

**UNION PACIFIC RAILROAD  
EMPLOYEES HEALTH SYSTEMS**

**HEALTH SYSTEMS RULES AND REGULATIONS  
FOR PENSIONERS UNDER 65**

***JANUARY 2003***



**BENEFITS SUMMARY FOR PENSIONERS UNDER 65**

EFFECTIVE January 1, 2003

FOR DETAILS REFER TO YOUR PLAN DOCUMENT

IMPORTANT: All services must be medically necessary and be covered benefits. Payments for out-of-network services are a percentage of the Plan Allowable, NOT the billed charges.

\*\*\*\*All out-of-network services must be approved by a Health Systems Care Coordinator.

LIFETIME BENEFIT MAXIMUM - \$150,000 (includes in-network, pre-approved out-of-network and prescriptions drugs)

BENEFITS	IN NETWORK	OUT-OF-NETWORK
Physician Office Visit - \$15 Co-Pay	100%	****
Emergency Ambulance	100%	100%
Emergency Room Services After \$50 Co-Pay <sup>1,2</sup>	100%	100% First 24 hours only
Formulary Prescription Drugs	\$1700 per calendar year. Use Of Mail-Order Pharmacy Required For Maintenance Medication (co-payments required)	Emergency Only (co-payments required)
Inpatient Hospital Services <sup>1</sup>	100%	****
Outpatient Hospital Services	100%	****
Ambulatory Surgery Center Services	100%	****
Chiropractic Services - Annual Limit	80% \$600	80% \$600
Physical Therapy (56 Modalities) - Over 56 Modalities <sup>2</sup>	100%	****
Annual Routine Eye Exam - \$15 Co-Pay	100%	****
Screening Health Care Services	limited	****
Organ Transplants <sup>4</sup> - Lifetime Maximum	100% \$100,000	****
Dialysis Outpatient Care First 30 Months (33 In Some Cases)	100%	****

<sup>1</sup> Hospital Admission Pre-Approval Required (800-572-5508)

<sup>2</sup> Call for Pre-Approval – Health Systems Care Coordinator (800-547-0421)

<sup>5</sup> Co-Pay required – Mail Order Pharmacy Refills (800 547-0421)



Skilled Nursing Facility <sup>4</sup> - Maximum Days Nursing Home Care (Domicile) <sup>4</sup> Home Health Care <sup>4</sup>	100% 30 days per calendar year Not A Benefit 100%	****
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GENERAL INFORMATION

Read these Regulations carefully and keep them where they can be found for reference. Additional copies will be furnished at any time upon request to Union Pacific Railroad Employees Health Systems, hereafter "Health Systems" (or the 'Plan"), Business Office.

Members are urged to utilize the services of Health Systems Network Providers. The responsibility for obtaining the services of an available Health Systems Network Provider is entirely that of the Member, family, or personal representative.

If you fail to utilize the services of a Health Systems Network Provider, you may be responsible for all or part of the expenses incurred for your care.

The names and addresses of Health Systems Providers can be obtained from the Health Systems Office, or on the Internet at [www.uphealth.com](http://www.uphealth.com).

All correspondence must include your Social Security or unique identification number. To file a health claim refer to Article VIII.

There are provisions in these Regulations for temporary emergency treatment when a Health Systems Network Provider is not available. However, such treatment is very limited and strictly enforced.

To maintain membership, payment of Health Systems dues must be continuous.

Members who become eligible for Medicare, regardless of the reason must accept Medicare coverage, both Part A and Part B, and are advised to promptly write or call Health Systems for proper instructions. Failure to accept full Medicare coverage will result in the loss of your Health Systems membership. The address is:

795 North 400 West  
Salt Lake City, Utah 84103  
Phone (801) 595-4300  
Railroad line 8-595-4300 or  
Toll free 1-800-547-0421

Remember, it is your responsibility to know your benefits. If you are in doubt or have any questions whatsoever, you should contact Health Systems.

Members should consult the Pharmacy Benefit Guide for pharmacy benefits in conjunction with this plan and advise your doctor to prescribe accordingly.

An employee who applies for an annuity and has received Railroad Retirement Board (RRB) award notification, will not be eligible for benefits under the Challenger Health Plan for Active Members. Such a person is eligible for benefits under the Health Systems Rules and Regulations for Pensioners Under 65.



## PLAN TELEPHONE NUMBERS & ADDRESSES

### HEALTH SYSTEMS CARE COORDINATORS

795 North 400 West  
Salt Lake City, UT 84103

Tel: 1-800-547-0421

RR: 8-595-4300

### CLAIMS STATUS AND GENERAL INFORMATION

Calls requiring claims status or all other general information should be directed to the UPREHS Customer Service Department.

### UPREHS CUSTOMER SERVICE

795 North 400 West  
Salt Lake City, UT 84103  
www.uphealth.com

Tel: 1-800-547-0421  
(801) 595-4300

RR: 8-595-4300

### PHARMACIES

Mail-Order Pharmacy  
P. O. Box 3228  
Ogden, UT 84409

Tel: (800) 331-6353  
(801) 394-6414  
RR: 8-626-8272

Automated Telephone Refills for Maintenance Prescriptions:

Tel: (800) 547-0421  
(801) 595-4300

### NEBRASKA

UPREHS Pharmacy  
810 West Reid, Suite 2  
North Platte, NE 69101

Tel: (308) 534-8886  
Fax: (308) 534-7824

UPREHS Pharmacy  
UP Headquarters Building  
1416 Dodge Street, Suite 100  
Omaha, NE 68179

Tel: (402) 271-3740 or 3098  
Fax: (402) 271-4623

### IDAHO

UPREHS Pharmacy  
120 South Railroad Avenue  
Pocatello, ID 83204

Tel: (208) 236-5396  
Fax: (208) 236-5201

### DISPENSARIES

#### NEBRASKA

UPREHS  
UP Headquarter Building  
1416 Dodge Street, Suite 100  
Omaha, NE 68179  
Tel: (402) 271-3697 or 3655  
Fax: (402) 271-4623

#### IDAHO

UPREHS  
120 South Railroad Avenue  
Pocatello, ID 83204  
Tel: (208) 236-5220 or 236-5215  
Fax: (208) 236-5201



## ARTICLE I - DEFINITION OF TERMS

For the purpose of these Rules and Regulations:

- a) Health Systems means Union Pacific Railroad Employees Health Systems.
- b) Board means the Board of Trustees of Health Systems as described in Article IV.
- c) Member means any Retired Employee who is paying dues to Health Systems.
- d) Company means the Union Pacific Railroad Company or its subsidiaries and affiliated companies whose employees are now or may hereafter become associated with Health Systems by the payment of dues.
- e) Health Systems Network Provider means any physician, facility, or service under contract with Health Systems to provide services to Health Systems Members. The term includes a Health Systems Provider and a Health Systems Facility.
- f) Emergency means a medical condition manifesting itself by symptoms including acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; serious dysfunction of any bodily organ or part.
- g) Domicile or Custodial Care means the type of care, wherever furnished and by whatever name called, that is designed primarily to assist an individual in meeting his or her activities of daily living.
- h) Skilled Nursing Facility means an institution that meets the following criteria:
  - i. It is operated under the applicable laws, and is Medicare certified.
  - ii. It is under the supervision of a licensed physician or registered nurse (RN) who is devoted full-time to supervision.
  - iii. It is regularly engaged in providing room and board and continuously provides twenty-four (24) hours a day skilled nursing care of sick and injured persons during the convalescent stage of an injury or sickness.
  - iv. It maintains a daily medical record of each patient who is under the care of a duly licensed physician.
  - v. It is authorized to administer medication to patients on the order of duly licensed physicians.
  - vi. It is not, other than incidentally, a home for the aged, blind or deaf, a hotel, a domiciliary care home, a maternity home or a home for substance abuse or mental health treatment.
- i) Home Health Care means medically necessary, cost-effective, services provided by a licensed home health agency to a Member in his/her place of residence that is prescribed by the Member's attending physician as part of a written plan of care if it means the Member can remain at home safely instead of a hospital or skilled nursing facility.
- j) Hospice means a licensed agency that operates within the scope of such license providing palliative care and treatment of patients with a life expectancy of six (6) months or less where the focus is the acknowledgment of death and dealing with its physical and psychological aspects. Hospice must meet the following criteria:
  - i. It is approved under any required state or governmental Certificate of Need.
  - ii. It provides service twenty-four (24) hours a day, seven (7) days a week.
  - iii. It is under the direct supervision of a licensed physician.
  - iv. It has a nurse coordinator who is a registered nurse with four (4) years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
  - v. It has a social service coordinator who is licensed in the area in which it is located.
  - vi. The main purpose of the agency is to provide hospice services.
  - vii. It has a full-time administrator.
  - viii. It maintains written records of services given to the patient.
  - ix. Its employees are bonded. It provides malpractice and malplacement insurance.
  - x. It is established and operated in accordance with any applicable state laws.

- k) Plan Allowable means for in-network goods or services, the charge on the UPREHS fee schedule for the goods or services or, if none, the lesser of the billed charge(s) or those established by UPREHS for those goods or services in the area. For out-of-network goods or services payment will be based on the lesser of the billed charge(s) or those established by UPREHS for those goods or services in the area.
- l) Health Systems Care Coordinator is a licensed Registered Nurse who works for Health Systems to help Members of all plans coordinate appropriate health care services for cases involving complicated illness and injury.

## ARTICLE II - OBJECT AND PURPOSE

### Section 1.

The object and purpose of Health Systems shall be to furnish medical, surgical and hospital benefits to:

- a) Sick and injured Members of Health Systems and certain dependents of such Members as designated by the Board.
- b) Sick and injured passengers or others to whom the Company may feel duty-bound to provide such service, but only when directed by a duly authorized Company Representative; and
- c) Pensioned Employees and eligible spouses.

### Section 2.

Health Systems, by means of the funds collected, will endeavor to furnish comprehensive medical care to those entitled to benefits, subject to the limitations of these Rules and Regulations, without gain or profit to Health Systems. The funds of Health Systems shall be used solely in carrying out the object and purpose of Health Systems.

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## ARTICLE III - FUNDS AND PROPERTY OF HEALTH SYSTEMS

### Section 1.

It is the duty of all officers, employees and Members of Health Systems having any property of Health Systems to see that it is carefully preserved. Loss of such property must be reported promptly to the President. Any loss or damage through negligence will be chargeable to those entrusted with its care.

### Section 2.

No Member, former Member, employee, former employee, pensioned employee or spouse shall have any vested right in the funds or property of Health Systems. All funds and property shall belong to the Union Pacific Railroad Employees Health Systems and be used for the object and purpose of Health Systems as set forth in Article II hereof. No Member shall be entitled to any refund of dues because of leaving Health Systems for any other cause except that upon request refunds will be made to next of kin when a Member dies for those amounts covering monthly dues beyond the month in which death occurred which were paid in advance by such Member.

## ARTICLE IV - ADMINISTRATION

### Section 1. Board Of Trustees

All business and affairs of Health Systems shall be under the management and control of a Board of Trustees that shall consist of eleven (11) Members of Health Systems, four (4) to be appointed by the President of the Union Pacific Railroad Company and five (5) to be elected by the General Chairmen (in the case of the Brotherhood of Sleeping Car Porters, by a designated representative of that Brotherhood employed by Company) of fourteen (14) Cooperating Railway Labor Organizations. One from each of the groups of said organizations, as follows:

- |         |    |   |
|---------|----|---|
| Group 1 | 1. | United Transportation Union   |
| Group 2 | 1. | Brotherhood of Locomotive Engineers   |
| Group 3 | 1. | Transportation and Communications Union   |
|         | 2. | American Railway Supervisors Association, Inc.  |
| Group 4 | 1. | Brotherhood of Railway Carmen   |
|         | 2. | Brotherhood of Railroad Signalmen   |
|         | 3. | Dining Car Employees Union, Local No. 372   |
|         | 4. | Protective Order of Dining Car Waiters, Local No. 465   |
|         | 5. | Brotherhood of Sleeping Car Porters as more particularly set forth in the Bylaws of the Corporation |
| Group 5 | 1. | International Association of Machinists   |
|         | 2. | International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers     |
|         | 3. | Sheet Metal Workers International Association   |
|         | 4. | International Brotherhood of Firemen, Oilers, Helpers, Roundhouse and Railway Shop Laborers         |
|         | 5. | Brotherhood of Maintenance of Way Employees   |

Two (2) Trustees shall be the General Chairmen elected by the membership of the two (2) railway labor organizations that have the largest number of former Members of the Missouri Pacific Employees' Health Association who are Participating Employees under the plan offered by the Company (or the designee of each such General Chairman).

The Board of Trustees shall have the authority and responsibility for administering Health Systems Regulations. The Board of Trustees shall have the right to use its full discretion in construing and resolving any discrepancies regarding the use of application of any term or provision of these Rules and Regulations.

## Section 2. - President and District Surgeons

The Board shall appoint the President and District Surgeons.

The President shall, under the direction of the Board, have immediate supervision of business affairs of Health Systems. All questions concerning the business administration and professional services of Health Systems will be decided by the President, subject only to an appeal to the Board, whose decision on appeal shall be final and binding on the parties concerned.

The District Surgeons shall, under the direction of the Board, have supervision and control of the professional services afforded by Health Systems in their respective districts.

When a Member wishes to appeal a decision of the President or District Surgeon to the Board of Trustees, such appeal must be taken at least ninety (90) days prior to the date of any meeting of the Board. No later than sixty (60) days prior to the meeting, the complainant or representative or local or general chairman will send to the President a statement outlining the facts and setting forth the Member's position. The President or District Surgeon will, in turn, cite the rules or other factors upon which the decision was based. The President will then prepare the appeal for consideration of the Board of Trustees and will forward a copy of the completed docket to each Member of the Board not later than thirty (30) days prior to the date of the meeting. The President will also notify the Member or representative of the date on which the appeal will be heard before the Board. The Board of Trustees will consider no appeal if such appeal is not taken within two (2) years from the date of the decision of the President or District Surgeon upon which the appeal is based. In reaching its decision, the Board has discretionary authority to make factual findings and to interpret these Rules and Regulations.

## ARTICLE V - OPERATING FUNDS

### Section 1. - Source of Funds

Monthly dues in amounts as determined by the Board necessary to carry out the object and purpose of Health Systems, paid to Health Systems by all Members, in the manner provided in these Regulations.

Payments made by the Company through agreement with the National Carriers Conference Committee and the Cooperating Railway Labor Organizations.

Payments by Company for bills submitted by Health Systems for the cost incurred by Health Systems in providing treatment reasonably required for the care of passengers and persons other than employees who may be injured or become sick on property of Company, who receive treatment from Health Systems through its physicians and surgeons when directed by a duly authorized representative of Company.

## Section 2. - Payment of Dues by Member

To retain Health Systems benefits upon retirement, dues must be received by check or money order to the President of Health Systems quarterly, in advance, by the first day of the month of each calendar quarter.

Other payment options include electronic funds transfer on a monthly or quarterly basis via electronic funds transfer through the Automatic Dues Payment System (ADPS).

Failure to remit dues in advance within these time limits shall automatically and without notice terminate the right of the pensioned employee to thereafter contribute and receive benefits set forth in these Regulations.

## ARTICLE VI - BENEFITS

### Section 1. Benefits

The payment of dues to Health Systems shall entitle Members to all the benefits of Health Systems as deemed medically necessary subject to the exceptions and conditions set forth as follows:

- a) In-network benefits will be paid at 100% of the applicable benefit.
- b) Out-of-network benefits are not covered unless pre-approved by a Health Systems Care Coordinator.

### Section 2. Hospital Benefits

- (a) Payment shall be allowed for accommodations and ancillary charges for inpatient or outpatient medical and surgical treatment by Health Systems providers at hospitals or other qualified medical facilities. Private rooms will be covered only when deemed medically necessary and authorized by the Health Systems provider.
- (b) Member shall receive inpatient hospitalization benefits as follows:
  - i. Inpatient benefits, in a critical care facility, shall be unlimited, except that members will be discharged from hospitals when, in the opinion of Health Systems providers, they do not require further hospitalization and subject to Article VII, Benefit Exclusions, of these Rules and Regulations.
  - ii. Care in a skilled nursing facility not to exceed thirty (30) days during a calendar year.
- c) Prior to admission to a hospital, except in case of an emergency, Member is required to call for pre-approval. The number for pre-approval is on the back of Member's Health Insurance Card. (see section 12)

### Section 3. - Services of Physicians

Health Systems Providers shall render medical and surgical treatments to Members. Lists of Health Systems Providers are available from the Health Systems Office or on the Internet at [www.uphealth.com](http://www.uphealth.com).

The Member is responsible to pay a \$15 Co-Pay for each office visit. The Co-Pay is to be made to the physician at the time of the visit and applies to covered benefits.

#### Section 4. - Home Health Care

Home nursing care will be provided only when deemed medically necessary and authorized by a HEALTH SYSTEMS CARE COORDINATOR.

#### Section 5. - Prescription Drugs

Prescriptions must be written by a licensed physician. Only medication listed in the Health Systems Pharmacy Formulary for Retired Members will be a benefit.

- a) Medicines prescribed shall be subject to the current Co-Pay amount for each prescription item ordered or refilled.
- b) It is mandatory that all Members using maintenance drugs have such drugs filled through Health Systems Mail-Order Pharmacy Program.
- c) Members residing in locations or areas where a Health Systems Pharmacy or Contract Network Pharmacy is maintained shall be required to have their one-time-only prescriptions filled at such facilities. Health Systems maintains an extensive national network that includes most local retail pharmacies.
- d) In those cases where an Emergency exists, making it impractical to have a prescription filled at a Health Systems Pharmacy or Contract Network Pharmacy, the prescription may be filled at the nearest pharmacy and refund less the current Co-Pay will be made for the actual cost had the prescription been filled at a Health Systems Pharmacy. A written explanation of the nature of the Emergency must accompany the itemized bill.
- e) Generic drugs are provided as a covered benefit. When a generic equivalent drug is not available, the brand name drug will be provided if listed as an approved formulary drug. When a brand name drug is not listed as an approved formulary drug, the 3rd tier pharmacy benefit applies under Section 5 (j)
- f) All prescriptions for maintenance medications, including blood glucose strips, insulin and syringes, must be filled through Health Systems Mail-Order Pharmacy. However, medication requiring absolute refrigeration may be purchased from a Contract Network pharmacy and reimbursement less the current Co-Pay will be made for the actual cost had the prescription been filled at the Health Systems Pharmacy.
- g) The maximum benefit available during a calendar year is \$1,700 in accrued prescription drug expense. Co-payments do not count toward the maximum benefit.
- h) In the event the maximum benefit is exceeded, Health Systems will continue to provide generic maintenance medications at Health Systems cost, plus a dispensing fee for each prescription filled. Cost of the medication and the dispensing fee shall be paid by the member.
- i) Insulin syringes, upon prescription order by a licensed physician, will be provided through the Mail Order Pharmacy only, subject to the current Co-Pay.
- j) The 3rd tier of pharmacy benefits are supplied only through the Health Systems Mail-Order Pharmacy on prescription drugs that are for covered medical benefits. The 3rd tier drugs are subject to a Co-Pay for each prescribed amount or 30-day supply, whichever is less. The 3rd tier applies under the following conditions:
  - i. Certain catastrophic, extremely expensive, or extended treatment prescription drugs as listed and determined by the Health Systems Pharmacy & Therapeutics Committee.
  - ii. When a Member or physician requests a prescription drug that is not included in the Health Systems Pharmacy Benefit Guide for Retired Members. The prescription drug must be a covered medical benefit.
  - iii. When a Member or physician requests a brand name drug and a generic drug is available and included in the UPREHS Pharmacy Benefit Guide for Retired Members.

## Section 6. - Artificial and Surgical Appliances

Artificial limbs, artificial eyes, trusses, CPAP units, TENS units (subject to \$100.00 deductible), braces and other appliances of similar nature will be furnished when deemed medically necessary by the attending Health Systems Provider or a HEALTH SYSTEMS CARE COORDINATOR. Only one (1) each of such article shall be furnished; however, upon approval of the President the article may be renewed, replaced or repaired.

Crutches, canes, walkers, etc. will be furnished when ordered or approved by a Health Systems Provider.

## Section 7. - Additional Benefits

- a) X-rays, radiation therapy, laboratory services, surgical dressings, splints, casts etc.
- b) Anesthesiology services.
- c) Physical therapy when medically necessary and limited to 56 modalities per calendar year and other approved ancillary therapy services that are deemed medically necessary and approved by a Health Systems Care Coordinator.
- d) Blood transfusions.
- e) Care in an accredited Skilled Nursing Facility as that term is defined in Article I herein, upon prior notification of Health Systems Care Coordinator.
- f) Skin tests for allergies.
- g) Home oxygen therapy.
- h) Annual routine eye examinations
- i) Refractive eye surgery benefit payment is limited to \$1,520, per Member, per lifetime.
- j) Sterilization and/or oral contraceptives when deemed medically necessary and approved by a board certified specialist.
- k) Covered benefits include mastectomy and related reconstructive surgery on both breasts to produce a symmetrical appearance. Prostheses and physical complications in all stages of mastectomy, including lymphedemas, are covered.

## Section 8. - Emergency Benefits

In Emergency cases of sickness or injury, when a Member cannot be sent to a Health Systems Facility or await the arrival of a Health Systems Provider, any available provider or treatment facility may be utilized and Health Systems will pay 100% of the Plan Allowable less the Co-Pay of such temporary Emergency care up to and including the first twenty-four (24) hours only, unless otherwise authorized by a HEALTH SYSTEMS CARE COORDINATOR. Such providers summoned for temporary Emergency treatment shall not perform surgical procedures unless it is necessary for the safety of the Member. To continue reimbursement at 100% of the Plan Allowable, the Member or someone in their behalf shall promptly notify a Health Systems Provider or Health Systems Care Coordinator, giving details of the case and the action taken. Health Systems Provider so notified will at once inform the Member or the person responsible for the Member's welfare that Health Systems Provider will take charge of the case providing the attending physician is directed to relinquish the care of the Member to Health Systems Provider. In such cases, the Member, family or personal representative shall dismiss the Non-Health Systems Provider. If for any reason Health Systems Provider cannot comply, the physician will promptly contact a HEALTH SYSTEMS CARE COORDINATOR for instructions. Failure to comply with this process will result in a loss of benefits.

In such cases, the Member or someone in their behalf will present suitable evidence of the Emergency to the President. If the President determines from the evidence presented that the circumstances prevented the Member from obtaining treatment from a Health Systems provider, payment of the expense incurred

for Emergency treatment will be allowed at 100% of the Plan Allowable for temporary Emergency care up to and including the first twenty-four (24) hours.

The Member is responsible for a \$50 Co-Pay for each visit to the Emergency room of any hospital. The Emergency room Co-Pay applies to covered benefits for charges made by the hospital for Emergency care received in the Emergency room. The Co-Pay is waived if inpatient admission is required.

The Member is responsible for a \$15 Co-Pay for each visit to a participating urgent care center. The Co-Pay is to be made at the time of the visit and applies to covered benefits for charges from the urgent care center.

In the event of an Emergency, ambulance service will be covered to the extent necessary to transport the injured or ill Member to the nearest facility where appropriate care can be rendered. Air ambulance will be covered only in cases with supporting medical necessity and then only to the nearest facility where appropriate care can be rendered.

Ambulance transfers from one facility to another must have the prior approval of a Health Systems Care Coordinator.

#### Section 9. - Chiropractic Services

Chiropractic services including but not limited to adjustments, x-rays and lab will be paid at the rate of 80% of the Plan Allowable to a maximum of \$600 per calendar year. Evaluation and management codes are excluded from this benefit.

#### Section 10. - Organ Transplants

Payment of expenses related to organ transplants will be provided under the following conditions:

- a) Prior notification to a Health Systems Care Coordinator is required.
- b) A one-time limit of up to \$100,000 per lifetime for all organ transplants will apply.

#### Section 11. - Screening Health Care Services

Screening health care services will be provided and limited to the following services only when provided by a Health Systems Network Provider:

- a) One (1) routine Pap smear each year.
- b) One (1) baseline mammogram for a Member age thirty-five (35) to thirty-nine (39), or more frequently if recommended by a Health Systems Network Provider.
- c) One (1) mammogram every two (2) years, or more frequently if recommended by a Health Systems Network Provider, for a Member age forty (40) to forty-nine (49).
- d) One (1) mammogram each year for a Member age fifty (50) and over, or more frequently if recommended by a Health Systems Provider.
- e) One (1) digital rectal exam each year after age thirty-nine (39).
- f) One (1)-stool blood slide test each year after age forty-nine (49).
- g) One (1) proctosigmoidoscopy or colonoscopy every three (3) years after age forty-nine (49).
- h) One (1) prostate screening antigen (PSA) test every three (3) years after age forty-nine (49). More frequently if recommended by a Health Systems Network Provider.

#### Section 12. - Pre-approval

All Members of Health Systems will be subject to Pre-approval of certain medical services and it will be the responsibility of the Member, the Member's family or personal representative, the hospital or the Member's attending provider, whether a Health Systems Provider or Non-Health Systems Provider, to contact Health Systems Pre-approval Line (see UPREHS Health Insurance Card for telephone number) for inpatient hospital admission, MRI, CAT scan and cardiac catheterization.

In the event of an Emergency admission or procedure, the Pre-approval Line must be notified within one (1) working day (excluding weekends and holidays) of the emergency.

Failure to comply with pre-approval requirements and recommendations will result in benefits being payable at 60% of the contracted amount for in network providers and no payment will be made for out of network providers.

In instances where the Member or the Member's attending provider, whether a Health Systems Network Provider or Non-Health Systems Provider, disagree with the Pre-approval Line determination, an appeal of the decision may be initiated as follows:

- i. The Member or the Member's attending physician will advise the Pre-approval Line Representative of the disagreement and the points on which they disagree and request an appeal of the Pre-approval Line decision.
- ii. The Pre-approval Line Representative will arrange within twenty-four (24) hours to have the case reviewed by a physician of the same specialty as the appealing physician and advise the appealing physician and the Member of the appeal results.
- iii. If the disagreement is unresolved by (ii), the Pre-approval Line Representative will arrange within twenty-four (24) hours to have the case reviewed by an independent physician of the same specialty as the appealing physician and advise the appealing physician and the Member of the appeal results.
- iv. In the event (ii) and (iii) fail to resolve the disagreement, the individual may proceed with the services; however, benefits will be paid at 60% of the contracted amount for network providers and no payment will be made for out of network providers. If the Member desires, an appeal may be filed with Health Systems Board of Trustees in accordance with Article IV, Section 2 of these Rules and Regulations.

### Section 13. - Hospice Benefits

The following applies for hospice benefits:

- i. Pre-authorization is required.
- ii. The physician must certify that the Member is terminally ill with six (6) months or less to live.
- iii. The maximum benefit is \$3,000 and includes, but is not limited to, charges for room, board, care, and services provided by a licensed social worker.
- iv. Any counseling services given in connection with hospice services will not be considered as mental health care or substance abuse care.
- v. All hospice benefits terminate when the covered Member is deceased.

## ARTICLE VII - BENEFIT EXCLUSIONS

### Section 1. Exclusions

Benefits will not be granted in the following circumstances except as provided in these Rules and Regulations.

- a) A Member who abuses the benefits of Health Systems and who knowingly:
  - i. Files a fraudulent claim; or
  - ii. Makes a fraudulent statement to have a claim paid; or
  - iii. Who violates the Rules and Regulations of Health Systems or of a facility in which the Member may be receiving treatment may be excluded from further benefits.
- b) Ailments resulting from self-inflicted injuries.
- c) Injuries received in a fight or brawl or self-inflicted injuries.
- d) Attempted suicide or suicide under all circumstances.
- e) Weight loss clinics, programs or drugs.
- f) Gastric bypass or similar procedure(s).
- g) Any drug or appliance(s) used in birth control or pregnancy, fertility drugs, diet medications, vitamins, minoxidil solution for topical use, or experimental drugs, regardless of intended use. All nicotine patches and smoking cessation items. Any over the counter (OTC) drug or item regardless of intended use except insulin, insulin syringes, blood glucose strips, and glucometers, which are benefits if ordered from the Health Systems Mail-Order Pharmacy.
- h) Injuries sustained which are the result of the commission of or participation in a felonious act.
- i) Wheelchairs, hospital beds, physical therapy equipment, hearing aids, eyeglasses, contact lenses, footwear, bed pans, urinals, hot water bottles, cold therapy, thermometers, syringes (except insulin syringes) and similar articles.
- j) On-duty injuries suffered while in the employment of some person, firm, company or organization other than Union Pacific Railroad Company and/or its subsidiaries and affiliated companies.
- k) Decayed, faulty, diseased or damaged teeth; replacement of natural teeth or repairs to dentures or bridges.
- l) Members will not be permitted to duplicate benefits under Medicare with benefits under the Rules and Regulations of Health Systems.
- m) Cosmetic surgery or treatment.
- n) Personal comfort items.
- o) Services, procedures or supplies provided for the treatment of sexual arousal disorders or erectile dysfunction, regardless of cause.
- p) Reversal of sterilization procedures.
- q) Routine physical examinations.
- r) Alcoholic detoxification or rehabilitation.
- s) Mental disorders including but not limited to services of psychiatrists and psychologists, and drugs used for treatment of mental disorders including depression.
- t) Fertility procedures and tests.
- u) Experimental and/or investigational procedures, treatments, drugs, or surgeries. Experimental procedures, treatments, drugs, or surgeries are tests or trial drugs that are preformed or administered to discover or to demonstrate something that is not proven as an accepted standard of care. Investigational procedures, treatments, surgeries, or drugs are health care services of which the safety and efficacy have not been proven.
- v) Services provided in a United States government hospital or through the provisions of state Medicaid including MediCal programs.
- w) Nursing home. Domicile or custodial care as defined in Article I herein.

## ARTICLE VIII - FILING OF CLAIMS

The time limit for filing claims for all Members is two (2) years from the date services were provided and it is the Member's responsibility to ensure that the claim(s) are filed properly and on a timely basis with Health Systems Claims Department. (see Appendix D)

Providers of service usually present their bills directly to Health Systems. If bills are sent to Members, they should be forwarded to Health Systems Claims Department for processing. All bills MUST be printed on a HCFA-1500 (Physician) or UB-92 (Hospital) form.

Claims should be forwarded to the Health Systems Business Office at 795 North 400 West, Salt Lake City, Utah 84103.

## Article IX - EXCEPTIONAL CASES

Cases may arise that may not be covered by these Regulations or from the nature of which it would be impractical to prescribe specific Regulations. In such cases, the facts should be fully and promptly reported to the President as the case indicates for instructions. Health Systems will not be responsible for any expenses incurred that are not authorized by these Regulations or by express instructions from the President.

## Article X - ACCESS TO MEDICAL AND HOSPITAL RECORDS

Health Systems will provide access to medical and hospital records under their control upon presentation of a medical record release form signed by the Member or the Member's duly accredited or authorized representative. Provision of records by Health Systems is limited to applicable city, county, state and/or federal law(s).

## Article XI- SUBROGATION

In consideration of treatment or payment for treatment of a Member by Health Systems, said Member assigns, transfers and subrogates to Health Systems, to the extent of all expenditures made in behalf of said Member by Health Systems, all rights, claims, interest and rights of action that the Member may have against any party, person, firm or corporation that may be liable for the loss except the Union Pacific Railroad Company and its affiliated and subsidiary companies. Said Health Systems Member authorizes Health Systems to sue, compromise or settle in the Member's name and Health Systems is fully substituted for the Member and subrogated to all of the Member's rights to the extent of all expenditures made in behalf of said Member. Said Member upon written request of Health Systems shall execute such written authority as Health Systems, in its sole judgment, deems necessary to enable Health Systems to exercise its right of subrogation granted herein.

In the event a Member elects to pursue a suit, claim, or right of action against any party, person, firm, or corporation that may be liable for loss, except the Union Pacific Railroad Company and its affiliated and subsidiary companies, with respect to on-duty injuries, Health Systems is entitled to full reimbursement to the extent of all benefits it pays out of any proceeds, settlement, or verdict recovered by the Member. In all such cases, Health Systems shall have a lien against any recovery and expects and is entitled to be reimbursed in full in the amount of all benefits it pays, without any reduction for costs or attorney's fees. This subparagraph shall not in any way limit or impair Health Systems' right to independently recover such expenditures as set forth above.

## Article XII AMENDMENTS

Except as provided in Article 21 of the bylaws of Health Systems, these rules and regulations may be amended as deemed necessary by the Board of Trustees.

### APPENDIX A - COORDINATION OF BENEFITS

- a) Health Systems benefit program is not intended to pay the expense of any medical, surgical, hospital or dental treatment for which any insurance carrier is liable under the provisions of any group insurance policy or plan, the cost of which is paid in whole or in part by an employer. Accordingly, all benefits payable by Health Systems for the medical, surgical, hospital or dental care of any Member shall be reduced by such amounts which the Member is entitled to claim for his or her use or benefit under any group insurance plan as herein defined.
- b) The term group insurance plan as used in this Section shall mean any group insurance policy, plan or program paid for in whole or in part by any employer and which provides medical, surgical, hospital or dental benefits by:
  - i. Group, blanket or franchise insurance coverage,
  - ii. Group, National Health & Welfare Plan, group practice and other prepayment group coverage,
  - iii. Any labor management trustee plan, union welfare plan, employer organization plan or employee benefit plan or
  - iv. Any governmental program or any coverage under automobile insurance including no-fault insurance.
- c) If Health Systems determines that it will coordinate with another plan, either Health Systems or the other plan will be primary and must pay its benefits first. Payment is determined in the following order:
  - i. The plan with no coordination of benefits will be primary.
  - ii. If the primary plan was not established by (i), the plan covering the person as an employee or former employee will be primary if the person is covered as a dependent by two (2) or more plans.
  - iii. If the primary plan was not established by (i) or (ii), then the plan which covers that person as a dependent of the person whose birthday is earlier in the calendar year will be primary to a plan which covers that person as a dependent of a person whose birthday is later in the calendar year.
  - iv. If the primary plan was not established by (i), (ii) or (iii), the plan covering the person as an actively working employee at the time of their injury or onset of their illness will be primary.
  - v. If the primary plan was not established by (i), (ii), (iii) or (iv), the plan that has covered the person for the longer period of time will be primary.
- d) Whenever any payment in excess of the maximum amount payable under this Section shall have been made by Health Systems, Health Systems shall have the right to recover such payment or payments to the extent of such excess from any one or more of the following, as Health Systems shall elect:
  - i. Any person to or for whom such payment or payments were made.
  - ii. Any insurance company.
  - iii. Any other association, organization or corporation.
- e) Coordination ensures that a Member will not receive payment for more than 100% of the allowed medical charges. However, the total payment received by the Member will never be less than if coordination did not apply.

## APPENDIX B - Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

On April 7, 1986 a federal law (Public Law 99-2272, Title X) was enacted requiring that most employers sponsoring group health plans offer employees the opportunity for a temporary extension of health coverage (called Continuation Coverage) at group rates in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the Continuation Coverage provisions of the law. We suggest you take the time to read this notice carefully. If you are an employee of Union Pacific Railroad Company covered by Union Pacific Railroad Employee Health Systems, you have a right to choose this Continuation Coverage if you lose your group health coverage because of reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

Union Pacific Railroad Company has the responsibility to notify Union Pacific Railroad Employee Health Systems ("Health Systems") of the employee's termination of employment or reduction in hours, or Medicare eligibility, or retirement.

When Health Systems is notified that one of these events has happened, Health Systems will in turn notify you that you have the right to choose Continuation Coverage. Under the new law, you have sixty (60) days from the date you would lose coverage because of one of the events described above to inform Health Systems that you want Continuation Coverage.

If you do not choose Continuation Coverage, your group health insurance coverage will end.

If you choose Continuation Coverage, Union Pacific Railroad Company is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees. The law requires that you be afforded the opportunity to maintain Continuation Coverage for eighteen (18) months if you lost group health coverage because of termination of employment or reduction in hours, which can be extended to 29 months under certain disability circumstances. However, the law also provides that your Continuation Coverage may terminate for ANY of the following reasons:

- 1) Union Pacific Railroad Company no longer provides group health coverage to any of its employees.
- 2) The premium for your Continuation Coverage is not paid.
- 3) You become an employee covered under another group health plan.
- 4) You become eligible for Medicare benefits. However, your dependents may become eligible for continuation of coverage at this time.

Under COBRA, your right to Continuation Coverage terminates if you become covered by another employer's group health plan (number (3) above) that does not limit or exclude coverage for your preexisting conditions. If you become covered by another group health plan and that plan contains a preexisting condition limitation that affects you, your COBRA Continuation Coverage cannot be terminated.

However, UPREHS may terminate your COBRA coverage if the other plan's preexisting condition rule does not apply to you by reason of restrictions defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) on preexisting condition clauses. Refer to Appendix C for HIPAA EXPLANATION

You do not have to show that you are insurable to choose Continuation Coverage. However, under the law you may have to pay all or part of the premium for your Continuation Coverage. This law applies to Union Pacific Railroad Employee Health Systems beginning on January 1, 1989. If you have any questions about the law, please contact:



Union Pacific Railroad Employee Health Systems  
795 North 400 West  
Salt Lake City, Utah 84103

Your spouse and dependents are also entitled to Continuation Coverage; however, since the National Health & Welfare Plan provides their medical benefits, any information regarding Continuation Coverage for them should be addressed to:

National Health & Welfare Plan  
Benefits Department  
Railroad Administration COBRA  
One Tower Square  
Hartford, CT 06183-6006

#### APPENDIX C - Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which insurance coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). If your employment is terminated or you lose insurance coverage for other reasons, you may enroll in a new plan that has a preexisting condition waiting period

You have the right to receive a Certificate of Prior Creditable Coverage from your insurance plan. You may use a Certificate to offset or reduce a preexisting condition-waiting period imposed by the new insurance plan. If you buy health insurance from other than an employer group health plan, your Certificate may help you obtain coverage without a preexisting condition exclusion or waiting period. If your new insurance plan has no preexisting exclusions or waiting periods, you may not need a Certificate. Contact your new plan administrator or state insurance department for further information.

For employer group health plans, these changes take effect at the beginning of the first plan year starting after June 30, 1997.

Certificates of Creditable Coverage are provided by Health Systems for Members losing coverage under the UPREHS Plan and ERMMB or COBRA Extended Coverage Plans administered by UPREHS. You may request a Certificate if you have been covered after July 1, 1996. The Certificate must be provided to you promptly. UPREHS Members losing coverage may send a request to:

Union Pacific Railroad Employee Health Systems  
795 North 400 West  
Salt Lake City, Utah 84103

You may request a Certificate for any of your dependents (including spouse) who were enrolled under your health coverage with the National Health & Welfare Plan PPO/Indemnity Option (Basic, Option 1 or Option 2) and HMO, any dental option, the Healthcare Flexible Spending Account, the Employee Assistance Program (EAP) AND the Wellness Option. Dependent requests should be sent to:

Union Pacific Railroad  
1416 Dodge Street, Room 320  
Omaha, Nebraska 68179



## APPENDIX D - CLAIMS AND APPEAL INFORMATION

### Filing a Medical Claim

The appropriate identification cards may be obtained directly from UPREHS. The following information needs to be provided after a provider or facility renders services:

If you go to an In-Network provider the provider or facility will submit the following information to UPREHS on a HCFA 1500, or UB92 form.

- a) A description of services or supplies provided, detailing the charge for each supply or service;
- b) The diagnosis;
- c) The date(s) of service;
- d) The patient's name;
- e) The provider's name, address, phone number, and title (MD, Ph.D., DDS, etc.);
- f) The federal tax identification number of the provider.

If you go to an Out-of-Network provider, the covered person is responsible for filing a claim. You must file a claim in a format that contains all of the information required as described below:

- a) The Covered Person's and/or patient's name and address;
- b) The member and group number stated on your medical ID card;
- c) An itemized bill from the provider that includes the following:
  - i) Patient Diagnosis
  - ii) Date(s) of service
  - iii) Procedure Code(s) and description of service(s) rendered
  - iv) Charge for each service rendered
  - v) Provider of service Name, Address and Tax Identification Number
  - vi) The date the Injury or Sickness began; and
  - vii) A statement indicating either that the covered person is or is not enrolled under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

You must submit a claim for benefits within two years after the date of service. If a non-network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you do not provide this information to UPREHS within two years of the date of service, benefits for that health service will be denied or reduced at the discretion of UPREHS. This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

If another plan is the primary payer, a copy of the other plan's Explanation of Benefits (EOB) must accompany the claims sent to this Plan.

Mail completed claims to:

Union Pacific Railroad Employee Health Systems  
795 North 400 West  
Salt Lake City, UT 84103

In the event your claim is denied in whole or in part, UPREHS will provide you with written notice of the following:



- a) The specific reason(s) for the denial;
- b) Specific reference to pertinent Plan provisions on which the denial was based;
- c) A description of any additional material or information necessary to perfect your claim and an explanation of why such material or information is necessary;
- d) Information regarding how you may appeal the decision denying your claim.

If you have questions regarding a claim, please call: 1-800-547-0421.

All claims must be filed with the plan within a 24-month period from the date of service.

### APPEAL

In the event a medical claim has been denied in whole or in part, you can request, in writing, a review of your claim by UPREHS within 60 days of your receipt of written notice denying the claim. When requesting a review, state the reason you believe the claim was improperly denied and submit any data, questions or comments you deem appropriate. You also have the right to review pertinent documents related to your claim. UPREHS will re-evaluate all the information pertaining to the claim. You will receive written notice of the decision in a timely manner. The notice will specify the reason(s) for the decision and will reference pertinent Plan provisions on which the decision was based.

This request for review should be sent to:

Union Pacific Railroad Employee Health Systems  
795 North 400 West  
Salt Lake City, UT 84103

For all claims and appeals, Union Pacific Railroad Company has delegated to UPREHS the exclusive and discretionary right to interpret and administer the provisions of the Plan. The decisions of UPREHS are conclusive and binding.

### FUTURE OF THE PLAN

While Health Systems intends to continue the Plan indefinitely, it reserves the right to terminate or amend the Plan for any reason. If the Company terminates or amends the Plan, benefits under the Plan would cease or change. The Company may also increase the required employee or retiree contributions at any time. Similarly, a participating employer can take any such actions with respect to its employees or retirees. Every effort will be made to provide Plan participants with reasonable notice of any such change.

APPENDIX E - Information Required By the Employee Retirement Income Security Act of 1974 (“ERISA”)

Name of Plan	Union Pacific Railroad Employees Health Systems (the “Plan”)	
Plan Sponsor	Union Pacific Railroad Company	
Plan Identification Numbers	Employee Identification Number (EIN): 87-0427760 Plan Number (PN): H-4652	
Plan Administrator	Union Pacific Railroad Employees Health Systems 795 North 400 West Salt Lake City, UT 84103 Tel: (801) 595-4300 Fax: (801) 595-4399	
Type of Plan	Health Care Benefit Plan	
Trustee	Zions First National Bank 102 S Main Street Salt Lake City, UT 84101	
Current Board of Trustees of the Plan	M.A. Young, Chairman D. Richling, M.D. W.J. Behrendt G. Campbell N.J. Lucas J.J. Marchant	B.R. Palmer C.J. Schoner J. McArthur R. Karstetter M.H. Williams
Operating Trustees	M.A. Young, Chairman D.T. Butterfield, Chief Executive Officer K.J. Potts, Chief Operating Officer	
Agent for Service of Legal Process	Service of Legal Process may be made upon the Plan Administrator or any Trustee listed above.	
Sources of Employer and Employee Contributions to the Plan	The Railroad National Carriers Conference Committee sets employer contributions each year. The employee contribution is then calculated by subtracting the employer contribution amount from projected actual claims costs. Health care benefits under the Plan are payable from funds that are held in trust until needed to pay such benefits.	
Type of Administration of Health Care Benefits Provided by the Plan	Trustees and Self-Administered. The Plan is administered directly by the Plan Administrator. The Plan’s health care benefits are funded directly by the Plan and are not insured by an outside entity. Each Plan-Year ends on December 31.	

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

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

In addition to creating rights for Plan participants, ERISA imposes duty upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "Fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health care benefit or exercising your rights under ERISA. If your claim for a health care benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the 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. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, 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 NW, Washington D.C. 20210.

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