Network care.) **SCHEDULE OF BENEFITS** NETWORK DENTIST / NON-NETWORK Dental Care (PDP DENTIST) DENTIST Ann'l Deductible None $50/$150 Type A-Preventative 100% 100% Type B-Basic & Restorative 80% 80% Type C-Prosthetic 80% 60% Orthodontic* 80% 60% Orthodontic Max* $2,300.00 $2,300.00 Calendar Yr. Max. $2,500.00 $2,500.00 Preferred Dental Program (PDP) Provides nationwide network of dentists who agree to accept a scheduled fee for services as maximum charge for services performed. Calendar year and lifetime Orthodontic maximums are combined between PDP and Non-PDP network dentists. *Orthodontic Treatment for Dependents Under Age 19 Only.	Coverage for life upon retirement as a manager from LIRR after 12/01/1996 for retiree and eligible dependents. Dependent children covered up to age 19, or 25 if full-time student.	LIRR pays the monthly premium cost. Certain other charges above the reasonable & customary amounts, scheduled fees & deductibles are your responsibility.

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Vision Plan **EyeMed Vision Services** **Member/Patient Services** **1-866-799-9984** **Group No. *9745795***	Exams & Lenses provided to Employee & Dependents each calendar year. The Vision Plan offers Network & Non-Network Providers. **Type of Service** — **In Network Cost To Employee** — **Non Network Reimbursement** **EYE EXAM** — $0 — Up to $40 **CONTACT LENS** — Fees associated with fitting and follow-up — Not Covered **FRAMES** — Balance over $90 — Up to $45 **LENSES** Single Vision — $0 — Up to $40 Bifocal — $0 — Up to $60 Trifocal — $0 — Up to $60 ..Lenticular — $0 — Up to $150 Progressive — $0 — Up to $180 Premium Progressive — 80% of charge, less $120 allowance — Up to $180 Cataract — $0 — Up to $150 Other Lens Types — 80 % of Charge — Not Covered **LENS OPTIONS** Anti-Reflextive Coating — $35 — Not Covered Basic Polycarbonate — $30 — Not Covered Scratch Resistant Coating — $12 — Not Covered Ultraviolet Coating — $12 — Not Covered Solid/GradientTint — $0 — Up to $25.00 Glass (non-minors only) — $15 — Not Covered Photochromic Glass — $30 — Not Covered Other Coatings — 80% of Charge — Not Covered CONTACT LENSES (In lieu of lenses and frames) Disposable — Retail, less $100 allowance — Up to $100 Conventional — Retail, less $100 allowance — Up to $100 **Lasik or PRK Vision Correction: Member pays 85% of charge**	Coverage for life upon retirement as a manager from LIRR after 12/01/1996 for retiree and eligible dependents. Dependent children covered up to age 19, or 25 if full-time student.	LIRR pays the monthly premium cost.

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Life Insurance (MetLife) **Hired or promoted on/after 1/1/97**	$5,000 benefit to a designated beneficiary.	Employees hired or promoted to a management position on or after 1/1/1997.	LIRR pays the entire cost.
Life Insurance (MetLife) **Must have been in management position on 12/31/96 & remained in management until retirement**	Two (2) times your base annual salary up to a maximum of $500,000 to a designated beneficiary until you attain age 65. At age 65, this amount will be limited as follows: Limiting Age — Limited Percent 65 — 90% 66 — 80% 67 — 70% 68 — 60% 69 & over — 50%	**Must have been in management position on 12/31/96 & remained in management until retirement.**	LIRR pays the entire cost.
Dependent Life Insurance & Supplemental Life Insurance	Conversion to a private policy is available for dependents. Contact the MTA BSC for more information at (646) 376-0123.	Employee must apply for conversion within 31 days of separation.	Retiree pays the premium directly to the insurance company.
Cash Out of Accumulated Sick Leave	With a minimum of 10 years of service, employees at termination, separation or retirement without fault, will receive payment of one-half of their sick leave bank up to a maximum of 120 days paid. No minimum number of days required in sick leave bank to qualify for sick leave bank cash out. If within 5 years of separation employee experienced medically documented catastrophic illness, which depleted his/her sick leave bank, employee is paid one calendar month (30 days) for every 10 years of service in lieu of the above (see LIRR Corporate Policy 2409 “Sick Leave Policy for Management Employees”)	Minimum of 10 years of service to qualify. Plus 2 consecutive years immediately prior to retirement as a manager or as represented employee with management benefits governed by the collective bargaining agreement	

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Retiree Transportation Pass	The Company grants free transportation privileges as a benefit to its management retirees and their spouse/domestic partner. The pass is the property of the Company, must be displayed when requested and must be surrendered upon demand.	Retiree with a minimum of ten (10) years of service prior to retirement.	N/A

OFFICIAL PLAN OR POLICY DESCRIPTION TAKES PRECEDENCE OVER THIS SUMMARY AND ALL NON-OFFICIAL MATERIAL AND WILL BE THE DETERMINING DOCUMENT ON ANY QUESTIONS OF POLICY OR PRACTICE. THE COMPANY RESERVES THE RIGHT, ON ITS SOLE AND UNLIMITED DISCRETION, TO AMEND, ALTER, CHANGE, MODIFY, SUSPEND, SUBSTITUTE, REVOKE OR TERMINATE THE PLAN, IN WHOLE OR IN PART, IN ANY RESPECT, INCLUDING TO INCREASE THE LEVEL OF REQUIRED PARTICIPANT CONTRIBUTIONS, AT ANY TIME AND FOR ANY REASON, WITHOUT NOTICE TO AND WITHOUT THE CONSENT OF ANY CURRENT, FUTURE OR FORMER EMPLOYEE.