BURLINGTON NORTHERN SANTA FE MEDICAL PROGRAM

United HealthCare Select Option

Summary Plan Description

January 1, 2001

Contents

BNSF
Medical Program

The BNSF Medical Program offers you protection against the financial burden an illness or injury can create. You choose the Medical Program option and coverage level that best meet your coverage needs.

This Summary Plan Description is for BNSF Employees enrolled in the United HealthCare Select (UHC Select) option only.

Coverage level options from which you can choose include:

• Employee only,

• Employee plus spouse,

• Employee plus child(ren) only, and

• Employee plus family, which includes coverage for you, your dependent children and your spouse.

The Company shares the cost of coverage. Your contribution will be paid on a before-tax basis through the BNSF Internal Revenue Code Section 125 cafeteria plan.

This Summary Plan Description (SPD) covers benefits available under the UHC Select option only. There is a separate SPD for employees electing other coverage options. HMO coverage and benefit information is provided in separate HMO booklets. Whatever coverage you choose, you have special rights under ERISA as described in the section of this SPD titled “Your Rights Under ERISA.”

This SPD does not include retiree medical benefits. Retiree benefits are explained in the Retiree Medical SPD.

If you are enrolled in the UHC Select option under the Medical Program, you will receive an Identification ("ID") Card. You must show your ID card every time you request health care services from a UHC network provider. If you do not show your ID card, the UHC network provider has no way of knowing that you are enrolled under UHC Select and you may be billed for health services. ALWAYS CARRY YOUR UHC SELECT ID CARD WITH YOU.

Eligibility and Enrollment

Your Eligibility for Coverage

You are eligible to enroll in the Medical Program if you are a regularly assigned, full-time salaried employee of BNSF or a related Employer, actively working 32 or more hours per week. Employees covered under a collective bargaining agreement that does not provide for participation in the Medical Program are not eligible to enroll. Medical coverage is not available to other employees or service providers, such as part-time employees, leased employees or independent contractors, unless otherwise specified in the Medical Program document.

Dependent Eligibility

Family members you may cover as eligible Dependents under the Medical Program include:

• Your legal spouse, unless you are legally separated or divorced.

• Your unmarried children under age 19 (or age 23 if the child is a full-time student at an accredited institution) and dependent primarily on you for financial support. Eligible children include:

– your unmarried natural children;

– your stepchildren, legally adopted children, children placed for adoption, or children placed under the full legal guardianship of you or your spouse; and

– children related to you by blood or marriage, including grandchildren who live with you in a parent child relationship (for grandchildren, a parent-child relationship does not exist if the child's natural parent lives in the same home).

• A child subject to a Qualified Medical Child Support Order (QMCSO) issued under ERISA Section 609, as determined by BNSF. You may request copies of the BNSF QMCSO policies and procedures free of charge through the Benefits Department in Ft. Worth.

Your children are considered to depend primarily on you for financial support if you provide more than 50% of their support and claim them as dependents on your federal income tax return. Coverage ends the day before the child's 19th birthday or, if the child is a full-time student, on the first to occur of the following:

• the child's graduation, or

• the child's 23rd birthday.

To be considered a full-time student at an accredited institution, your child must be registered as a full-time student in a high school, college, university, trade school, professional school, school in a foreign country or remedial education facility. The Benefits Administrator, Sageo, will require proof of whether a child qualifies as a full-time student.

Eligible enrolled children who are mentally or physically disabled may retain coverage beyond age 19 (or age 23, if they are full-time students when they become disabled) if their disability occurred before reaching the Medical Program's maximum age. To be eligible for continued coverage, the child must be

unmarried, legally reside with you, must be incapable of self-sustaining employment and must be primarily dependent on you for financial support. To continue coverage for a disabled child, you must contact UHC Select with proof of the disability within 60 days of the date the child turns age 19 (or age 23 if the child is a full-time student) and as requested from time to time thereafter.

Enrollment

You must enroll within 31 days after the date you first become eligible for coverage, or by the deadline set by your Employer for each annual enrollment. Your enrollment elections will remain in place for the calendar year in which you enroll. You are allowed to enroll at a later date or to change enrollment elections only if you have an eligible Family Status Event as follows:

• Your marriage, legal separation, divorce or annulment;

• The birth, placement for adoption or adoption of a child;

• The death of a Dependent (including your spouse);

• The termination or commencement of your spouse's employment, a change in hours worked, or an unpaid leave of absence taken by you or your spouse resulting in a change in eligibility for medical coverage;

• A significant change in your spouse's group medical coverage, as determined by the Program Administrator; or

• Service of a Qualified Medical Child Support Order (QMCSO) issued under ERISA Section 609, as approved by BNSF.

You must request enrollment or a change in enrollment within 31 days of your Family Status Event.

When you enroll in the Medical Program, you will be advised of the cost of coverage. From time to time, BNSF reviews the cost of the various Medical Program options. You will be notified of any changes in the cost of coverage for the Medical Plan option you have elected before the change goes into effect.

Giving Notice of a Family Status Event

If you have a Family Status Event, or if you want to enroll under the HIPAA rule (see HIPAA Special Enrollment rules on page 4), you can log on to www.sageo.com. You can also link to Sageo's web site from the BNSF Intranet site to make changes. If you prefer to use the phone, you can use the Sageo Resource Line by dialing 1-877-847-2436. If you do not request the change within 31 days of the event, you will not be allowed to make any changes until the next annual enrollment period unless you have a subsequent Special Enrollment event described on page 4.

First Enrollment

If you are a newly hired employee you must enroll within 31 days of your first day of employment. Your coverage will begin on the first day of employment provided you enroll on time. For newly eligible employees (e.g., employees promoted from union to salaried exempt positions), the effective date of coverage is the first day of the month following 30 days' classification as a regularly assigned full-time salaried employee. An exception applies to newly promoted salaried exempt employees whose promotion

date is February 1. This group of employees will be covered effective March 1, provided the employee chooses a Medical Program option and enrolls on time.

Annual Enrollment

Each year you have the opportunity to change your coverage option election during Annual Enrollment. During Annual Enrollment for the 2001 Program Year, you were required to enroll in a Program option through Sageo. If you failed to elect one of the Medical Program options available through Sageo enrollment, you were automatically enrolled under "employee only" default coverage under the CIGNA PPO Program option (no family members were enrolled, even if they were enrolled in 2000). If the CIGNA PPO option was not available, you were enrolled for "employee only" coverage under the BCBS option.

In subsequent Annual Enrollment periods, if you do not wish to change the Medical Program option you chose in the prior year, the prior option will automatically renew, if the option is available. If a Program option is no longer available, and you fail to make a new election, there will be a new default "employee only" option that will automatically apply as described above except that your coverage level will remain the same.

If you opted out of Medical Program coverage, you must show a Family Status Event or otherwise qualify for HIPAA Special Enrollment as described below, in order to enroll in the Program before the next Annual Enrollment. In that case you must enroll through the Sageo web site or by phone through the Sageo automated Resource Line within 31 days of the Family Status Event or the Special Enrollment event.

Electing the Opt-Out Option

If you choose to opt out of Medical Program coverage, you want to think about having other group or individual medical coverage in place to cover yourself and your Dependents at the time you opt out. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows you to carry over credit from coverage under another medical plan (whether the coverage is individual coverage or group coverage) and to apply it to a new group medical plan's pre-existing condition exclusion period. Under HIPAA, if you have a break in coverage that is greater than 62 days, you may not be able to carry over credit for any prior medical coverage to any new medical coverage.

Although this Medical Program does not have a pre-existing condition exclusion period, you should still familiarize yourself with HIPAA's coverage credit carryover rules. You may want to purchase medical coverage that does have a pre-existing exclusion period at some future date.

HIPAA Special Enrollment

If you opted out of Medical Program coverage for yourself or an eligible Dependent during annual enrollment, you may enter the Plan on a special enrollment date if you enroll through Sageo **within 31 days** of the occurrence of one of the following events:

• If you become married, even though you may have waived coverage initially, you and your spouse may take advantage of special enrollment;

• If you are married and chose Employee only coverage, and you subsequently acquire a new Dependent (whether through birth, placement for adoption or adoption), you may elect special enrollment for your spouse and child, or for the child only.

• If you opted out of Medical Program coverage because you were covered under another employer's group medical plan and you lose coverage under that plan for a reason other than failing to pay premiums or misrepresentation (for example, a Family Status Event), you may elect special enrollment for you and any eligible Dependents. You are not required to take COBRA continuation under another plan to elect special enrollment under this Medical Program.

• If you opted out of Medical Program coverage (or you opted not to enroll your Dependents) because COBRA continuation was in effect on your eligibility date, you (or your Dependents) must exhaust the COBRA continuation period before special enrollment can be elected under the Medical Program. This means you (or your dependents) must continue COBRA coverage for the entire COBRA period. Failure to pay a COBRA premium does not result in the exhaustion of COBRA.

Neither you nor an eligible Dependent is required to elect COBRA continuation under another employer's plan in order to become eligible for special enrollment. However, once you or your Dependent elects COBRA continuation, if you also opted out of coverage under this Medical Program, the entire COBRA continuation period must be completed before you can enroll in this Program.

• If you either opted out of the Medical Program or chose Employee only coverage, and Sageo receives a valid Qualified Medical Child Support Order under ERISA Section 609, the child will be enrolled under the Program's Special Enrollment rules. If you are not enrolled, you and the child will be enrolled in Employee plus child coverage, and you will be required to pay the applicable cost of coverage. You may request a copy of the BNSF policies and procedures for QMCSOs from Sageo.

A HIPAA special enrollment is also allowed if (1) your other group medical plan terminates, or (2) the employer sponsoring the other group medical plan ceases to make employer contributions. However, you must give notice and actually enroll in the BNSF Medical Program within 31 days of the occurrence of a special enrollment event described in (1) or (2). If you fail to do so, you must wait until the next Annual Enrollment for the Medical Program, unless you have a subsequent Family Status Event and give notice within 31 days of the subsequent change.

Special Enrollment under the HIPAA rules can occur at any time during the calendar year.

Benefit Changes Due to Relocation or Closing of an HMO

If you originally elected HMO coverage and later relocate outside the HMO service area, you can change your Medical Program election within 31 days after the date of your relocation. You may not change your coverage level election until the next annual enrollment unless you have a Family Status Event. You also may change your Medical Program election if the HMO you chose closes its service office in your location or significantly reduces its coverage.

If you do not request a change within 31 days of one of these events, you will have to wait until Annual Enrollment to become covered under the Medical Program. You should know that a change in professional staffing within an HMO does not constitute a significant reduction in coverage, even though you might be required to change primary care physicians.

The United HealthCare Select Option

Choosing A Primary Physician

You must choose a Primary Physician for yourself and each of your family members. You do not need to choose the same Primary Physician for all family members. You may choose a pediatrician as the Primary Physician for your children. Your Primary Physician will provide basic preventive medical care. Where necessary, the Primary Physician will refer you or your dependents to a specialist in the United HealthCare Select (UHC Select) network.

There are no out-of-network benefits under UHC Select. All services must be provided or referred by your Primary Physician. If you obtain medical services without the referral of the UHC Select Primary Physician, you will be responsible for the entire cost of those services.

As a Covered Person under the UHC Select option:

• You will pay a set dollar copayment for certain UHC Select provider visits.

• You will not have to pay a calendar-year deductible.

• There is no calendar-year out-of-pocket maximum to meet.

See the Schedule of Benefits beginning on page 8 of this SPD for copayment details.

In order to receive Covered Health Services under UHC Select, you or your covered Dependent is responsible for contacting and obtaining the Primary Physician's authorization for any referrals to other UHC Select providers prior to seeking specialist medical care. You or your spouse must obtain the Primary Physician's authorization on behalf of any minor covered Dependent. Failure to obtain the Primary Physician's referral may result in UHC Select refusing to pay for the medical services you receive. The only exceptions to this rule are Emergency Health Services, Urgent Care Services, or certain services pre-authorized by UHC Select.

You may elect another Primary Physician by calling UHC Select. The change will go into effect immediately.

Women electing a Primary Physician have direct access to a licensed/certified network practitioner for covered ob/gyn services. There is no requirement to obtain an authorization of care from the Primary Physician for visits to a UHC Select network practitioner of a woman’s choice for pregnancy, well-woman gynecological exams, primary and preventive gynecological care, and acute gynecological conditions.

You will not be required to file a claim for benefits when receiving health care in the UHC Select network either directly from your Primary Physician or through a referral to a UHC network provider by your Primary Physician. The network provider will automatically submit your claim to UHC Select. You will be responsible for paying the copayments, however. There is no lifetime dollar limit on the services provided to covered persons by UHC Select network providers. However, there are limits that apply to certain benefits including, but not limited to, mental health and substance abuse benefits.

Reimbursement for Certain Out-of-Network Services

If you incur expenses for out-of-network Emergency Health Services or Urgent Care services, or if you have been pre-authorized by UHC Select to use an out-of-network medical service provider, you are responsible for sending a request for reimbursement of the out-of-network provider charges to UHC Select. You should request a UHC Select claim form from UHC Select. You should submit the request within 90 days after the date of service. If you do not submit the claim within 90 days of the date of service, UHC Select may refuse to pay the claim or it may reduce the amount it would otherwise pay for the claim. If you cannot submit the claim within 90 days of the date of service because you are legally incapacitated, you should have a family member submit the claim whenever possible.

The claim you submit must include your name and address, your social security number, and the name, social security number, and age of the Covered Person who received the services, the name and address of the out-of-network service provider and an itemized bill that includes the CPT codes or description of each charge. The medical provider should supply the CPT code and the description of services on the billing.

Remember, only UHC-determined medically necessary out-of-network provider emergency or urgent care services will be eligible for reimbursement by UHC Select. Any other out-of-network provider services must be pre-authorized by UHC Select.

Schedule of UHC Select Benefits

This Schedule of Benefits: (1) outlines the copayments that you are required to pay for covered services; and (2) describes any maximum benefit that may apply.

When copayments are charged as a percentage of eligible expenses, the amount you pay for UHC Select network health services is determined as a percentage of the negotiated contract rates rather than as a percentage of the UHC Select network provider's billed charge. The network provider's negotiated rate is ordinarily lower than the UHC Select network provider's billed charge.

NETWORK BENEFIT DESCRIPTION	**NETWORK COPAYMENT**
Medical Services in a network Physician's Office.	$15 per visit, except for copayments required for specific health services set forth below. No copayment applies when no network Physician charge is assessed.
Allergy Services in a network physician's office.	No copayment applies for injections.
Professional Fees for network surgical and medical services.	No copayment.
Network Inpatient Hospital and related health services.	No copayment.
Network Transplantation health services.	Same as any other health service.
Emergency Outpatient health services.	$50 per visit. Copayment waived if confined within 24 hours for the same condition.
Urgent Care.	$15 per visit.
Network Outpatient Surgery, Diagnostic and Therapeutic Services.	No copayment. $0 per outpatient surgery admission and 0% for diagnostic and therapeutic services.
Network Maternity Services.	First visit - $15. No copayment for prenatal or postnatal care and delivery.
Network Outpatient Mental Health and Substance Abuse Services. Limited to 30 visits per calendar year.	$25 per individual visit; $25 per group visit.

NETWORK BENEFIT DESCRIPTION	NETWORK COPAYMENT
Network Inpatient Mental Health and Substance Abuse Services. Limited to 30 days per calendar year.	No copayment.
Network Home Health Agency Services. Limited to 40 visits per calendar year.	No copayment.
Network Skilled Nursing Facility/Inpatient Network Rehabilitation Facility Services. Limited to 60 days per calendar year.	No copayment. No Copayment applies if a Covered Person is transferred to a network Skilled Nursing Facility or network Inpatient Rehabilitation Facility directly from an acute care facility.
Hospice Care. Limited to 180 days during the entire period of time a Covered Person is enrolled.	No Copayment.
Ambulance Services.	No Copayment.
Accident-related Dental Services.	No copayment.
Prosthetic Devices and Durable Medical Equipment. Coverage for Durable Medical Equipment is limited to $2,500 per calendar year.	No copayment.
Network Outpatient Rehabilitation Services. (Physical therapy, occupational therapy, speech therapy, and cardiac/pulmonary rehabilitation.) Limited to: 20 visits of physical therapy per calendar year. 20 visits of occupational therapy per calendar year. 20 visits speech therapy per calendar year. 20 visits of cardiac/pulmonary rehabilitation per calendar year.	$15 per visit. $15 per visit

NETWORK BENEFIT DESCRIPTION	NETWORK COPAYMENT
Network Infertility Services.	Subject to Plan limits and exclusions. Copayment depends on service.
Outpatient Prescription Drug Products at Participating Pharmacies. Limited to a consecutive thirty-one (31) day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size; or limited to a one-cycle supply of oral contraceptives. Up to 3 cycles of oral contraceptives can be purchased at one time if a copayment is paid for each cycle supplied.	$10 per prescription order or refill for a Generic prescription drug product on the Preferred Drug List. $15 per prescription order or refill for a Brand-name prescription drug product on the Preferred Drug List. $25 for a Brand-name prescription drug product which is not on the Preferred Drug List.
Mail Service Prescription Drugs. Limited to a consecutive ninety (90) day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packing size.	$20 per prescription order or refill for a Generic prescription drug product on the Preferred Drug List. $30 per prescription order or refill for a Brand-name prescription drug product on the Preferred Drug List. $50 for a Brand-name prescription drug product which is not on the Preferred Drug List.
Network Chiropractic Health Services, Treatment or Care. Coverage is provided only for services in the network Chiropractor's office and is limited to a maximum of 20 office visits per year. These services must be authorized in advance by UHC Select.	$15 Copayment.
Annual Maximum Copayment.	Not Applicable.

What You Should Know About Covered Health Services

UHC Select makes payment only for those covered health services that are medically necessary and not otherwise excluded or limited under the Program. Special rules apply to mental health and substance abuse services. See pages 8-10 for the Schedule of Benefits.

Care Coordination

Health care services and supplies under UHC Select are subject to the UHC Care Coordination program. No benefits are payable unless Care Coordination determines the service or supply is actually covered under Program terms. Care coordination may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management services. Care Coordination is not a substitute for the medical judgment of your Primary Physician, or any specialist to whom your Primary Physician refers you or your covered Dependents.

Care Coordination should be contacted prior to the following:

• Inpatient admission;

• Home Healthcare Services;

• End Stage Renal Disease treatment or services;

• Cosmetic services that are specifically covered under the UHC Select option;

• Dental services required due to an accident while covered under the Program;

• Rental or purchase of Durable Medical Equipment costing over $1,000 (other than prosthetics which are subject to other program rules);

• Organ transplant services.

Your Primary Physician will generally work with Care Coordination in all instances where authorization is required. You may always call Care Coordination to confirm that they have been notified. The number to call can be found on your UHC Select ID card. You can expect to receive phone calls from Care Coordination when you or a Dependent undergoes certain medical treatment. You and your Primary Physician are responsible for making determinations regarding your health care needs. Care Coordination will only advise if the service or supply is a covered health service under the BNSF Medical Program UHC Select option.

If Care Coordination tells you a service or supply is not covered under Program terms, or that coverage is limited, you have the right to appeal the decision. Turn to page 29 of this SPD to find out what you will need to do to file an appeal. Your appeal should be filed immediately. If you fail to file your appeal within 60 days of Care Coordination's advising you of its decision, you may have given up your right to appeal.

How to Work With Your Primary Physician

All of your health care needs must be coordinated through your Primary Physician. If your Primary Physician is not able to provide a necessary covered health care service, he or she will refer you to a network specialist or other network provider.

For some services, UHC allows the Primary Physician to let you know that a specific referral is not required. In these cases, you can choose any network provider. You must always contact your Primary Physician first if you think you need a referral to a network provider for any service or supply. If you seek network provider services without first contacting your Primary Physician, the Program will not pay benefits where the Primary Physician is required to give a referral.

Remember, the UHC Select option does not cover out-of-network medical provider services. You will be responsible for the full cost of any out-of-network medical provider services.

Sometimes a specific health care service or supply cannot be provided through a network provider. Your Primary Physician will advise you if you will need to go out of network to find the medical services. You may be eligible for Program benefits for these services. You must always check with your Primary Physician first. You must receive authorization to use out of network medical providers. If you choose to go out of network without checking with your Primary Physician first and receiving UHC Select authorization, the Program will not pay benefits for those services. Out of network medical services and supplies authorized by UHC Select are subject the Program's limits and exclusions.

What to Do if Emergency or Urgent Care is Required

If you or a Dependent experience a sudden serious medical condition or symptom resulting from injury, sickness or mental illness, which in the judgment of a reasonable person requires immediate medical care to avoid a threat to life or health *seek immediate emergency care or treatment.* The care or treatment must be received within the first 24 hours after the symptom or condition first appears in order to qualify for coverage as **emergency care** under the UHC Select option.

Whenever possible, you should contact your Primary Physician as soon as the emergency situation arises. If it is impossible to contact your Primary Physician, and you are not near a network hospital, you should go to the nearest hospital for emergency treatment. You must notify UHC Select within 48 hours, or as soon as reasonably possible, after emergency health services are received in an out of network hospital. You must cooperate with UHC Select and provide information on the nature of the emergency and the treatment received. The Program will pay a benefit for out of network emergency services subject to UHC Select rules.

It may be that you or a Dependent may need urgent care that does not qualify as emergency care. An **urgent care** situation may involve an unforeseen sickness, injury or the onset of threatening symptoms that a reasonable person would believe to be non-life threatening. You may receive urgent care services in a physician's office or in an Urgent Care Center. An Urgent Care Center is a non-hospital-based facility that provides walk-in health services in urgent care situations. If you use an out of network Urgent Care Center or an out-of-network physician for urgent care, you must notify UHC Select within two working days. The Program will pay a benefit for out of network Urgent Care treatment subject to UHC Select rules.

Benefits for **emergency care** and **urgent care** services are paid subject to the terms, conditions, exclusions and limitations of the UHC Medical option. Emergency care and urgent care services must be

for the stabilization and start of treatment. The services must be provided by or under the direction of a physician.

If continued medical services are required after initial emergency or urgent care, you must coordinate that coverage with your Primary Physician. If you or a Dependent is hospitalized due to an emergency in an out of network hospital, transfer to a network hospital may be required as soon as it is medically appropriate. If you choose to remain in an out of network hospital after you have been notified by your Primary Physician or UHC Select that you must transfer to a network hospital, the Program will not pay benefits for the out-of-network hospital stay.

Transplant Program

The BNSF Medical Program UHC Select option covers the following organ transplants:

- cornea
- kidney
- kidney/pancreas
- liver
- heart
- lung
- heart/lung

Coverage is also provided for bone marrow transplants (either from the Covered Person or a compatible donor) and peripheral Stem Cell transplants, with or without high dose chemotherapy. You must contact UHC Select prior to making arrangements for these transplant services. UHC Select will explain the requirements you must meet in order for the services to be covered benefits.

Benefits for transplants must be ordered by your Primary Physician, provided at or arranged by a Designated Facility for transplants and authorized in advance by UHC Select. Either your Primary Physician or your network specialist must contact UHC for prior authorization.

Covered Health Services

The following Covered Health Services are included as BNSF Medical Program benefits when they are provided by or under the direction or your Primary Physician and, when required, are authorized.

- **Physician Office Service:** Health services provided by or through your Primary Physician in the Physician's office. Covered services include preventive medical care such as well-baby care, routine physical examinations, vision and hearing screenings, voluntary family planning, and immunizations.

- **Allergy Services:** Allergy health services provided by or through your Primary Physician. Allergy health services must be provided in the treating physician's office.

- **Surgical and Medical Services:** Professional fees for surgical services and other medical care provided by or through your Primary Physician. The services must be provided in a network facility. A network facility can be a hospital, skilled nursing facility, inpatient rehabilitation facility or alternate facility. An "alternate facility" is a non-hospital health care facility, or an attached facility to a hospital that provides outpatient prescheduled surgical services, emergency services, rehabilitation, laboratory or diagnostic services, or inpatient or outpatient mental health or substance abuse services in compliance with local law.

- **Inpatient Hospital Services:** Inpatient confinement, including room and board, and services and supplies provided by a network hospital only during confinement (at a semi-private room rate). Health services must be provided by or through your Primary Physician and authorized in advance by UHC Select. Your Primary Physician will contact UHC for authorization. Certain inpatient services are subject to separate benefits restrictions and/or copayments as described in the Schedule of Benefits starting on page 8 of the SPD.

- **Outpatient Surgery, Diagnostic and Therapeutic Services:** Outpatient surgery, diagnostic and therapeutic services, including laboratory, radiological and other diagnostic tests. Therapeutic treatments (such as chemotherapy if otherwise covered under UHC Select option terms) are also covered. The services must be provided by or through your Primary Physicians and must be provided in a network hospital or a network alternate facility.

- **Maternity Services:** Maternity-related medical, hospital and other covered health services are treated as any other sickness or injury. Coverage includes prenatal and postnatal care, and health services during childbirth. Special prenatal programs are available through the UHC Select network. To participate, you should notify UHC Select during the first trimester, but no later than one month prior to the anticipated delivery date. The Program does not restrict benefits for any hospital length stay in connection with childbirth for mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section, or require that a physician obtain authorization for prescribing a length of stay not in excess of the above periods.

- **Mastectomy Benefit:** Surgical services provided in a network hospital for a mastectomy including coverage for

  - reconstruction of the breast on which the mastectomy has been performed;

  - surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- prostheses and coverage for any complications on all stages of mastectomy, including lymphedamus.

- **Outpatient Mental Health and Substance Abuse Services:** Outpatient services for mental health and substance abuse services provided by or under the direction of United Behavioral Health (UBH). Contact UBH using the phone number on your ID card. This coverage is limited as shown on the Schedule of Benefits beginning on page 8 of the SPD. The following services are covered, provided you comply with UBH rules.

  - evaluations and referral services,

  - short-term individual, family and/or group outpatient therapeutic services (including intensive outpatient therapy),

  - crisis intervention.

- **Inpatient Mental Health and Substance Abuse Services:** Mental health and substance abuse services provided on an inpatient or intermediate care basis, as determined to be medical necessary by United Behavioral Health (UBH). Confinement is provided only on a semi-private room basis. At the discretion of UBH, two sessions of intermediate care (e.g. partial hospitalization) may be substituted for one inpatient day. Coverage includes medically necessary detoxification from abusive chemicals or substances and is limited to physical detoxification when necessary to protect the physical health and well-being of the Covered Person. Referrals to a network provider are in the sole discretion of UBH. Coverage is limited as shown on the Schedule of Benefits beginning on page 8 of the SPD.

- **Home Health Agency Services:** Part-time, intermittent health services of a network home health agency, when provided under the direction of your Primary Physician are covered. Skilled Care Services are skilled nursing, skilled teaching, and skilled rehabilitation services that meet all of the following:

  - The services must be delivered or supervised by licensed technical or professional medical personnel in order to obtain a specific medical outcome and provide for the patient's safety;

  - Are ordered by the Primary Physician; and

  - Qualify as covered health services under the UHC Select option.

  Home Health Agency services are covered only when skilled care services are involved. Home Health Agency Services must be provided in your home, by or under the supervision of a registered nurse and approved in advance by UHC Select. The Primary Physician will contact Care Coordination for authorization.

- **Skilled Nursing/Inpatient Rehabilitation:** Confinement (in a semi-private room in a skilled nursing or rehabilitation facility), including medical services and supplies, when provided under the direction of your Primary Physician are covered. Health services must be provided in a network skilled nursing facility or network inpatient rehabilitation facility and are covered only for the care and treatment of an injury or sickness which otherwise would required confinement in a network hospital. These services must be approved in advance by UHC Select. The Primary Physician will contact Care

Coordination for authorization. Coverage is limited as shown on the Schedule of Benefits beginning on page 8 of the SPD.

- **Hospice Care:** Hospice care services which are recommended by your Primary Physician and authorized in advance by UHC. The hospice care services must be provided through a hospice or hospice care agency designated by Care Coordination.

- **Ambulance Services:** Emergency ambulance transportation by a licensed ambulance service to the nearest hospital where emergency health services can be rendered.

- **Accident Related Dental Services:** Accident-related dental services performed by a Doctor of Dental Surgery, "D.D.S.", or a Doctor of Medical Dentistry, "D.M.D.", for the treatment of any sound natural teeth made necessary as a result of an injury. Coverage is provided only when services are required as a result of an injury (except for an injury resulting from biting or chewing which is not covered) which occurs while you or a Dependent are covered under the Plan. No coverage is provided unless the dentist certifies to UHC Select, that teeth were sound natural teeth which were injured as a result of an accident. Services must be provided and completed within 6 months of the Injury and approved in advance by UHC Select. A sound natural tooth has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant, and functions normally in chewing and speech.) No coverage is provided for dental implants.

- **Prosthetic Devices and Durable Medical Equipment:** Prosthetic devices and durable medical equipment are covered subject to limits shown on the Schedule of Benefits beginning on page 8 of this SPD. Covered prosthetic devices and durable medical equipment must meet the following criteria:

  - It must be approved in advance by UHC Select; and

  - It must be obtained from a provider or vendor selected by UHC Select.

  Coverage is provided for prosthetics and durable medical equipment which meet the minimum specifications and qualify as covered health services. Except when needed due to a change in the patient's medical condition or to improve physical function, the UHC Select option does not cover repairs, replacements or duplicates. Neither does UHC Select cover any health services related to repair or replacement. The following devices and equipment are covered.

  - Purchase of artificial limbs, artificial eyes, and other necessary prosthetic devices needed as a result of an illness or injury. This benefit is limited to a single purchase of each type of prosthetic that replaces a limb or body part.

  - Rental or purchase, at the discretion of UHC Select, of Durable Medical Equipment, including, but not limited to the following:

    1. Braces, including necessary adjustments to shoes to accommodate braces. Dental braces are not included under Plan coverage.

    2. Oxygen and rental of equipment for the administration of oxygen, including tubing, connectors and mask.

3. Standard wheelchairs.

4. Standard hospital-type beds.

5. Delivery pumps for tube feedings including tubing and connectors.

6. Mechanical equipment necessary for the treatment of chronic or acute respiratory failure. Air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and other personal comfort items are not covered under the Program.

- Short-term outpatient rehabilitation services are covered. Coverage is provided only for physical therapy, occupational therapy, speech therapy and cardiac/pulmonary rehabilitation. The services must be expected to result in significant physical improvement in the patient's condition within 2 months of the start of treatment in order to be covered. Speech therapy is covered only when required as a result of injury, stroke or a congenital anomaly, as determined by UHC Select. Coverage is limited as shown on the Schedule of Benefits beginning on SPD page 8.

  All rehabilitation services must be performed in a network hospital or a network skilled nursing facility or through a network home health agency or other network provider. Rehabilitation services must be provided under the direction of the Primary Physician and approved in advance by UHC Select.

- **Infertility Services.** Health services for the diagnosis and treatment of infertility when provided by or under the direction of the Primary Physician. Coverage is provided only when UHC determines, in advance, that the Health Services are covered under the Program. Coverage is limited as shown on the Schedule of Benefits beginning on SPD page 8, and as stated in the SPD section, "What the Program Does Not Cover", beginning on SPD page 22.

- **Outpatient Prescription Drug Products at Participating Pharmacies.** Outpatient drug prescriptions must be filled at participating pharmacies, and must be medically necessary as determined by UHC or for the purpose of preventing conception. Certain prescription drug products require prior authorization by a pharmacist or a physician from UHC Select, or are subject to quantity limits. After enrollment, UHC Select will mail you a copy of The Preferred Drug List, and it can also be accessed on the UHC website. Prescription drug coverage is subject to certain limits as shown on the Schedule of Benefits beginning on SPD page 8.

- **Mail Service Prescription Drugs.** Prescription drugs that are to be taken for more than 30 days are available through a mail order pharmacy program administered by Merck Medco. Further information and forms can be obtained by calling UHC at the number of your ID cards. Copayments are outlined in the Prescription Drug Benefit Section on beginning page 18.

- **Chiropractic Health Services, Treatment or Care.** Coverage is provided for chiropractic health services, treatment or care when provided through a network chiropractor and authorized in advance by UHC Select. Referrals to a network chiropractor, network hospital or network alternate facility or other network provider shall be made solely in the discretion of UHC. You may call the Member Services number on your ID card for authorization.

- **Reconstructive Surgery**. Surgery authorized by or thorough the Primary Physician and performed in a network hospital that is incidental to an injury, sickness or congenital condition is covered if the

primary purpose is to improve the physiological functioning of the part of body that is involved. Procedures that correct a congenital condition without improving or restoring physiologic function are not included because they are considered to be cosmetic in nature.

Prescription Drug Benefit

Your UHC Select option election includes prescription drug benefits through a managed pharmacy service. You will be able to fill prescriptions through a participating pharmacy or by mail order for a specified copayment. **No payment will be made under any other section of the Medical Program for expenses incurred to the extent that expenses are payable as a prescription drug benefit.**

Participating Pharmacy Benefit

You will receive a directory of participating pharmacies in your area. You may fill a prescription for up to a 30-day supply at any participating pharmacy by showing your identification card and paying the applicable copayment.

• You will pay a copayment of $10 for each generic prescription drug or refill on the Preferred Drug List.

• You will pay a copayment of $15 for each prescription or refill of a brand name drug on the Preferred Drug List.

• You will pay a copayment of $25 for each prescription or refill on a brand name drug not on the Preferred Drug List.

If you use a non-participating pharmacy you must pay the full cost of the prescription. You may file a claim and be reimbursed for the discounted price of the drug, minus the applicable copayments.

Mail Order Pharmacy Benefit

You should fill prescriptions for more than a 30-day supply and prescriptions for medication that you or a dependent must take on a regular basis over an extended time period through the mail order pharmacy administered by Merck Medco.

• You will pay a $20 copayment for generic prescriptions on the Preferred Drug List.

• You will pay a $30 copayment for brand name prescriptions on the Preferred Drug List.

• You will pay a $50 copayment for brand name prescriptions <u>not</u> on the Preferred Drug List.

You will receive information on how to use the mail order pharmacy benefit from UHC Select. You may also call the Member Services Number on your ID card.

Covered Prescription Drugs

The term *covered prescription drug* means:
• A Prescription Legend Drug for which a written prescription is required;

• Oral or injectable insulin dispensed only upon the written prescription of a physician;

• Insulin needles and syringes;

• A compound medication of which at least one ingredient is a Prescription Legend Drug;

• Tretinoin for individuals through age 26;

• Any other drug that, under the applicable state law, may be dispensed only upon the written prescription of a physician;

• Oral contraceptives;

• Prenatal vitamins, upon written prescription;

• An injectable drug, excluding injectable infertility drugs, for which a prescription is required, including needles and syringes;

• Glucose test strips; and

• A drug that has been prescribed for a particular use for which it has not been approved by the Food and Drug Administration (FDA). Such a drug must be covered if it meets the following criteria:

– The drug is recognized for the specific use in any one of the following established reference compendia: the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluation, the American Hospital Formulary Service, or any peer-reviewed national professional medical journal;

– The drug has been otherwise approved by the FDA; and

– The drug has not been contraindicated by the FDA for the use prescribed.

Limitations

No payment will be made under the plan for the following expenses:

• For non-legend drugs, other than those specified above under “Covered Prescription Drugs”;

• To the extent that payment is unlawful where the person resides when expenses are incurred;

• For charges that the person is not legally required to pay;

• For charges that would not have been made if the person was not covered under one of the plan options;

• For experimental drugs or for drugs labeled “Caution —limited by federal law to investigational use”;

• For drugs that are not considered essential for the necessary care and treatment of an injury or sickness, as determined by the Claims Administrator for the plan or the retail pharmacy administrator;

• For drugs obtained from a non-participating mail order pharmacy;

• For any prescription filled in excess of the number specified by the physician or dispensed more than one year from the date of the physician’s order;

• For more than a 30-day supply when dispensed in any one prescription order through a retail pharmacy;

• For more than a 90-day supply when dispensed in any one prescription order through a participating mail order pharmacy;

• For indications not approved by the Food and Drug Administration;

• To the extent that the person is covered under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law (any adjustment option chosen under such part will be taken into account);

• For a brand name drug to the extent that the charge for the brand name drug exceeds the charge for a comparable FDA "A-rated" generic, where available (this limitation does not apply if the physician requests the brand name drug and specifies "Dispense as Written" on the prescription order);

• For immunization agents, biological sera, blood or blood plasma;

• For therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medicinal substances, excluding insulin syringes;

• For drugs used for cosmetic purposes;

• For tretinoin for individuals age 27 or over;

• For administration of any drug;

• For medication that is taken or administered — in whole or in part — at the place where it is dispensed, or while a person is a patient in an institution that operates — or allows to be operated on its premises — a facility for dispensing pharmaceuticals;

• For prescriptions that an eligible person is entitled to receive without charge from any Workers' Compensation or similar law or any public program other than Medicaid;

• For growth hormones and anabolic steroids;

• For nutritional or dietary supplements, antiobesity drugs or anorexiants;

• For contraceptive devices, including implantable contraceptive devices;

• For vitamins, excluding prenatal vitamins, upon written prescription;

• For oral infertility drugs; or

• For smoking cessation products.

What the Program Does Not Cover

In addition to the limitations and exclusions described elsewhere in this SPD, including the Schedule of Benefits beginning on page 8, the Program will **not** reimburse charges for the following:

• Services that are not medically necessary as determined by UHC Select.

• Care received from out of network providers, unless specifically authorized by or through the Primary Physician under procedures established by UHC Select.

• Dental services provided by a Doctor of Dental Surgery, "D.D.S.", a Doctor of Medical Dentistry, "D.M.D.", or by a physician licensed to perform dental services. Excluded dental services include implants, services for overbite or underbite, services related to surgery for cutting through the lower or upper jaw bone, and services for the treatment of temporomandibular joint syndrome (TMJ). It makes no difference whether the services are considered to be medical or dental in nature.

• Dental x-rays, supplies and appliances (including occlusal splints) and all associated expenses arising out of such dental services including hospitalizations and anesthesia, except as might otherwise be required for direct treatment of acute traumatic injury or cancer, are not covered.

• Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint) except for direct treatment of acute traumatic injury or cancer. No Program coverage is provided for orthognathic surgery, jaw alignment, or treatment for TMJ.

• Custodial care; care in the patient's home; private duty nursing; respite care; or rest cures. Custodial care means the services are non-health related services, such as assistance in activities of daily life. Custodial care includes health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changed. Custodial care includes services that do not require continued administration by trained medical personnel.

• Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.

• Cosmetic procedures including surgery and associated expenses. Examples of cosmetic procedures that are excluded include pharmacological regimens; nutritional procedures or treatments; plastic surgery; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes, and/or that are performed as a treatment for acne; radial keratotmy and other refractive eye surgery. Cosmetic procedures are those procedures which improve physical appearance, or that correct a congenital problem without improving or restoring physiologic function. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital defect does not classify surgery or other procedures to relieve such consequences or behavior as non-cosmetic or reconstructive in nature. UHC Select must be notified 5 business days prior to receiving services so that UHC may advise whether the service is cosmetic or reconstructive in nature.

• Surgical treatment for correction of refractive errors, including radial keratotomy.

• Routine foot care.

• The following drugs and medicines: diet pills, minoxidil, Retin-A after age 26 unless medically necessary, and non-prescription drugs of any kind.

• Charges in excess of reasonable and customary as determined by the UHC Select.

• Treatment of teeth/peridontium except for emergency dental work to stabilize teeth due to injury to sound natural teeth.

• Expenses for which benefits are payable under another benefit plan or under insurance provided by an employer, or for which an employer pays all or part of the cost.

• Services or supplies furnished before coverage under the BNSF Medical Program and/or the UHC Select option became effective.

• Services or supplies furnished to you or a Dependent as an inpatient on a day when the patient's physical or mental condition could be safely diagnosed or treated on an outpatient basis.

• Missed appointments or the completion of claim forms.

• Treatment of injuries sustained during the commission of a felony or other criminal act.

• Services or supplies for medical care paid for or expected to be paid for by any persons (or the insurers of such persons) considered to be responsible for the condition giving rise to the charges as a result of a judgment, settlement or otherwise.

• Charges for Experimental, Investigational or Unproven services. These are medical, surgical, diagnostic, psychiatric, substance abuse of other health care services, technologies, supplies, treatments procedures, drug therapies or devices that, at the time UHC Select makes a determination regarding coverage in a particular case, are determined to be one or more of the following:

1. Not approved by the U.S. Food and Drug administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.

2. Subject to review and approval by any institutional review board for the proposed use.

3. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

4. Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

UHC Select, in its discretion, may deem an Experimental, Investigational or Unproven service a covered health service for treating a life threatening sickness or condition if it is determined by UHC Select that the Experimental, Investigation or Unproven service at the time of the determination meets all of the requirements in 5 through 7 below. (For purposes of this definition, the term "life threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

5. It is safe with promising efficacy.

6. It is provided in a clinically controlled research setting.

7. It uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

The fact that something is Experimental and Investigational and the treatment, device, service or pharmacological therapy is the only available treatment for a particular condition will not automatically result in coverage if UHC Select in its discretion determines the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

• Any injury resulting from, or in the course of, any employment for wage or profit except for exempt employees injured while performing duties for BNSF.

• Any injury or sickness covered under any Worker's Compensation or similar law.

• Services and associated expenses for removal of an organ from a Covered Person for purposes of transplantation into another person, except where the other person is also a Covered Person under the Program. Services and associated expenses for transplanting mechanical or animal organs are not covered in any manner under the Program.

• Health services and expenses for organ or tissue transplants not specifically covered under the UHC Select option. There is no coverage for any solid organ transplant otherwise covered under the UHC Select option when the transplant is performed as a treatment for cancer.

• Health services and associated expenses for megavitamin therapy, psychosurgery, and nutritional-based therapy.

• Services and supplies for smoking cessation programs and the treatment of nicotine addiction.

• Expenses relating to surrogate parenting, unnecessary amniocentesis, health services and associated sex transformation operations, reversal of voluntary sterilizations, and elective abortion.

• Repair or replacement of any implant otherwise covered under the Program. The Program does not cover penile implants for the treatment of impotence having a psychological origin.

• Except where necessitated due to a change in the Covered Person's medical condition or to improve physical function, repair or replacement for any otherwise covered prosthetic or durable medical equipment is excluded. Orthotic appliances (including shoe orthotics) are excluded. Personal comfort items, including air conditions and humidifiers, even though prescribed by a physician.

• Growth hormone therapy except as may be provided as a prescription drug benefit for a documented grown hormone deficiency, Turner's Syndrome, growth delay due to cranial radiation, or chronic renal disease.

• Charges incurred in connection with the provision or fitting of hearing aids, eye glasses or contact lenses. Optometric therapy is not covered under the Program.

• Travel or transportation expenses, even though prescribed by a physician.

• Health services for treatment of military service-related disabilities, when the Covered Person is legally entitled to other coverage and facilities are reasonable available to the Covered Person.

• Mental health and/or substance abuse services rendered in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental health and/ or substance abuse services, when such services extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crises intervention as determined by UHC Select. Specifically excluded are mental health/substance abuse services for the treatment of insomnia and other sleep disorders, dementia, neurological disorders and other disorders with a known physical basis.

• Mental health services for the treatment of mental illnesses which will not substantially improve beyond the current level of functioning, or for conditions not subject to favorable modification or management according to generally accepted standards of psychiatric care, as determined by United Behavioral Health (UBH), including, but not limited to, conduct and impulse control disorders; personality disorders; and paraphilias.

• Mental health and/or substance abuse services for the following: (1) services utilizing methadone treatment as maintenance, L.A.A.J. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents; and (2) services and treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by UBH medically necessary.

• Outpatient prescribed or non-prescribed medical supplies including but not limited to elastic stocking, ace bandages, gauze, syringes, diabetic test strips, and like products; over the counter drugs and treatments.

• Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments not otherwise covered under the Plan, when such services are: (1) for purposes of obtaining, maintaining or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

• Devices used specifically as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

• Services rendered by a provider with the same legal residence as the Covered Person or who is a member of the Covered Person's family, including spouse, brother, sister, parent or child.

• Health services rendered after the date individual Program coverage terminates.

• Enteral feedings and other nutritional and electrolyte supplements.

• Health services for which the Covered Person has no legal obligation to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Medical Program.

• Health services for an otherwise Eligible Person or a Dependent who is on active military duty. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country are not covered.

• Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation.

• Except as otherwise provided in this SPD, services and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure, or for muscle stimulation by any means (except treatment of fractures and dislocations of the extremities).

• Services such as acupuncture, acupressure, hypnotism, rolfing, massage therapy, aroma therapy, and other forms of alternative treatment.

• Health services and associated expenses for in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment, embryo transport, donor ovum and semen and related costs, including collection and preparation.

• Appetite suppressants and other weight loss products;

• Prescription drug products for tobacco dependency or smoking cessation

• Medication for cosmetic purposes only;

• Compounded prescription drug products not containing at least one ingredient requiring a prescription order or refill;

• Medication dispensed in excess of the Medical Program's days' supply limitations;

• Replacement of prescription drug products resulting from lost, stolen, broken, or destroyed prescription order or refill;

• Drugs that are prescribed and intended for use while a person is in the hospital, skilled nursing facility or alternative facility;

• Injectable drugs except when self-administered as defined by UHC Select and the drug can be inject subcutaneously or intra-muscularly;

• Durable medical equipment - prescribed and non-prescribed outpatient supplies, other than the diabetic supplies specifically stated as covered under Medical Program terms;

• General and injectable vitamins, except prenatal vitamins, vitamins with fluoride, and B-12 injections;

• Unit dose packaging of prescription drug products;

• Progesterone suppositories;

• Experimental, investigational or unproven medications;

• Medications used for experimental, investigational or unproven indications and/or dosage regimens as determined by UHC Select;

• Prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of employment for which benefits are available under any workers' compensation law or similar laws whether or not a claim for such benefits is made or payment or benefits are received;

• Drugs available over-the-counter that do not required a prescription order or refill by federal or state law before being dispensed and any drug that is therapeutically equivalent to an over-the-counter drug.

• Prescription drug products prescribed to treat infertility.

How to File a Claim

*N*o claim forms are necessary when you or a Dependent use a UHC Select Primary Physician or a network provider through referral by the Primary Physician.

If you or a Dependent use an out of network provider in an **emergency** or an **urgent** care situation or if your Primary Physician refers you out of network with UHC Select approval, you must submit a completed claim form before benefits can be paid. Obtain a claim form from UHC. Complete and sign the form and submit your claim to P.O. Box 30555, Salt Lake City, UT 84130-0555. When you submit your claim, include with it a copy of your medical bill showing the following:

• Employee's name and Social Security number;

• Patient's full name;

• Nature of the sickness or injury;

• Type of service or supply furnished;

• Date or dates the service was rendered or the purchase was made;

• Itemized charges for each service or supply; and

• Provider of service with tax ID number.

You must submit separate claims for yourself and each of your covered Dependents who have incurred medical expenses out of network. Incomplete claim forms will not be processed. Remember that the UHC Select Medical option will only consider out of network claims for emergency or urgent care, or on referral by your Primary Physician with UHC Select approval. You will be responsible for the full cost of all other out of network claims.

If you do not submit claims for out-of-network emergency care as soon as possible, payment of your claims may be affected.

If Your Claim Is Denied

The BNSF Employee Benefits Committee (the "Committee") is the Named Fiduciary under ERISA for all claim appeals under the Program. If your claim for Program benefits is denied when initially submitted, UHC will give you written notice of the specific reasons for the denial, specific references to the Program provisions upon which the denial was based, a description of any additional information that you could provide to perfect your claim, and an explanation of the Program's claim review procedures.

You have a right to appeal any claim denial, including any denial at the Care Connection level. It does not make a difference whether the denial is a complete denial or a partial denial. You should file a **written request for appeal as soon as you receive a denial of benefits that you believe should be covered under the Program, but no later than 60 days after you receive the denial. If you fail to appeal in writing in 60 days, you can lose your right to appeal.**

Along with your written request for a review, you may submit any additional documents and written issues and comments you believe should be considered during the review. Within 60 to 120 days from the time the Committee receives the written request and any additional information, the Committee will notify you, in writing, as to its final decision. The Committee will give you specific reasons for the decision, which shall be a final and binding decision under the Program.

Your request for an appeal should be addressed to:

Employee Benefits Committee
c/o Burlington Northern Santa Fe Railway Company
2500 Lou Menk Drive
Fort Worth, Texas 76131

The Employee Benefits Commitee decision on appeal is final and binding. If you continue to disagree with the decision, you may exercise "Your Rights under ERISA" as explained on page 44 of this SPD.

When Coverage Ends

Coverage for you and your covered dependents will end on the *first to occur* of the following:

• The date your employment terminates.

• The date the BNSF Medical Program is terminated or, if you work for a BNSF affiliate, the date the BNSF affiliate terminates its participation in the Program.

• The date you are no longer eligible for coverage under Program rules.

• The first day of the payroll period for which you fail to make the required contributions for Program coverage.

• The date you are no longer eligible for Program coverage for any reason, or

• The date the Dependent no longer meets the Program's eligibility rules for Dependent coverage.

Continuation of Coverage

Family and Medical Leaves of Absence

Under the Family and Medical Leave Act of 1993 (FMLA), you may be entitled to up to a total of 12 weeks of unpaid, job-protected leave during each calendar year for the following:

• For the birth of your child, to care for your newborn child, or for placement of a child in your home for adoption or foster care;

• To care for your spouse, child or parent with a serious health condition; or

• For your own serious health condition.

If your FMLA leave is a paid leave, your pay will be reduced by your before-tax contributions as usual for the coverage level in effect on the date your FMLA leave begins. If your FMLA leave is unpaid, you will be required to pay your contributions directly to Sageo until you return to active pay status.

If you notify your Employer that you are terminating employment during your FMLA leave, your BNSF Medical Program coverage will end on the date of your notification. If you do not return to work on your expected FMLA return date, and you do not notify your Employer of your intent either to terminate your employment or to extend the period of leave, your plan coverage will end on the date you were expected to return.

You may not change your BNSF Medical Program elections during your FMLA leave unless an annual enrollment occurs, or unless you are on a paid FMLA leave and you have a Family Status Event or a special enrollment event under HIPAA.

Other Approved Leaves of Absence

If you take an approved leave of absence other than an FMLA leave — and your leave is a paid leave — your pay will be reduced by the contribution required for the Medical Program coverage in effect on the date prior to the start of your leave. After your leave exceeds the authorized period, your Medical Program coverage will end and you will receive a COBRA continuation notice.

If your approved leave is unpaid, you will be required to pay your contributions directly Sageo until you return to active pay status. After your leave exceeds the authorized period, Medical Program coverage will end and you will receive a COBRA contribution notice.

Military Leaves

If you are absent from work due to military service, you may elect to continue coverage under the Program (including coverage for enrolled Dependents) for up to 18 months from the first day of absence (or, if earlier, until the day after the date you are required to apply for or return to active employment with your Employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 [USERRA]). Your contributions for continued coverage will be the same as for similarly situated active participants in the Program.

Whether or not you continue coverage during military service, you may reinstate coverage under the Program on your return to employment under USERRA. The reinstatement will be without any waiting

period otherwise required under the Program, except to the extent that you had not fully completed any required waiting period prior to the start of military service.

Continuation of Coverage Under COBRA

(Consolidated Omnibus Budget Act of 1985 as Amended)

Under federal law, if coverage is lost due to a qualifying event, continued coverage may be elected under the Medical Program.

Eligibility

You or your covered Dependents will become eligible for COBRA continuation coverage after any of the following qualifying events result in the loss of Medical Program coverage:

• Loss of benefits due to a reduction in your hours of employment.

• Termination of your employment, including retirement but excluding termination for gross misconduct.

• Termination of employment following an FMLA leave. In this case, the qualifying event will occur on the earlier of the date you indicated you were not returning to work or the last day of the FMLA leave.

• You or a dependent first become entitled to Medicare or covered under another group health plan prior to your loss of coverage due to termination of employment or reduction in hours.

In addition, your enrolled Dependents will become eligible for COBRA continuation coverage after any of the following qualifying events occur to cause a loss of Medical Program coverage:

• Your death.

• Your divorce or legal separation.

• You first become entitled to Medicare after your loss of coverage due to termination of employment or reduction in hours.

• Your dependent child no longer qualifying as a Dependent under the Program.

A child who is born to or placed for adoption with a covered former employee during the continuation coverage period has the same continuation coverage rights as a dependent child described above.

Notification

If a qualifying event other than divorce, legal separation or loss of dependent status or entitlement to Medicare occurs, Sageo, the COBRA Administrator, will be notified of the qualifying event by your Employer. Sageo will send you an election form. To continue Medical Program coverage, you must return the election form within 60 days from the later of:

• the date you receive the form, or

• the date your coverage ends due to a qualifying event.

• If divorce, legal separation, loss of Dependent status, or entitle to Medicare under the Program occurs, you or your covered Dependent must notify Sageo that a qualifying event has occurred. This notification must be received by Sageo within 60 days after the later of:

• the date of such event, or

• the date you or your eligible Dependent would lose coverage on account of such event.

Failure to promptly notify your Employer of these events will result in loss of the right to continue coverage for you and your Dependents.

After receiving this notice, Sageo will send you an election form within 14 days. If you or your Dependents wish to elect continuation coverage, the election form must be returned to Sageo within 60 days from the later of:

• the date you receive the form, or

• the date your coverage ends due to the qualifying event.

Cost

If you elect to continue coverage, you must pay the entire cost of coverage (BNSF's contribution and the active employee portion of the contribution), plus a 2% administrative fee for the duration of COBRA continuation.

If you or your Dependent is Social Security disabled as defined by Title II or Title XVI of the Social Security Act within 60 days of loss of coverage due to your termination of employment or reduction in hours, you may elect to continue coverage for the disabled person only or for some or all of COBRA eligible family members for up to 29 months. You must pay 102% of the first 18 months of COBRA continuation and 150% for the 19th through the 29th month of coverage.

For COBRA coverage to remain in effect, payment must be received by Sageo by the first day of the month for which the payment is due. (Your first payment is due no later than 45 days after your election to continue coverage, and it must cover the period of time back to the first day of your COBRA continuation coverage.)

Duration

COBRA continuation coverage is available for:

• 18 months if coverage ended due to a reduction in your work hours or termination of your employment if you or one of your covered Dependent(s) is not Social Security disabled within 60 days of the qualifying event. If you or a Dependent are Medicare entitled prior to the date you lose coverage due to termination of employment or reduction in hours, the Medicare entitled person may elect up to 18 months of COBRA. If you are that Medicare entitled person, your Dependents may elect COBRA for the longer of 36 months from your prior Medicare entitlement date, or 18 months from the date of your reduction in hours or termination of employment.

• 36 months if your Dependents lose eligibility for medical coverage due to your death; your divorce or legal separation; your entitlement to Medicare after your termination or reduction in hours; or your dependent child ceasing to qualify as a Dependent under the Program.

• 29 months if you lose coverage due to a termination of employment or reduction in hours and you or a Dependent is disabled, as defined by Title II or Title XVI of the Social Security Act, within 60 days of the original qualifying event. In this case, you may continue coverage for an additional 11 months after the original 18-month period either for the disabled person only, or for one or all of your COBRA covered family members.

To be eligible for extended coverage due to Social Security disability, you must notify Sageo of the disability before the end of the initial 18 months of COBRA continuation coverage and within 60 days following the date you or a covered Dependent is determined to be disabled by the Social Security Administration. If the disabled individual should no longer be considered to be disabled by the Social Security Administration, you must notify Sageo within 30 days following the end of the disability. Coverage that has exceeded the original 18- month continuation period will end when the individual is no longer Social Security disabled.

If more than one qualifying event occurs, no more than 36 months total of COBRA continuation coverage will be available. The COBRA beneficiary must experience the second qualifying event during the first 18 months of COBRA continuation and must give notice to the COBRA Administrator within the required time period. COBRA Continuation coverage will end sooner if the BNSF Medical Program terminates and BNSF does not provide replacement coverage, or if a person covered under COBRA:

• First becomes covered under another group health plan after the loss of coverage due to your termination or reduction in hours, unless the new group coverage is limited due to a pre-existing condition exclusion. This Program will be primary for the pre-existing condition and secondary for all other eligible health care expenses, provided contributions for COBRA coverage continue to be paid. Coverage may only continue for the remainder of the original COBRA period.

• Fails to make required contributions when due.

• First becomes entitled to Medicare benefits after the initial COBRA qualifying event.

• Is extending 18-month coverage because of disability and is no longer disabled as defined by the Social Security Act.

Coordination of Benefits

The BNSF Medical Program provides for coordination of benefits when medical expenses incurred by you or your covered Dependents are covered by a governmental program other than Medicare or Medicaid; automobile no-fault coverage; group, blanket or franchise insurance coverage, including student coverage; the California Unemployment Insurance Code; service plan contracts; group or individual practice or other pre-payment plans; or coverage under a labor-management trusteed plan, union welfare plan or any type of employer-sponsored plan.

Coverage under an individual policy or contract is not included. Each plan or part of a plan that has the right to coordinate benefits is treated as a separate plan. This coordination of benefits provision ensures that the total benefits available to you will not exceed 100% of the allowable expenses. An “allowable expense” is any medically necessary, reasonable and customary medical expense for which you or your Dependents are covered under at least one medical plan. When benefits from a plan are in the form of services, not cash payments, the reasonable cash value of the service will be used to coordinate benefits. An allowable expense does not include the difference between the cost of a private and semiprivate room, except while the person’s stay in a private room is medically necessary.

If benefits are payable under more than one group plan, the maximum benefits payable under this Program, when combined with benefits already paid by coordinating plans, will not be more than what this Program would have paid had it been the only plan responsible for coverage. In other words, the total benefits normally payable under this Medical Program will be reduced by the amount of benefits paid by all other plans for the same services and supplies. Benefits payable under other plans include benefits that would have been payable had proper claim been made for them.

When you are covered under more than one group plan, the plan that pays your benefits first, without regard to any other plan, is called the primary plan. If this Program is the primary plan for you or your covered Dependents, your medical expenses will be covered under this Program first. If this Program is the secondary plan for you or your covered Dependents, this Program will cover eligible expenses that are not covered under your primary plan. In no event will this Program, if it is your secondary plan, exceed the amount of benefits that would be payable to you if this were your primary plan.

For purposes of this coordination in benefits provision, an "allowable expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan covering a person provides benefits in the form of services (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans covering the person is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

A plan without a coordinating provision is always the primary plan. If all plans have a coordinating provision:

The plan covering the patient directly, rather than as a Dependent, is primary and the others secondary.

If a child is covered under both parents’ plans, the plan of the parent whose birthday occurs earlier during the calendar year is primary. If both parents have the same birthday, the plan covering the parent longer is primary. When the parents are separated or divorced, their plans pay in the following order:

– The plan of the parent with custody of the child.

– The plan of the spouse of the parent with custody of the child.

– The plan of the parent not having custody of the child.

However, if the terms of a court decree have established financial responsibility for the child's health care expenses, the benefits of that plan are determined first. The benefits of a plan that covers a child as the dependent of a stepparent will be determined before a plan that covers the child as a dependent of the parent without custody.

If neither of the above applies, the plan covering the patient longest is primary. When this Medical Program is the secondary plan, its payment is reduced to coordinate with the primary plan's benefits.

The plan that covers the person as an active employee, or as a Dependent of an active employee, pays before the plan that covers an individual as a laid-off employee or such employee's Dependent. If the other plan does not have this same rule then this rule will not apply if the result is that each plan determines its benefits after the other.

Coordination with Medicare

If you or your spouse becomes eligible for coverage under Medicare, the BNSF Medical Program will still provide coverage and pay benefits before your Medicare benefits are calculated under any of the following circumstances:

• If you are age 65 or over and your spouse is over age 65, you are still actively employed with BNSF on a full-time basis, and your spouse is enrolled in this Program and has no coverage under another employer's plan, this Program will provide primary coverage as long as you and your spouse remain enrolled and continue paying any required contributions.

• If you are an active, full-time covered Employee under age 65, but your spouse is over age 65, is enrolled in this Program and has no coverage under another employer's plan, you may maintain your spouse's coverage under this Program as long as you continue to pay any required contributions.

• If you are an active, full-time covered Employee and your spouse becomes disabled while covered under this Program and has no coverage from another employer, you may maintain your spouse's coverage under this Program by paying any required contributions.

• If you or an enrolled Dependent is diagnosed as suffering from renal disease and requires dialysis while you are an active, full-time covered Employee, the Program will continue to pay benefits during the first 30 months following the diagnosis.

Medicare will be the only medical coverage under the following:

• If you elect Medicare as your primary coverage while still actively employed at age 65 or older, you will not be covered under this Program under Medicare's regulations.

The following conditions determine how this Program pays benefits for your spouse, provided you are covered under this Program, actively employed with BNSF, and have elected Employee plus spouse or family coverage:

• If your spouse is retired or disabled, receiving Social Security or Railroad Retirement Board (RRB) benefits, and eligible both for Medicare coverage and extended medical coverage through his or her former employer, and if you are over age 65, the order of coverage for your spouse is:

1. The plan of your spouse's former employer.

2. This Program. (This Program is always secondary to a plan covering the patient directly, rather than as a Dependent.)

3. Medicare.

• If your spouse is retired, under age 65 and Medicare entitled due to a Social Security Disability, and has extended medical coverage through his or her former employer, and if you either are under age 65 or over age 65 and actively employed with BNSF, the order of coverage for your spouse is:

1. The plan of your spouse's former employer.

2. This Program. (This Program is always secondary to a plan covering the patient directly, rather than as a Dependent.)

3. Medicare.

If any of these rules conflict with federal regulations under Medicare, the federal regulations will control.

General Information Affecting Your Right to BNSF Medical Program

Recovery of Overpayments

If you or a Program beneficiary should receive a benefit payment from this Program in excess of the payment that should have been received BNSF, the Program Administrator, has the right to recover the amount of the overpayment. In addition, if the overpayment is not returned, the Program Administrator reserves the right to deduct the overpayment from future Medical Program benefits payable to you if the overpayment was made to you. If the overpayment was made to any other beneficiary under the Program, the excess payment may be deducted from future Medical Program benefits payable to that beneficiary

No Assignment of Benefits

The Program will not prevent a medical care provider from receiving payment for eligible charges for covered services if there is a valid assignment of benefits. The Program Administrator has the discretionary authority to determine whether an assignment of benefits to a medical provider is valid. You may not commit benefits payable to you to pay your personal debts or other obligations that are not otherwise covered under a valid assignment of Program benefits. You may not sell any right or interest you or a covered Dependent may have in any benefit under this Medical Program.

Right to Information

You must provide the Program Administrator and the Claims Administrator with any information they consider necessary to administer the Program. If the information you give on an enrollment form or claim application is wrong, or if you omit important information, your Program coverage may be canceled or your claim may be denied. If your address should change, or if a spouse's or dependent child's address should change, you must notify your Employer immediately.

No Guarantee of Employment

Participation in this Program does not guarantee your employment with BNSF or any related BNSF Employer. Neither does it guarantee your right to any benefit under the Program.

Program Termination and Amendment

The Program has been established for the exclusive benefit of eligible Employees and their eligible Dependents. BNSF reserves the right to amend, modify or terminate the Program, including any benefits, or the amount of any required employee contributions, at any time and for any reason. If any change in the Program should occur, you will be notified within a reasonable amount of time.

No Vested Rights

Your Program benefits are not vested. Your right to benefits is limited to claims incurred before the first to occur of the following events.

- Amendment of the Program.
- Termination of the Program.
- Expiration of the period that claims can be accepted by the Claims Administrator.

• Termination of your eligibility to participate.

• Your failure to pay any required contributions.

Right of Reimbursement

This Program does not cover the following expenses.

• Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your covered Dependent(s).

• Expenses to the extent they are covered under the terms of any automobile medical; automobile no-fault; uninsured or underinsured motorist; Workers' Compensation; government insurance (other than Medicaid); or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your covered Dependent(s).

If you or a Dependent incurs health care expenses as described above, the Claims Administrator will automatically have a lien on the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the Program. You or your Dependent(s) or their representative shall execute such documents as may be required to secure the right of the Program to reimbursement. The Program will be reimbursed the lesser of the following amounts:

• The amount actually paid by the Program; or

• The amount actually received from the third party at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or otherwise.

Administrative Information

Program Costs

Medical Program benefits and administrative costs are paid from a tax-qualified Internal Revenue Code Section 501(c)(9) trust, commonly referred to as a VEBA. Employer contributions and the contributions of eligible Employees who elected to reduce their pay on a before-tax basis under the BNSF Internal Revenue Code Section 125 cafeteria plan, are deposited in the VEBA. Benefits under the UHC Select option are self-insured by BNSF. Benefits under the HMO options are insured by the relevant HMO. Please review your HMO materials for additional details.

Plan Name and Program Number

The UHC Select option is made available under The Burlington Northern and Santa Fe Railway Group Medical Program. The Program is a participating Program in the Burlington Northern and Santa Fe Railroad Group Benefits Plan, a consolidated welfare benefits program under ERISA that files its annual returns under Plan Number 501.

Company and Employer

The terms “BNSF,” “Company,” and "Employer" as used in this SPD refer to Burlington Northern Santa Fe Corporation, or an affiliate of BNSF whose employees are eligible to participate in the Medical Program.

Company Name and Identification Number

The Medical Program is sponsored by Burlington Northern Santa Fe Corporation, Employer Identification Number 41-1804964.

Program Administrator and Agent for Service of Legal Process

The BNSF Medical Program Administrator’s name, address and telephone number are as follows:

Employee Benefits Committee
c/o The Burlington Northern and Santa Fe Railway Company
2500 Lou Menk Drive
Fort Worth, Texas 76131
817-352-3620

The agent for service of legal process is:

Mr. Jeffrey R. Moreland
Executive Vice President Law & Chief of Staff
2500 Lou Menk Drive
Fort Worth, Texas 76131

The Burlington Northern Santa Fe Employee Benefits Committee (the "Committee") is the Program Administrator and Named Fiduciary under ERISA for the UHC option. UHC has the discretionary authority to make initial benefit determinations under the UHC option. UHB has the discretionary authority to make initial claims determinations with respect to mental health and substance abuse benefits under the UHC option. The Committee has the discretionary authority to make eligibility and benefit

determinations when a Program participant or beneficiary appeals the initial claims determinations made by UHC or UBH, as may be applicable. The Committee's discretionary authority includes the authority to interpret the provisions of the Program for purposes of resolving any inconsistency or ambiguity, correcting any error, or supplying information to correct any omission.

Claims Administrator for BNSF Medical Program UHC Select Option

The Claims Administrator for the Program UHC Select option is:
United HealthCare
P.O. Box 30555
Salt Lake City, Utah 84130-0555
Phone: 800-842-5658

Mental Health and Substance Abuse Administrator

United Behavioral Health (UBH)
P.O. Box 23250
Oakland, California 94623
Phone: 800-333-8742

COBRA Administrator

Sageo
2300 Discovery Lane
Orlando, FL 32826
Phone: 1-877-847-2436

Program Year

The Program Year is the calendar year.

Your Rights Under ERISA

As a participant in the BNSF Medical Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Medical Program participants will be entitled to:

Receive Information About Your Medical Program Benefits

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

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

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

Continue Medical Program Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Medical Program as a result of a COBRA qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Medical Program on the rules governing your COBRA continuation coverage rights.

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

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 this Medical Program. The people who operate the BNSF Medical Program, called *fiduciaries* of the Program, have a duty to do so prudently and in the interest of you and other Program participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Program Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Program Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Program Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the Program's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that Program fiduciaries misuse the Program's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Program, you should contact the Program Administrator.

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

The next page lists the PWBA area offices.

Offices of the Pension and Welfare Benefits Administration, U.S. Department of Labor

Atlanta Regional Office
61 Forsyth Street, S.W.
Suite 7B54
Atlanta, GA 30303
Phone: 404/562-2156

Boston Regional Office
One Bowdoin Square
7th Floor
Boston, MA 02114
Phone: 617/424-4950

Chicago Regional Office
200 W. Adams Street
Suite 1600
Chicago, IL 60606
Phone: 312/353-0900

Cincinnati Regional Office
1885 Dixie Highway
Suite 210
Ft. Wright, KY 41011-2664
Phone: 606/578-4680

Dallas Regional Office
525 Griffin Street
Room 707
Dallas, TX 75202-5025
Phone: 214/767-6831

Detroit District Office
211 W. Fort Street
Suite 1310
Detroit, MI 48226-3211
Phone: 313/226-7450

Kansas City Regional Office
City Center Square
1100 Main
Suite 1200
Kansas City, MO 64105-2112
Phone: 816/426-5131

Los Angeles Regional Office
790 E. Colorado Boulevard
Suite 514
Pasadena, CA 91101
Phone: 818/583-7862

Miami District Office
111 N.W. 183rd Street
Suite 504
Miami, FL 33169
Phone: 305/651-6464

New York Regional Office
1633 Broadway, Room 226
New York, NY 10019
Phone: 212/399-5191

Philadelphia Regional Office
Gateway Building
3535 Market Street
Room M300
Philadelphia, PA 19104
Phone: 215/596-1134

St. Louis District Office
815 Olive Street
Room 338
St. Louis, MO 63101-1559
Phone: 314/539-2691

San Francisco Regional Office
71 Stevenson Street
Suite 915
P.O. Box 190250
San Francisco, CA 94119-0250
Phone: 415/975-4600

Seattle District Office
1111 Third Avenue
Suite 860
MIDCOM Tower
Seattle, WA 98101-3212
Phone: 206/553-4244

Washington, D.C. District Office
1730 K Street, N.W.
Suite 556
Washington, DC 20006
Phone: 202/254-7013

Who to Call About Your Benefits

For questions regarding the services under the UHC Select option, call Member Services at (800) 842-5668.

For additional questions, please call Sageo at (877) 847-2436.

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