UPREHS Challenger Health Plan

UPREHS
Union Pacific Railroad Employes Health Systems

PLAN FOR LIFE.

UPREHS. Plan for Life.

The Union Pacific Railroad Employes Health Systems, and its predecessor organizations were already providing major medical benefits to railroad workers long before the average person understood the concept of health insurance. In the late 1800s, the Union Pacific Railroad organized its Medical Department to care for workers who fell ill or were injured on the job.

Wherever the workers went, doctors and nurses followed. Railroad hospitals and clinics were established along the rail route in places where some workers had never seen a real doctor. In fact, the railroad industry was the first employer to offer health care benefits to its employees. In 1947, the Medical Department separated from the Union Pacific Railroad to become the Union Pacific Railroad Employes Health Systems.

Serving the needs of our members and providing superior service is the top priority of Union Pacific Railroad Employes Heath Systems. Professional administration of our plans and networks is the key to our success. Our staff is dedicated and committed to all the members we serve.

Today, the Union Pacific Railroad Employes Health Systems keeps pace with ever-changing technology and the changing needs of our members. We have customized our extensive network of hospitals, physicians, and other health care professionals to fit the needs of our active and retired members throughout the United States.

Freedom to choose providers, quality care, first class service and the security of knowing that we are here for you: this is the hallmark of Union Pacific Railroad Employs Health Systems—just as it has been for over a century.

Our philosophy is simple: UPREHS. Plan for Life.

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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 Employes Health Systems (hereafter "UPREHS" or the "Plan"), Business Office.

Members are urged to utilize the services of an available UPREHS Network Provider. UPREHS provides maximum benefits for treatment by physicians and surgeons who are under contract with UPREHS, as more fully set forth in these Regulations. The responsibility for obtaining the services of an available UPREHS Network Provider is entirely that of the Member, family, or personal representative.

If you fail to utilize the services of an available UPREHS Network Provider, your level of benefits will be reduced and you will have to assume part or all of the expenses incurred for your care.

The names and addresses of UPREHS Network Providers can be obtained from the UPREHS Office, or on the Internet on our Website www.uphealth.com.

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

There are provisions in these Regulations for temporary emergency treatment when a UPREHS Network Provider is not available. However, such treatment is very limited and strictly enforced. These Regulations allow for limited continuation of coverage when your employment terminates, you are furloughed, or are on a leave of absence. To maintain membership, payment of UPREHS dues must be continuous. If you are off the payroll for any full month and dues payments are not waived, it will be your personal responsibility to make payment of your UPREHS dues directly to UPREHS in accordance with provisions contained in Article V of these Regulations.

Members planning to retire from the service of the Company, regardless of the reason, are required to promptly write to or call UPREHS for proper instructions. The address is:

P.O. Box 161020
Salt Lake City, Utah 84116-1020
Phone (801) 595-4300
Railroad line 8-595-4300 or
Toll free (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 UPREHS.

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

*** THIS DOCUMENT REFLECTS THE
CHALLENGER PLAN IN EFFECT AS OF JANUARY 1, 2007***

PLAN TELEPHONE NUMBERS & ADDRESSES

UPREHS CARE COORDINATORS

P.O. Box 161020
Salt Lake City, UT 84116-1020

Tel: (800) 547-0421
RR: 8 595-4300

BEHAVIORAL HEALTH CARE COORDINATORS

Tel. (888) 484-3568

HOSPITAL ADMISSION PREAPPROVAL

Refer to the number on the UPREHS Health Insurance and RX card

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
P.O. Box 161020
Salt Lake City, Utah 84116-1020
www.uphealth.com

Tel: (800) 547-0421
(801) 595-4300
RR: 8 595-4300

UPREHS MAIL ORDER PHARMACY

UPREHS Mail –Order Pharmacy
P.O. Box 165090
Salt Lake City, Utah 84116-5090

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

Automated Telephone and website systems for Refills of Maintenance Prescriptions:
(800) 547-0421
(801) 595-4300
www.uphealth.com

PHARMACIES

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
1400 Douglas Street (STOP 0030)
Omaha, NE 68170-0030

Tel: (402) 544-3740
Fax: (402) 501-0495

IDAHO

UPREHS Pharmacy
120 South Railroad Avenue
Pocatello, ID 83204

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

CLINICS

NEBRASKA
UPREHS Clinic
UP Headquarters Building
1400 Douglas Street (STOP 0030)
Omaha, NE 68170-0030
Tel: (402) 544-3697 or 3655
Fax: (402) 501-0475

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

ARTICLE I – DEFINITION OF TERMS

For the purpose of these Rules and Regulations:

a) **Active Employee** means any officer or employee of the Company receiving compensation who is now or may hereafter become a Member of UPREHS by the payment of dues, except

   i) Non-member – An employee who is not eligible for membership in UPREHS.

   ii) Special Work Employee – An employee who would be an Active Employee, except that the person is employed on special work not requiring their entire time.

   iii) Part-time Employee – An employee who would be an Active Employee, except that the person is working on a part-time basis. An Active Employee who is paid a regular monthly salary that contemplates and may at times require full-time service is not a Part-time Employee.

b) **Behavioral Health Care Coordinator** means a person who works for UPREHS to assess a Member's behavioral health condition for purposes of directing the Member to the appropriate health care professional for appropriate treatment and is to be contacted for pre-approval or authorization of certain goods and services as set forth in the Challenger Plan.

c) **Board** means the Board of Trustees of UPREHS as described in Article IV hereof.

d) **Challenger Plan** means the UPREHS Challenger Health Plan for Active Members as set forth herein, and as may from time to time hereafter be amended.

e) **Company** means the Union Pacific Railroad Company or its subsidiaries and affiliated companies whose employees are now or may hereafter become associated with UPREHS by the payment of dues.

f) **Dismissed Employee** means any Active Employee who is a Member on the day before becoming a former employee (whether voluntarily or involuntarily) and who is not a Separated Employee.

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) **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 the absence of immediate medical attention to 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; or serious dysfunction of any bodily organ or part.

i) **Furloughed Employee** means any Active Employee who is a Member on the day before the start of a furlough (including furlough because of a reduction in force where seniority is retained).

j) **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 in a hospital or Skilled Nursing Facility.

k) **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 (2) 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 misplacement insurance.

x) It is established and operated in accordance with any applicable state laws.

l) **Hospital Pre-approval Coordinator** means the entity to be contacted for pre-approval of hospital admissions under Article VI Section 2.

m) **Leave of Absence Employee** means any Active Employee who is a Member on the day before an authorized leave of absence for personal, business, sickness, or injury (whether on-duty or off-duty), provided such leave of absence is not taken to engage in outside employment. An Active Employee who is a Member on the day before being physically disqualified for work by the Company is also a Leave of Absence Employee.

n) Member means any Active Employee, Dismissed Employee, Furloughed Employee, Leave of Absence Employee, Separated Employee or Suspended Employee who is paying dues to UPREHS or whose dues are waived by these Rules and Regulations.

o) **Pensioned Employee** means a former employee with 60 months or more of compensated service during the last period of service with the Company, or with a labor organization representing employees of the Company, who is receiving an annuity under the Railroad Retirement Act or Social Security, and who at the time of applying for annuity was:

i) In the service of the Company or such labor organization or on furlough with seniority and rights to recall retained, or carried on a craft seniority roster with the designation “physically disqualified”; and,

ii) Was, on the last day of service with the Company or such labor organization, a Member. Time off on authorized leave of absence or during furlough when seniority and rights to return to service are retained, or for discharge in cases where employees are subsequently reinstated, will not constitute a break in service under this provision; provided, however, that no former employee will be considered to be a “Pensioned Employee” unless such employee has 60 months or more of membership in UPREHS prior to the time of applying for annuity.

p) **Plan Allowable** means the amount allowed on the UPREHS fee schedule for services billed by a UPREHS Network Provider. For out-of-network goods or services payment will be based on the lesser of the billed charges(s) or those established by UPREHS for those goods and services in the area. Under no circumstances shall the plan allowable include any charge related to the period between when a good or service is incurred and paid or reimbursed by the Challenger Plan.

q) Separated Employee means any Active Employee who is a Member on the day before becoming a former employee (whether voluntarily or involuntarily) and who receives a separation allowance from the Company, provided such Active Employee has been a Member for five (5) years and is eligible to retire under the Railroad Retirement Act within ten (10) years of receiving such separation allowance.

r) **Skilled Nursing Facility** means an institution that meets the following criteria:

   i) It is operated under the applicable laws, and must be 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.

s) **Suspended Employee** means any Active Employee who is a Member on the day before being suspended from employment by the Company.

t) **UPREHS** means Union Pacific Railroad Employes Health Systems.

u) **UPREHS Appeals Administrator** means the President of UPREHS.

v) **UPREHS Care Coordinator** is a licensed registered nurse who works for UPREHS to help Members coordinate appropriate health care services for cases involving complicated illness and injury and to be contacted for pre-approval or authorization of certain goods and services as set forth in the Challenger Plan.

w) **UPREHS Claims Administrator** means the person(s) described in Article VIII Section 2 (e) to make claims determinations under Article VIII.

x) **UPREHS Network Provider** means any physician, facility, or service under contract with UPREHS to provide services to UPREHS Members. The term includes a UPREHS Physician and UPREHS Facility.

y) **UPREHS Prescription Drug Coordinator** is the UPREHS employee assigned responsibility by the President to make claims determinations with regard to benefits covered by Article VI, Section 5 (Prescription Drugs).

ARTICLE II – OBJECT AND PURPOSE

SECTION 1 – OBJECT AND PURPOSE

The object and purpose of UPREHS shall be to furnish benefits for the diagnosis and treatment of illness and injury to sick and injured Members of UPREHS and certain dependents of such Members as designated by the Board.

SECTION 2 – FUNDS COLLECTED

UPREHS, 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 UPREHS. The funds of UPREHS shall be used solely in carrying out the object and purpose of UPREHS.

ARTICLE III – FUNDS AND PROPERTY OF UPREHS

SECTION 1 – PURPOSE OF FUNDS

No Member, former Member, employee, former employee, Pensioned Employee or spouse shall have any vested right in the funds or property of UPREHS. All funds and property shall belong to the Union Pacific Railroad Employes Health Systems and be used for the object and purpose of UPREHS as set forth in Article II hereof. No Member shall be entitled to any refund of dues because of leaving the service of the Company 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 UPREHS shall be under the management and control of a Board of Trustees that shall consist of eleven (11) Members of UPREHS, four (4) to be appointed by the President of the Union Pacific Railroad Company and five (5) to be elected by the General Chairpersons Association.

Two (2) Trustees shall be the General Chairpersons elected by the membership of the two (2) railway labor organizations that participated at the time of the merger of UPREHS with the Missouri Pacific Employee's Health Association in such Association that have the largest number of Members (or the designee of each such General Chairpersons).

The Board of Trustees shall have the authority and responsibility for administering UPREHS Regulations. The Board of Trustees shall have the right to use its full discretion in construing and resolving any discrepancies regarding the use or application of any term or provision of these Rules and Regulations. Any interpretation made pursuant to such discretion shall be given full force and effect, unless it can be shown that the interpretation is arbitrary or capricious.

SECTION 2 – PRESIDENT

The Board shall appoint the President.

The President shall, under the direction of the Board, have immediate supervision of business affairs of UPREHS. All questions concerning the business administration and professional services of UPREHS will be decided by the President, subject only to an appeal to the Board.

ARTICLE V – OPERATING FUNDS AND COVERAGE

SECTION 1 – SOURCE OF FUNDS

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

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

SECTION 2 – COLLECTION OF DUES AND COVERAGE

a) **Active Employee who is a Member**

i) The dues provided in Section 1(a) of this Article V shall be collected each month or fraction thereof by the Company to the extent it may be lawfully deducted on the payrolls from each Active Employee for each month or fraction of a month in which the Active Employee is a Member.

ii) An Active Employee is eligible for reimbursement under the Challenger Plan for covered goods and services incurred during any month for which dues are paid by the Active Employee under Article V. Coverage as an Active Employee under the Challenger Plan terminates at the earlier of the last day of the month for which dues are paid or the last day of the month in which the person ceases to be an Active Employee.

b) **Dismissed Employee or Suspended Employee who is a Member**

i) The dues provided in Section 1(a) of this Article V shall be paid by a Dismissed Employee or Suspended Employee by direct payment as provided in Section 3 of this Article V by the fifth day of the month beginning immediately following the last month in which the Dismissed Employee or Suspended Employee has compensated service and thereafter by the fifth day of each subsequent month in which the Dismissed Employee or Suspended Employee is a Member.

ii) A Dismissed Employee or Suspended Employee is eligible for reimbursement under the Challenger Plan for covered goods and services incurred during any month for which dues are paid by the Dismissed Employee or Suspended Employee under Article V. Coverage as a Dismissed Employee or Suspended Employee under the Challenger Plan is provided under Appendix B – Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Not withstanding the foregoing for a period not longer than the last continuous period the Member paid dues under Article V as an Active Employee, the Member shall pay for such coverage instead of the COBRA rate, the rate set for an Active Employee for up to the first six (6) months of COBRA coverage and then at the rate set by the Board for up to the next six (6) months of COBRA coverage while the Member is pursuing reinstatement. A Dismissed Employee or Suspended Employee who fails to pay dues shall not be entitled to resume coverage under the Challenger Plan until the person again becomes an Active Employee.

c) **Furloughed Employee who is a Member**

i) The dues provided in Section 1(a) of this Article V shall be paid by a Furloughed Employee by direct payment as provided in Section 3 of this Article V:

(1) if the Furloughed Employee is a qualifying employee under one of the National Health and Welfare Plans, by the fifth day of the fourth month beginning immediately following the last month in which such Furloughed Employee has compensated service and thereafter by the fifth day of each subsequent month in which such Furloughed Employee is a Member, or

(2) if the Furloughed Employee is not a qualifying employee under one of the National Health and Welfare Plans, by the fifth day of the first month beginning immediately following the last month in which such Furloughed Employee has compensated service and thereafter by the fifth day of each subsequent month in which such Furloughed Employee is a Member.

ii) A Furloughed Employee is eligible for reimbursement under the Challenger Plan for covered goods and services incurred during any month for which dues are paid by or waived for the Furloughed Employee under Article V. Coverage as a Furloughed Employee under the Challenger Plan terminates at the earlier of the last day of the month for which dues are paid by or waived, or the last day of the month in which the person ceases to be a Furloughed Employee, provided that Challenger Plan coverage for a Furloughed Employee shall in no event extend beyond the last day of the month that equals the last continuous period during which the Furloughed Employee paid dues under Article V as an Active Employee. The Member shall pay for such coverage at the rate set for an Active Employee for up to the first six (6) months of coverage and then at the rate set by the Board for up to the next six (6) months and then at the rate set by the Board for the remaining period. A Furloughed Employee who fails to pay dues shall not be entitled to resume coverage under the Challenger Plan until the person again becomes an Active Employee.

d) **Leave of Absence Employee who is a Member**

i) The dues provided in Section 1(a) of this Article V shall be paid by a Leave of Absence Employee by direct payment as provided in Section 3 of this Article V:

(1) if the leave of absence is for personal or business, by the fifth day of the first month beginning immediately following the last month in which the Leave of Absence Employee has compensated service and thereafter by the fifth day of each subsequent month in which the Leave of Absence Employee is a Member provided such leave of absence is not taken to engage in outside employment,

(2) if the leave of absence is for sickness, off-duty injury or physical disqualification for service, by the fifth day of the first month following a two (2) month dues waiver and thereafter by the fifth day of each subsequent month in which such Leave of Absence Employee is a Member. Any extension of an existing leave of absence for sickness, off-duty injury or physical disqualification shall not result in any further waiver of dues, or

(3) if the leave of absence is for an on-duty injury, by the fifth day of the seventh month immediately following the month in which such Leave of Absence Employee incurred the on-duty injury and thereafter by the fifth day of each subsequent month in which such Leave of Absence Employee is a Member.

ii) A Leave of Absence Employee is eligible for reimbursement under the Challenger Plan for covered goods and services incurred during any month for which dues are paid by or waived for the Leave of Absence Employee under Article V. Coverage as a Leave of Absence Employee under the Challenger Plan terminates at the earlier of the last day of the month for which dues are paid or the last day of the month in which the person ceases to be a Leave of Absence Employee, provided that Challenger Plan coverage for a Leave of Absence Employee shall in no event extend beyond the last day of the month that equals the last continuous period during which the Leave of Absence Employee paid dues under Article V as an Active Employee. Said dues shall be paid at the rate set for an Active Employee for up to the first six (6) months of coverage and then at the rate set by the Board for up to the next six (6) months and then at the rate set by the Board for the remaining period.

e) **Separated Employee who is a Member**

i) The dues provided in Section 1(a) of this Article V shall be paid by a Separated Employee by direct payment as provided in Section 3 of this Article V on a quarterly basis in advance or monthly in advance if paid through the automated dues system for each month in which the Separated Employee is a Member.

ii) A Separated Employee is eligible for reimbursement under the Challenger Plan for covered goods and services incurred during any month for which dues are paid by the Separated Employee under Article V. Coverage as a Separated Employee under the Challenger Plan terminates at the end of the earlier of the last day of the month for which dues are paid or the last day of the month in which a Separated Employee has applied for an annuity and has received Railroad Retirement Board (RRB) award notification, provided that Challenger Plan coverage for a Separated Employee shall in no event extend beyond the first day of the month for which the Separated Employee becomes eligible for Medicare benefits.

SECTION 3 – DIRECT PAYMENT OF DUES BY MEMBER

When paying dues directly to UPREHS Members shall make check or money order payable to Union Pacific Railroad Employes Health Systems and forward it to P.O. Box 161020, Salt Lake City, Utah 84116-1020 and include a note or letter advising the following:

a) Member’s name, address, telephone number and occupation

b) Social Security or unique identification number

c) Seniority date

d) Last date of compensated service

e) Date and reason for absence from service and period covered

f) Date of discharge, if applicable

SECTION 4 – APPLICATION FOR PENSIONED EMPLOYEE COVERAGE

A Member who ceases to be eligible for reimbursement for goods and services under the Challenger Plan may be eligible for benefits under any of the three following plans:

a) UPREHS Rules and Regulations for 60/30 Plus Members;

b) UPREHS Medicare Secondary Plan (MSP); or

c) Pensioners Under 65 Plan.

The purpose of this section is to provide Members with a general notification about the availability of coverage under these plans. The terms and conditions of coverage under these plans are determined exclusively under their terms and conditions. Additional information about these plans may be obtained by writing UPREHS Customer Service, Union Pacific Railroad Employes Health Systems, P.O. Box 161020, Salt Lake City, Utah 84116-1020 or contacting UPREHS Customer Service at 1-800-547-0421, 801-595-4300 or RR 8-595-4300.

"SPECIAL NOTICE" – Employees who apply for disability or age retirement (annuity), must also make application to the UPREHS within thirty (30) days after the date of filing for disability or age retirement (annuity) with remittance of dues for the first three (3) applicable months as determined by the President for continued membership. If at any period of time coverage is incorrectly provided under the Challenger Plan when the Member should be in another Retiree Plan, UPREHS shall apply all associated benefits incorrectly provided under the Challenger Plan to the appropriate Retiree Plan, taking into consideration the applicable benefits and/or lifetime maximum(s) for that Retiree Plan.

Failure to make written application or failure to remit dues in advance within the time limits set forth in this Section 4, shall automatically and **without notice** terminate the right of the pensioned employee to thereafter contribute and receive benefits set forth in the appropriate UPERHS Summary Plan Description(s).

SECTION 5 – SPECIAL ELECTION FOR MEMBERS AGE 65 AND OVER

On and after attaining age 65, a Member may choose to remain covered by the Challenger Plan without reduction for Medicare benefits or designate Medicare as the primary payer of benefits. If a Member chooses to remain covered under the Challenger Plan, the Challenger Plan will be the primary payer of benefits and Medicare will be secondary.

ARTICLE VI – BENEFITS

SECTION 1 – BENEFITS

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

a) Except as otherwise provided by the Challenger Plan, covered goods or services received from a UPREHS Network Provider are payable at 100% of the contracted rate less any applicable co-payment(s) and or co-insurance.

b) Except as otherwise provided by the Challenger plan, covered goods or services received from an Out-of-network provider, regardless of referring provider, will be reduced to 40% of Plan Allowable. If Network Providers are not available, exceptions may be made by contacting UPREHS Care Coordinator in advance. You may be responsible for paying the difference between billed charges and the UPREHS Plan Allowable.

c) All benefit payments are subject to the Plan Allowable.

d) A Leave of Absence Employee who is a Member as a result of an on-duty injury shall receive goods and services for treatment of such on-duty injury only when treated by a UPREHS Network Provider, or when referred by a UPREHS Network Provider. Such a Member shall receive benefits for services unrelated to the on-duty injury only during the period the Member is covered by the dues waiver or is paying dues as set forth in Article V Section 2 (d)(i)(3).

e) Members may locate participating physicians and facilities by contacting the UPREHS office (800) 547-0421 or by searching the UPREHS website: www.uphealth.com.

SECTION 2 – HOSPITAL BENEFITS

a) Prior to admission to a hospital, except in case of an Emergency, the Member is required to call The Hospital Pre-approval Coordinator for pre-approval. The number for pre-approval is on the back of Member's Health Insurance Card.

b) In the event of an Emergency admission, the pre-approval Hot Line must be notified within one (1) working day (excluding weekends and holidays) of the Emergency.

c) It is the responsibility of the Member, the Member's family or personal representative, the hospital or the Member's attending physician, whether a UPREHS Network Physician or Non-UPREHS Network physician to contact the UPREHS Pre-approval Hot Line.

d) Payment shall be allowed for accommodations and ancillary charges for inpatient or outpatient medical and surgical treatment by UPREHS Network Providers at hospitals or other qualified medical facilities designated by UPREHS. The use of out-of-network hospitals will be paid at 40% of the Plan Allowable.

e) Failure to comply with the pre-approval requirements and recommendations will result in benefits being payable at 60% of the Plan Allowable (i.e., 24% of the Plan Allowable for claims otherwise reimbursable at 40% of the Plan Allowable and 60% of the Plan Allowable for claims otherwise reimbursable at 100% of the Plan Allowable.)

SECTION 3 – SERVICES OF PHYSICIANS

a) UPREHS Network Providers shall render medical and surgical treatments to Members. Lists of UPREHS Network Providers are available from the UPREHS Office or on the Internet Website at www.uphealth.com. The use of out-of-network providers will be paid at 40% of the Plan Allowable Amount.

b) The Member is responsible to pay the Co-payment required by the Board for each office visit to a Network Provider. The Co-payment is to be made to the physician at the time of the visit and applies to covered benefits.

SECTION 4 – HOME HEALTH CARE

Home Health Care will be provided only when deemed medically necessary and pre-authorized by a UPREHS Care Coordinator.

SECTION 5 – PRESCRIPTION DRUGS

A licensed physician must order prescriptions and only medication listed in the Union Pacific Railroad Employes Health Systems Pharmacy Formulary for Active Members will be a benefit. A copy of the Pharmacy Formulary for Active Members is available from the UPREHS Office or on the Internet Website at www.uphealth.com.

Medicines prescribed shall be subject to the current Co-payment amount for each prescription item ordered or refilled.

a) It is mandatory that all Members using maintenance drugs have such drugs filled through UPREHS Mail-Order Pharmacy. See Section 5(e).

b) Contract Network Pharmacies are an extensive national network that includes most local retail pharmacies. As part of the UPREHS network, these pharmacies electronically implement the UPREHS formulary when filling prescriptions. Members residing in locations or areas where a UPREHS Pharmacy or Network Pharmacy is located shall be required to have their non-Emergency, one-time-only prescriptions filled at such facilities. Maintenance drugs shall be provided in accordance with Section 5(e).

c) In those cases where an Emergency exists, making it impractical to have a prescription filled at a UPREHS Pharmacy or Network Pharmacy, the prescription may be filled at the nearest pharmacy and refund less the current Co-payment will be made for the actual cost had the prescription been filled at a UPREHS Pharmacy. A written explanation of the nature of the Emergency must accompany the itemized bill.

d) 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(g).

e) All prescriptions for maintenance medications, including blood glucose strips, insulin and syringes, must be filled through the UPREHS Mail-Order Pharmacy only. However, medication requiring absolute refrigeration may be purchased from Network pharmacies and reimbursement less the current Co-payment will be made for the actual cost had the prescription been filled at the UPREHS Mail-Order Pharmacy.

f) Insulin, blood glucose strips and insulin syringes will be provided at the UPREHS Mail Order Pharmacy, subject to the current Co-payment, upon prescription order by a licensed physician.

g) The 3rd tier of pharmacy benefits are supplied only through the UPREHS Mail-Order Pharmacy on prescription drugs that are for covered medical benefits. The 3rd tier drugs are subject to a Co-payment 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 Pharmacy & Therapeutics Committee.

    ii) When a Member or physician requests a prescription drug that is not included in the UPREHS Pharmacy Benefit guide for Active Members the prescription drug must be a covered medical benefit.

    iii) When a Member or physician requests a brand name drug though a generic drug is available and included in the UPREHS Pharmacy Benefit guide for Active Members.

SECTION 6 – ARTIFICIAL AND SURGICAL APPLIANCES

a) Crutches, canes, walkers, artificial limbs, artificial eyes, trusses, braces and other appliances of similar nature will be furnished when deemed medically necessary by the attending UPREHS Physician or pre-approved by a UPREHS Care Coordinator.

b) CPAP and BIPAP units will be paid at 100% of the Plan Allowable when deemed medically necessary, pre-approved by a UPREHS Care Coordinator and purchased through a vendor designated by UPREHS. If a Member leases or purchases such a unit and such lease or purchase is medically necessary, then reimbursement equal to the lesser of such lease or purchase cost or the cost had the unit been purchased from a UPREHS designated vendor shall be payable to the Member. One mask and supplies will be replaced annually, from the UPREHS Mail Order Pharmacy. A $25.00 co-payment is required for the replacement supplies

c) TENS units will be paid at 100% of the Plan Allowable when deemed medically necessary, pre-approved by a UPREHS Care Coordinator and purchased through a vendor designated by UPREHS. If a Member leases or purchases such a unit and such lease or purchase is medically necessary, then reimbursement equal to the lesser of such lease or purchase cost or the cost had the unit been purchased from a UPREHS designated vendor shall be payable to the Member.

d) Implantation of penile prosthesis will be furnished when there is a diagnosis of erectile dysfunction due to organic disease process such as, but not limited to, diabetes, hypertension, peripheral vascular disease, radical pelvic surgery or trauma, other treatment for Erectile Dysfunction has proved unsuccessful; is medically necessary and pre-approved by a UPREHS Care Coordinator.

e) Only one (1) each of such article shall be furnished; however, upon approval of a UPREHS Care Coordinator, the article may be renewed, replaced or repaired. The use of an out-of-network provider for such appliances will be paid at 40% of the Plan Allowable when deemed medically necessary and pre-approved by a UPREHS Care Coordinator.

SECTION 7 – ADDITIONAL BENEFITS

a) X-rays, radiation therapy, laboratory services, surgical dressings, splints, casts etc.

b) Anesthesiology services.

c) Physical therapy and other approved ancillary therapy services that are deemed medically necessary and pre-approved by a UPREHS Care Coordinator is limited to 100% of the first $1,000 (one-thousand dollars) and 50% of the next $500 (five-hundred dollars) per calendar year.

d) Blood transfusions.

e) Care in an accredited Skilled Nursing Facility as that term is defined in Article I herein, subject to pre-approval by a UPREHS Care Coordinator.

f) The Challenger Plan will assume the expense of repairs only to natural teeth where such repairs are necessary to correct damage caused by on-duty injuries.

g) Skin tests for allergies.

h) Home oxygen therapy.

i) Annual routine eye examinations.

j) Refractive eye surgery benefit payment is limited to $1,520 per Member, per lifetime.

k) Sterilization when deemed medically necessary and approved by a board certified specialist. The Plan will pay a one-in-a-lifetime benefit of $750 with a $100 co-insurance.

l) 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.

m) Hearing aid, hearing test, and hearing aid supplies obtained through the UPREHS Mail Order Pharmacy limited to $600 per Member, per calendar year.

n) Oral contraceptives and other prescribed birth control devices.

o) TMJ – Limited Benefits – Requires Care Coordinator Review

p) Insulin pump – Limited Benefits – Requires Care Coordinator Review

q) Insulin pump supplies when purchased through UPREHS Mail Order Pharmacy. The member is responsible for a $50.00 co-payment and the annual benefit is limited to $5,500.

SECTION 8 – EMERGENCY BENEFITS

In Emergency cases of sickness or injury, when a Member cannot be sent to a UPREHS Network Provider or await the arrival of a UPREHS Network Provider, any available physician or treatment facility may be utilized and UPREHS will pay 100% of the Plan Allowable less the co-payment of such temporary Emergency care up to and including the first twenty-four (24) hours only, unless otherwise pre-authorized by a UPREHS Care Coordinator. To continue reimbursement at 100% of the Plan Allowable, the Member or someone in their behalf shall make a prompt telephone report to a UPREHS Care Coordinator. UPREHS Care Coordinators will direct the Member's case. The UPREHS Care Coordinator shall authorize continuing reimbursement at 100% of the Plan Allowable if it is medically necessary for the Member to continue receiving care from the non-UPREHS Network Provider. If it is not medically necessary for the Member to continue receiving care from the non-UPREHS Network Provider, the reimbursement will be at forty percent (40%) of the Plan Allowable, unless the UPREHS Care Coordinator does not arrange for the Member's transfer to a UPREHS Network Provider, in which case the reimbursement shall remain at 100% of the Plan Allowable for the continuing care at the non-UPREHS Network Provider. Failure to comply with this process will result in out-of-network Emergency care, after the initial 24 hours, being paid at 40% of the Plan Allowable.

a) The Member is responsible for a $50 Co-payment for each visit to the Emergency room of any hospital. The Emergency room Co-payment applies to covered benefits for charges made by the hospital for Emergency care received in the Emergency room. The Co-payment is to be made at the time of the visit to a UPREHS Network Provider. If the Co-payment is not made to the UPREHS Network Provider or a non-UPREHS Network Provider is used, the Co-payment will be deducted from any reimbursable amount due the Member. The Co-payment is waived if in-patient admission is required.

b) The Member is responsible for a $15 Co-payment for each visit to an urgent care center. The Co-payment is to be made at the time of the visit to a UPREHS Network Provider and applies to covered benefits for charges from the urgent care center. If the Co-payment is not made to the UPREHS Network Provider or a non-UPREHS Network Provider is used, the Co-payment will be deducted from any reimbursable amount due the Member.

c) 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.

d) All ambulance transfers from one facility to another must have the prior approval of a UPREHS Care Coordinator, except for transfers due to an Emergency.

e) Payment for non-Emergency treatment will be limited to care provided in the United States of America or its territories.

SECTION 9 – EMERGENCY ALCOHOL OR CHEMICAL DEPENDENCY DETOXIFICATION

UPREHS shall provide emergency alcohol or chemical dependency detoxification treatment to Members at a UPREHS network provider under the following conditions:

a) Treatment has been recommended by: an authorized representative of the Company's Employee Assistance Program; by a labor representative; the Member's family or personal representative, and such recommendation is approved by a Behavioral Health Care Coordinator.

b) Treatment may be obtained on a self-referral basis upon approval by a Behavioral Health Care Coordinator.

c) The Member submitting to treatment shall have paid the initial $100, in combination with mental health deductible, of the cost plus 20% of the balance of the cost of each emergency treatment.

d) Treatment will be limited to a maximum period of six (6) days and treatment shall not be provided to a Member more than twice during Membership in UPREHS.

e) UPREHS will make payment only if the Member complies with the recommended treatment program.

SECTION 10 – ALCOHOL OR CHEMICAL DEPENDENCY REHABILITATION TREATMENT

UPREHS shall provide alcohol or chemical dependency rehabilitation treatment to Members at a UPREHS network provider under the following conditions:

a) Maximum combined detoxification and rehabilitation treatment in continuous sequence shall be limited to thirty (30) days and rehabilitation treatment shall be limited to a maximum period of thirty (30) days when not in continuous sequence with emergency detoxification treatment. Rehabilitation treatment shall not be provided to a Member more than twice during membership in UPREHS.

b) UPREHS shall not pay for and or assume any travel expenses incurred by a Member to and from a rehabilitation treatment center except in those cases where an expenditure for travel will result in reducing the total cost of treatment and in such exceptional circumstances the travel expense must be incurred at the specific direction and approval of the Behavioral Health Care Coordinator.

c) Treatment will be provided only at a UPREHS network provider with the approval of a Behavioral Health Care Coordinator.

d) The Member submitting to inpatient rehabilitation treatment shall pay the initial $100, in combination with Mental Health deductible, of the cost of treatment to the treatment center and shall also pay 20% of the cost of any treatment over and above the initial $100 cost. UPREHS will make payment only after successful completion of the approved facility's program.

e) A Member may obtain treatment, on a self-referral basis, upon approval by a Behavioral Health Care Coordinator.

f) UPREHS will make payment only if the Member complies with the recommended treatment program.

Outpatient Treatment

a) Outpatient treatment for alcohol or chemical dependency shall be provided by UPREHS. The Member submitting to such outpatient treatment shall pay the initial $100, in combination with Mental Health deductible, of the cost of treatment to the treatment center and shall also pay 20% of the cost of any treatment over and above the initial $100 cost.

b) Outpatient treatment of alcohol or chemical dependency shall not be provided to a Member more than twice during membership in UPREHS. Payment for Intensive Outpatient or outpatient counseling shall be limited to a combination of thirty (30) treatments per episode.

c) UPREHS shall provide coverage for alcohol and drug education programs for those Members who have violated the Union Pacific Railroad Rules (as published April 10, 1994) "Drugs and Alcohol" and do not require rehabilitation. Maximum benefit payable for such education is limited to $100.

d) Alcohol and drug education programs shall not be provided to a Member more than twice during membership in UPREHS.

e) UPREHS will make payment only if the Member complies with the recommended treatment program.

SECTION 11 – MENTAL HEALTH BENEFITS

UPREHS shall provide benefits for consultation, treatment and/or hospitalization at a UPREHS Network Provider to treat mental and nervous conditions such as anxiety, neurosis, schizophrenia, depressive reaction, manic-depressive psychosis, paranoid states, personality disorders and such to Members under the following conditions:

a) Inpatient and Outpatient

i) A Member may obtain Treatment, on a self-referral basis upon approval by a Behavioral Health Care Coordinator. Further, a Member may obtain treatment if *a* UPREHS Physician and/or a Behavioral Health Care Coordinator have recommended treatment.

ii) A general hospital or in a psychiatric hospital that is a UPREHS Network Provider. A qualified psychiatrist, clinical psychologist or other licensed mental health professional shall provide professional services. Custodial or nursing home care will not be provided.

iii) The Member shall pay the initial $100, in combination with chemical dependency and/or detox, of the cost of treatment. UPREHS shall pay 80% thereafter of the contracted rate and the Member shall pay the remaining 20%. Payment for inpatient confinement, extended outpatient, day treatment programs or outpatient counseling shall be limited to a combination of forty-five (45) treatments in a calendar year.

iv) Payment is excluded when services are provided by a federal, state or municipal government or government agency or when ordered by a court.

v) UPREHS will make payment only if the Member complies with the recommended treatment program.

SECTION 12 – PREGNANCY

UPREHS will provide in-network coverage for pregnancy-related claims of a Member. In accordance with the Newborns' and Mothers' Health Protection Act (NMHPA), enacted on September 26, 1996, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours after vaginal delivery or 96 hours after a cesarean section. In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the Plan of insured for prescribing a length of stay not in excess of 48 hours or 96 hours.

SECTION 13 – 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 under this benefit.

SECTION 14 – ORGAN AND TISSUE TRANSPLANTS

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

a) Prior notification to a UPREHS Care Coordinator is required.

b) A one-time limit of $150,000 per lifetime for all organ and tissue transplants will apply.

c) Member should use a UPREHS Facility, otherwise, benefits will be provided in accordance with Article VI, Section 1(b) as out-of-network claims subject to the limit set in (b) above.

SECTION 15 – PREVENTIVE HEALTH CARE SERVICES

Preventive health care services will be provided and limited to the following services:

a) One (1) routine physical examination per calendar year if performed by a UPREHS Network Provider. Benefit payment is limited to $150 for the examination and related charges. Expenses incurred over $150 are paid at 75% of UPREHS Plan Allowable. The remaining balance of 25% is the responsibility of the Member. No payment will be made for a routine physical examination not performed by a UPREHS Network Provider, except in certain circumstances and pre-approved by a care coordinator.

b) The following services are an exception and not included as part of the routine physical examination. These services are covered at 100% if provided by a UPREHS Network Provider and 40% if provided by an out-of-network provider, subject to the Plan Allowable:

   i) One (1) routine pap smear each calendar year.

   ii) One (1) baseline mammogram for a female Member age thirty-five (35) to thirty-nine (39), or more frequently if recommended by a UPREHS Network Provider.

   iii) One (1) mammogram every two (2) years, or more frequently if recommended by a UPREHS Network Provider, for a female Member age forty (40) to forty-nine (49).

   iv) One (1) mammogram each year for a female Member age fifty (50) and over, or more frequently if recommended by a UPREHS Network Provider.

   v) One (1) digital rectal exam each year after age thirty-nine (39).

   vi) One (1) stool blood slide test each year after age forty-nine (49).

vii) One (1) proctosigmoidoscopy or colonoscopy every three (3) years after age forty-nine (49).

viii) One (1) prostate screening antigen (PSA) test every three (3) years after age forty-nine (49). More frequently if recommended by a UPREHS Network Provider.

SECTION 16 – HOSPICE BENEFITS

The following applies for hospice benefits:
Pre-authorization is required by a UPREHS Care Coordinator.

a) The physician must certify that the Member is terminally ill with six (6) months or less to live.

b) The maximum benefit is $3,000 and includes, but is not limited to, charges for room and board, care, and services provided by a licensed social worker.

c) Any counseling services given in connection with hospice services will not be considered as mental health care or substance abuse care.

d) All hospice benefits terminate when the covered Member is deceased.

SECTION 17 – BARIATRIC SURGERY

Bariatric surgery must be pre-approved through a UPERHS Care Coordinator. Such approval will consist of an extensive evaluation outlined by the UPERHS Care Coordinator, which will include, but is not limited to the following:

a) The surgery must be performed in a UPREHS Facility by a UPREHS Bariatric Surgeon who is board certified and has received the appropriate training to perform such surgery.

b) The Member must be at least 18 years of age.

c) The Member must obtain a second opinion for the surgery from a board certified UPREHS Physician whose specialty is internal medicine.

d) The Member must undergo a psychological evaluation which documents that all psychosocial issues have been identified and addressed from a UPREHS Provider who is a licensed mental health professional, after a UPREHS Physician recommends such surgery.

The benefit is payable at 80% of the Plan Allowable up to a maximum of $16,000, which includes all surgery related fees and costs, post-surgery related fees and costs and fees and costs associated with any complications that may arise as a result of such surgery, regardless of when such fees and cost are incurred by the Member. The benefit is limited to once per lifetime.

ARTICLE VII – BENEFIT EXCLUSIONS

SECTION 1 – BENEFIT EXCLUSIONS

Benefits will not be granted except as provided in these Regulations. The Challenger Plan will not provide benefits for any of the items listed in this section, regardless of medical necessity or recommendation of a health care provider. This list is intended to give you an illustrative description of expenses for service and supplies not covered by the Challenger Plan.

a) Benefits will not be granted in the following circumstances to:

i) A Member who abuses the benefits of UPREHS.

ii) A Member who knowingly files a fraudulent claim.

iii) A Member who knowingly makes a fraudulent statement to have a claim paid.

iv) A Member who knowingly violates the Rules and Regulations of UPREHS or a facility in which the Member may be receiving treatment may be excluded from further benefits.

b) Ailments resulting from self-inflicted injuries, unless the infliction of such injury is the result of a medical condition.

c) Injuries received in a fight or brawl unless the injuries are sustained as a result of an act of domestic violence or as the result of a medical condition.

d) Attempted suicide or suicide under all circumstances unless such action is the result of a medical condition.

e) Weight loss clinics, programs, instructions, activities or drugs.

f) Fertility drugs, diet medications, vitamins, minoxidil solution for topical use, or experimental drugs, regardless of intended use. All nicotine patches and smoking cessation items except as provided in connection with a Company approved smoking cessation program. Any over the counter (OTC) drug or item regardless of intended use except insulin, insulin syringes, blood glucose strips, and glucometers, which are benefits only if ordered from the UPREHS Mail-Order Pharmacy.

g) Any injury sustained which is the result of the commission of and/or participation in a felonious or illegal act unless the injuries are sustained as a result of domestic violence or as the result of a medical condition.

h) Wheelchairs, hospital beds, physical therapy equipment, eyeglasses, contact lenses, footwear, bed pans, urinals, hot water bottles, cold therapy (cryotherapy) equipment, blood pressure cuffs, thermometers, syringes (except insulin syringes) and similar articles.

i) On-duty injuries suffered while in the employment of some person, firm, company or organization other than Union Pacific Railroad Company and/or subsidiaries and affiliated companies.

j) Decayed, faulty, diseased or damaged teeth; replacement of natural teeth or repairs to dentures or bridges except as specified in these Regulations.

k) Members will not be permitted to duplicate UPREHS benefits with benefits available under Medicare.

l) Cosmetic surgery or treatment.

m) Personal comfort items.

n) Supplies other than prescription drugs provided for the treatment of sexual arousal disorders or erectile dysfunction, regardless of cause.

o) Reversal of any reproductive sterilization procedure unless medically necessary.

p) All fertility procedures and tests.

q) Experimental and/or investigational procedures, treatments, drugs or surgeries. Experimental procedures, treatments, drugs, or surgeries are tests that are performed 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.

r) Payment for services furnished by or for the United States Government, including a government hospital, or by any government, including state Medicaid including MediCal programs unless payment is legally required. Also excluded are services and/or supplies which are required by reason of past or present service of any covered family member in the armed forces of a government.

s) Illness or injury as a result of participation in a civil revolution or a riot.

t) Illness or injury as a result of war as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

u) Nursing home, sanitarium, rest home, domicile or custodial care.

v) Treatment of on-duty related injuries or illnesses by a non-network Provider, except as specified in these Regulations Article VI Section 1 (d).

w) Expenses exceeding the Plan Allowable.

x) Services rendered by anyone other than a covered and licensed health care provider.

y) Treatment not prescribed or recommended by a health care provider.

z) Services, supplies or treatment not medically necessary.

aa) Expenses for preparing medical reports, itemized bills, or claim forms.

bb) Mailing and/or shipping and handling expenses or sales tax.

cc) Expenses for broken appointments or telephone calls.

dd) Travel expenses of a physician or covered person, except in special circumstances.

ee) Any services received from a Health Maintenance Organization (HMO) if the individual is a participant in the HMO.

ff) Expenses used to satisfy any plan deductible.

gg) Expenses eligible for consideration under any other plan of the employer, including vision or dental plans.

hh) Expenses incurred for services rendered prior to the effective date of coverage under this Plan.

ii) Treatment or services rendered outside the United States of America or it's territories, except for an Emergency.

jj) Complications arising from any non-covered surgery or treatment. However, complications due to a non-covered abortion will be considered.

kk) Expenses for or related to the removal of breast or other prosthetic implants, except for breast reconstruction following a mastectomy as required under state and federal law / regulation, that were:

  i) inserted in connection with cosmetic surgery, regardless of the reason for removal; or

  ii) not inserted in connection with cosmetic surgery, the removal of which is not currently medically necessary.

ll) Massage therapy or rolfing.

mm) Acupuncture.

nn) Surrogate expenses.

oo) Adoption expenses.

pp) Sex change surgery or treatment, including psychiatric treatment.

qq) Circumcision, except as medically necessary.

rr) Marital, family or sex counseling.

ss) Rapid opiate detoxification under general anesthesia.

tt) Maintenance therapy for opiate dependency.

uu) Light therapy for mood disorders for seasonal patterns.

vv) Biofeedback

ww) Hypnosis

xx) Genetic counseling or genetic testing.

yy) Abortions, except as medically necessary.

zz) Psychoanalysis

ARTICLE VIII – CLAIMS PROCEDURES

SECTION 1 – PERIOD FOR FILING CLAIMS

The time limit for filing claims for all Members, except for claims related to an on-duty injury, is **one (1) year** from the date goods or services were incurred and it is the Member's responsibility to ensure that the claim(s) are filed properly and in a timely manner.

SECTION 2 – GENERAL INFORMATION

a) A claim is a request for benefits from the Challenger Plan made pursuant to these claims procedures.

b) These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that

   i) In the case of an incorrectly-filed pre-service claim, the Member shall be notified orally, unless the Member requests written notice, as soon as possible but no later than five (5) days following receipt of the incorrectly-filed claim that the request is not a claim and the proper procedures for filing a claim, and

   ii) In the case of an incorrectly-filed urgent care claim, the Member shall be notified orally, unless the Member requests written notice, as soon as possible but no later than twenty-four (24) hours following receipt of the incorrectly-filed claim that the request is not a claim and the proper procedures for filing a claim.

c) The UPREHS Claims Administrator and the UPREHS Appeals Administrator are responsible for making claims and appeal decisions, respectively. They have the discretionary authority to interpret the Challenger Plan in order to make decisions in their sole discretion. They also have the discretionary authority to make factual determinations as to whether any Member is entitled to receive benefits under the Challenger Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it

can be shown that the interpretation or determination was arbitrary and capricious. In the event a Member makes a voluntary appeal to the Board under Article VIII, Section 8, the Board shall have discretionary authority for making its appeal decision that is coextensive with such authority of the UPREHS Claims Administrator and the UPREHS Appeals Administrator.

d) There are five (5) types of claims that a Member has the right to make under these claims procedures. These include the right of a Member to appeal an adverse determination made by the Challenger Plan. An adverse determination means a determination made by the Challenger Plan not in response to a claim made by a Member involving a denial, reduction, or termination of, or a failure to provide or make payment (in whole or part) of a benefit under the Challenger Plan.

e) The UPREHS Claims Administrator is:

   i) The UPREHS Care Coordinator in the case of any request for pre-approval or authorization of benefits assigned to such Coordinator by the Challenger Plan and for all other claims for benefits under Article VI, Section 3 (Services of Physicians), Section 6 (Artificial and Surgical Appliances), Section 7 (Additional Benefits), Section 8 (Emergency Benefits), Section 12 (Pregnancy), Section 13 (Chiropractic Services), Section 15 (Preventive Health Care Services), Section 16 (Hospice Benefits) and Section 17 (Bariatric Surgery Benefits),

   ii) The Behavioral Health Care Coordinator in the case of any request for pre-approval or authorization of benefits assigned to such Coordinator by the Challenger Plan and for all other claims for benefits under Article VI, Section 9 (Emergency Alcohol or Chemical Dependency Detoxification), Section 10 (Alcohol or Chemical Dependency Rehabilitation Treatment) or Section 11 (Mental Health Benefits),

   iii) The Hospital Pre-Approval Coordinator contacted through the number for pre-approval on the back of a Member's Health Insurance Card for claims for benefits under Article VI, Section 2 (Hospital Benefits), or

   iv) The UPREHS Prescription Drug Coordinator for claims for benefits under Article VI, Section 5 (Prescription Drugs).

SECTION 3 – PRE-SERVICE CLAIM, NOT AN URGENT CARE CLAIM

a) A pre-service claim means a claim regarding a good or service the availability of which, in whole or part, is conditioned upon advance approval by the Challenger Plan.

b) A pre-service claim, which is not an urgent care claim (see Article VIII, Section 4), is subject to the following rules:

   i) A pre-service claim is made by a Member submitting a claim in writing or orally to the UPREHS Claims Administrator.

   ii) A written or oral claim must include the following information:

      (1) Member's identity

      (2) Specific medical condition or symptom

      (3) Specific treatment, service or good for which advance approval is requested

c) The UPREHS Claims Administrator will decide a pre-service claim:

i) If a claim is submitted with all needed information, within a reasonable time appropriate to the medical circumstances, but no later than fifteen (15) days after receipt of such claim, unless the UPREHS Claims Administrator determines that for matters beyond the control of the Challenger Plan that the UPREHS Claims Administrator is not able to decide the claim within such period. In this event, the UPREHS Claims Administrator may extend the period by fifteen (15) additional days, provided that the Member is notified in writing prior to the expiration of the initial time frame applicable to the pre-service claim. Such notice must include a description of the matters beyond the Challenger Plan's control that justify the extension and the date by which a decision is expected, or

ii) If a claim is not submitted with all the needed information, the UPREHS Claims Administrator may deny the claim or may take a fifteen (15) day extension of time, provided the Member is notified in writing prior to the expiration of the initial period applicable to the pre-service claim about the missing information and is given a period of no less than forty-five (45) days in which to supply the UPREHS Claims Administrator with the missing information. The time for deciding the claim shall be suspended from the date the extension notice is received by the Member until the date the missing information is provided to the UPREHS Claims Administrator within the specified time. If the requested information is provided, the UPREHS Claims Administrator shall decide the claim within the extended period provided in the notice. If the requested information is not provided within the specified time, the claim may be decided without that information.

d) The UPREHS Claims Administrator shall provide the Member with a written decision, whether or not the decision is adverse. A decision is adverse if it denies, reduces, terminates or fails to provide or make payment (in whole or part) for a good and service. The written decision of an adverse determination shall include the following, in a manner calculated to be understood by the Member:

i) A statement of the specific reason(s) for the decision

ii) Reference(s) to the specific plan provision(s) on which the decision is based

iii) A description of any additional material or information necessary to perfect the claim and why such information is necessary

iv) A description of the plan provisions and time limits for appeal of the decision, and the right to obtain information about those procedures and the right to sue in federal court

v) A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request)

vi) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the plan to the Member's circumstances or a statement that such explanation will be provided at no charge upon request.

e) A Member shall have the right to appeal an adverse determination by the UPREHS Claims Administrator in writing to the UPREHS Appeals Administrator, subject to the following rules:

i) A Member shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the Member's claim. If the advice of a medical or vocational expert was obtained in connection with

the initial decision, the names of each such expert shall be provided on request by the Member, regardless of whether the advice was relied upon by the UPREHS Claims Administrator.

ii) An appeal of an adverse determination must be filed within 180 days following the Member's receipt of the initial notice of adverse determination.

iii) An appeal is made when a Member submits a written notice to:

UPREHS Appeals Administrator
P.O. Box 161020
Salt Lake City, Utah 84116-1020

iv) A Member's written appeal may include documents, comments, or other information in support of the appeal.

f) The UPREHS Appeals Administrator shall decide an appeal from an adverse initial determination regarding a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than thirty (30) days after receipt of the appeal

g) The review by the UPREHS Appeals Administrator shall take into account all the information submitted by the Member, whether or not presented or available at the initial determination.

h) The UPREHS Appeals Administrator shall give no deference to the initial determination.

i) In the case of a claim denied on the grounds of medical judgment, the UPREHS Appeals Administrator shall consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal shall not be the same individual who was consulted, if any, regarding the initial determination or a subordinate of that individual.

j) The UPREHS Appeals Administrator shall provide the Member with a written decision, whether or not the decision is adverse. The written decision of an adverse determination shall include the following, in a manner calculated to be understood by the Member:

i) The specific reason(s) for the appeal decision

ii) A reference to the specific plan provision(s) on which the decision is based

iii) A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request)

iv) A statement of the right to sue in federal court and information relating to the voluntary level of appeal to the Board, including a statement that such appeal will not impact the Member's rights to any other benefits under the Challenger Plan, the rules for filing such an appeal, and the Member's right to representation on appeal

v) A statement indicating entitlement on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination

vi) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the plan to the Member's medical circumstances or a statement that such explanation will be provided at no charge upon request.

SECTION 4 – PRE-SERVICE CLAIM, AN URGENT CARE CLAIM

a) A pre-service claim means a claim regarding a good or service the availability of which, in whole or part, is conditioned upon advance approval by the Challenger Plan. Pre-service claims, which are urgent care claims, are those claims where application of the time periods that otherwise apply to a pre-service claim under Article VIII, Section 3 could seriously jeopardize a Member's life or health or the ability of a Member to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition could cause severe pain.

b) A pre-service claim, which is an urgent care claim is subject to the following rules:

   i) A pre-service claim is made by a Member submitting a claim in writing or orally to the UPREHS Claims Administrator.

   ii) A written or oral claim must include the following information:

      (1) Member's identity

      (2) Specific medical condition or symptom

      (3) Specific treatment, service or good for which advance approval is requested

c) The UPREHS Claims Administrator shall decide a pre-service claim:

   i) If a claim is submitted with all needed information, as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt of the claim, or

   ii) If a claim is not submitted with all the needed information, the UPREHS Claims Administrator shall notify the Member, orally or in writing if requested by the Member, as soon as possible, but not later than 24 hours following receipt of the claim about the missing information and the Member is given a period of no less than forty-eight (48) hours in which to supply the UPREHS Claims Administrator with the missing information. The UPREHS Claims Administrator shall decide the claim as soon as possible, but not later than forty-eight (48) hours after the earlier of receipt of the specified information or the end of the period provided to submit the missing information.

d) The UPREHS Claims Administrator may provide the Member with an oral decision, provided that a written decision, whether or not the decision is adverse, is furnished not later than three (3) days after the oral notice. A decision is adverse if it denies, reduces, terminates or fails to provide or make payment (in whole or part) for a good and service. The oral and written decision of an adverse determination shall include the following, in a manner calculated to be understood by the Member:

   i) A statement of the specific reason(s) for the decision

   ii) Reference(s) to the specific plan provision(s) on which the decision is based

   iii) A description of any additional material or information necessary to perfect the claim and why such information is necessary

   iv) A description of the plan provisions and time limits for appeal of the decision, and the right to obtain information about those procedures and the right to sue in federal court

v) A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request)

vi) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the plan to the Member's circumstances or a statement that such explanation will be provided at no charge upon request.

e) A Member shall have the right to appeal an adverse determination by the UPREHS Claim Administrator to the UPREHS Appeals Administrator, subject to the following rules:

i) A Member shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the Member's claim. If the advice of a medical or vocational expert was obtained in connection with the initial decision, the names of each such expert shall be provided on request by the Member, regardless of whether the advice was relied upon by the UPREHS Claims Administrator.

ii) An appeal of an adverse determination must be filed within 180 days following the Member's receipt of the initial notice of adverse determination.

iii) An appeal is made when a Member submits a written notice to:

UPREHS Appeals Administrator
P.O. Box 161020
Salt Lake City, Utah 84116-1020

iv) A Member's appeal may include documents, comments, or other information in support of the appeal. It should also include at least the following information:

(1) Member's identity

(2) Specific medical condition or symptom

(3) Specific treatment, service or good for which advance approval is requested

(4) Any reasons why the appeal should be processed on a more expedited basis.

f) The UPREHS Appeals Administrator will decide an appeal from an adverse initial determination regarding a pre-service claim as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt of the appeal.

i) The review by the UPREHS Appeals Administrator shall take into account all the information submitted by the Member, whether or not presented or available at the initial determination.

ii) The UPREHS Appeals Administrator shall give no deference to the initial determination.

iii) In the case of a claim denied on the grounds of medical judgment, the UPREHS Appeals Administrator shall consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal shall not be the same individual who was consulted, if any, regarding the initial determination or a subordinate of that individual.

iv) The UPREHS Appeals Administrator may provide the Member with an oral decision, provided that a written decision, whether or not the decision is adverse, is furnished not later than three (3) days after the oral notice. The oral and written decision of an

adverse determination shall include the following, in a manner calculated to be understood by the Member:

(1) The specific reason(s) for the appeal decision

(2) A reference to the specific plan provision(s) on which the decision is based

(3) A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request)

(4) A statement of the right to sue in federal court and information relating to the voluntary level of appeal to the Board, including a statement that such appeal will not impact the Member's rights to any other benefits under the Challenger Plan, the rules for filing such an appeal, and the Member's right to representation on appeal

(5) A statement indicating entitlement on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination

(6) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the plan to the Member's medical circumstances or a statement that such explanation will be provided at no charge upon request.

SECTION 5 – POST-SERVICE CLAIM

a) A post-service claim means a claim for a good or service under the Challenger Plan that is not a pre-service claim or a concurrent care claim (see Article VIII, Section 6).

b) A post-service claim is subject to the following rules:

i) A post-service claim is made by a Member submitting a claim in writing to the UPREHS Claims Administrator. If services or goods are received from an UPREHS Network Provider, there is no need for the Member to file a claim. The network provider is responsible for filing claims. UPREHS pays the network provider directly.

ii) A written claim must be printed on a CMS-1500 (Physician) or HCFA-1450 (Hospital) Form.

c) The UPREHS Claims Administrator shall decide a post-service claim:

i) If a claim is submitted with all needed information, within a reasonable time, but no later than thirty (30) days after receipt of such claim, unless the UPREHS Claims Administrator determines that for matters beyond the control of the Challenger Plan that the UPREHS Claims Administrator is not able to decide the claim within such period. In this event, the UPREHS Claims Administrator may extend the period by fifteen (15) additional days, provided that the Member is notified in writing prior to the expiration of the initial time frame applicable to the post-service claim. Such notice must include a description of the matters beyond the Challenger Plan's control that justify the extension and the date by which a decision is expected, or

ii) If a claim is not submitted with all the needed information, the UPREHS Claims Administrator may deny the claim or may take a fifteen (15) day extension of time, provided the Member is notified in writing prior to the expiration of the initial period applicable to the post-service claim about the missing information and is given a

period of no less than forty-five (45) days in which to supply the UPREHS Claims Administrator with the missing information. The time for deciding the claim shall be suspended from the date the extension notice is received by the Member until the date the missing information is provided to the UPREHS Claims Administrator. If the requested information is provided within the specified period, the UPREHS Claims Administrator shall decide the claim within the extended period provided in the notice. If the requested information is not provided within the specified time, the claim may be decided without that information.

d) The UPREHS Claims Administrator shall provide the Member with a written decision, if the decision is adverse. A decision is adverse if it denies, reduces, terminates or fails to provide or make payment (in whole or part) for a good and service. The written decision of an adverse determination shall include the following, in a manner calculated to be understood by the Member:

   i) A statement of the specific reason(s) for the decision

   ii) Reference(s) to the specific plan provision(s) on which the decision is based

   iii) A description of any additional material or information necessary to perfect the claim and why such information is necessary

   iv) A description of the plan provisions and time limits for appeal of the decision, and the right to obtain information about those procedures and the right to sue in federal court

   v) A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request)

   vi) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the plan to the Member's circumstances or a statement that such explanation will be provided at no charge upon request.

e) A Member shall have the right to appeal an adverse determination by the UPREHS Claims Administrator in writing to the UPREHS Appeals Administrator, subject to the following rules:

   i) A Member shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the Member's claim. If the advice of a medical or vocational expert was obtained in connection with the initial decision, the names of each such expert shall be provided on request by the Member, regardless of whether the advice was relied upon by the UPREHS Claims Administrator.

   ii) An appeal of an adverse determination must be filed within 180 days following the Member's receipt of the initial notice of adverse determination.

   iii) An appeal is made when a Member submits a written notice to:

      UPREHS Appeals Administrator
      P.O. Box 161020
      Salt Lake City, Utah 84103

   iv) A Member's written appeal may include documents, comments, or other information in support of the appeal.

f) The UPREHS Appeals Administrator will decide an appeal from an adverse initial determination regarding a post-service claim within a reasonable time appropriate to the medical circumstances, but no later than sixty (60) days after receipt of the appeal.

i) The review by the UPREHS Appeals Administrator shall take into account all the information submitted by the Member, whether or not presented or available at the initial determination.

ii) The UPREHS Appeals Administrator shall give no deference to the initial determination.

iii) In the case of a claims denied on the grounds of medical judgment, the UPREHS Appeals Administrator shall consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal shall not be the same individual who was consulted, if any, regarding the initial determination or a subordinate of that individual.

iv) The UPREHS Appeals Administrator shall provide the Member with a written decision, if the decision is adverse. The written decision will be calculated to be understood by the Member.

(1) The specific reason(s) for the appeal decision

(2) A reference to the specific plan provision(s) on which the decision is based

(3) A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request)

(4) A statement of the right to sue in federal court and information relating to the voluntary level of appeal to the Board, including a statement that such appeal will not impact the Member's rights to any other benefits under the Challenger Plan, the rules for filing such an appeal, and the Member's right to representation on appeal

(5) A statement indicating entitlement on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination

(6) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the plan to the Member's medical circumstances or a statement that such explanation will be provided at no charge upon request.

SECTION 6 – CONCURRENT CARE CLAIM, EXTENSION REQUEST

a) A concurrent care claim means a claim regarding an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. A concurrent care claim is an extension request where a Member requests an extension beyond the initially-approved period of time or number of treatments.

b) A concurrent-care claim, which is not an urgent care claim, that is a request by a Member for an extension beyond the initially-approved period of time or number of treatments is subject to the following rules:

i) if the concurrent care claim is also a pre-service claim, which is not an urgent care claim, the claim should be made under the rules set forth in Article VIII, Section 3, or

ii) if the concurrent care claim is also a post-service claim, the claim should be made under the rules set forth in Article VIII, Section 5.

c) A concurrent-care claim that is a request by a Member for an extension beyond the initially-approved period of time or number of treatments is a pre-service claim, which is an urgent care claim, where the application of the time periods that otherwise apply to a pre-service claim under Article VIII, Section 3 could seriously jeopardize a Member's life or health or the ability of the Member to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition could cause severe pain, is subject to the following rules:

i) The claim shall be made by a Member contacting the UPREHS Claims Administrator.

ii) A claim must include the following information:

(1) Member's identity

(2) Specific medical condition or symptom

(3) Specific treatment, service or good for which advance approval is requested

d) The UPREHS Claims Administrator shall decide the claim:

i) if a claim is submitted with all the needed information at least twenty-four (24) hours prior to the expiration of the initially-approved period of time or number of treatments, within twenty-four (24) hours of receipt of the claim;

ii) if a claim is submitted less than twenty-four (24) hours prior to the expiration of the initially-approved period of time or number of treatments with all needed information, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim, or

iii) if a claim is submitted less than twenty-four (24) hours prior to the expiration of the initially-approved period of time or number of treatments without all the needed information, the UPREHS Claims Administrator shall notify the Member, orally or in writing if requested by the Member, as soon as possible, but not later than twenty-four (24) hours following receipt of the claim, about the missing information and the Member is given a period of no less than forty-eight (48) hours in which to supply the UPREHS Claims Administrator with the missing information. The UPREHS Claims Administrator shall decide the claim as soon as possible, but not later than forty-eight (48) hours after the earlier of receipt of the specified information or the end of the period provided to submit the missing information.

e) The UPREHS Claims Administrator may provide the Member with an oral decision, provided that a written decision, whether or not adverse, is furnished not later than three (3) days after the oral notice. A decision is adverse if it denies, reduces, terminates or fails to provide or make payment (in whole or part) for a good and service. The oral and written decision of an adverse determination shall include the following, in a manner calculated to be understood by the Member:

i) A statement of the specific reason(s) for the decision

ii) Reference(s) to the specific plan provision(s) on which the decision is based

iii) A description of any additional material or information necessary to perfect the claim and why such information is necessary

iv) A description of the plan provisions and time limits for appeal of the decision, and the right to obtain information about those procedures and the right to sue in federal court

v) A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request)

vi) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the plan to the Member's circumstances or a statement that such explanation will be provided at no charge upon request.

f) A Member shall have the right to appeal an adverse determination by the UPREHS Claim Administrator to the UPREHS Appeals Administrator, subject to the following rules:

i) A Member shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the Member's claim. If the advice of a medical or vocational expert was obtained in connection with the initial decision, the names of each such expert shall be provided on request by the Member, regardless of whether the advice was relied upon by the UPREHS Claims Administrator.

ii) An appeal of an adverse determination must be filed within 180 days following the Member's receipt of the initial notice of adverse determination.

iii) An appeal is made when a Member submits a written notice to:

UPREHS Appeals Administrator
P.O. Box 161020
Salt Lake City, Utah 84103

iv) A Member's appeal may include documents, comments, or other information in support of the appeal. It should also include at least the following information:

(1) Member's identity

(2) Specific medical condition or symptom

(3) Specific treatment, service or good for which advance approval is requested

(4) Any reasons why the appeal should be processed on a more expedited basis

g) The UPREHS Appeals Administrator shall decide an appeal from an adverse initial determination as soon as possible, taking into account the medical necessity, but no later than seventy-two (72) hours after receipt of the appeal.

i) The review by the UPREHS Appeals Administrator shall take into account all the information submitted by the Member, whether or not presented or available at the initial determination.

ii) The UPREHS Appeals Administrator shall give no deference to the initial determination. In the case of a claim denied on the grounds of medical judgment, the UPREHS Appeals Administrator shall consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal shall not be the same individual who was consulted, if any, regarding the initial determination or a subordinate of that individual.

iii) The UPREHS Appeals Administrator may provide the Member with an oral decision, provided that a written decision, whether or not the decision is adverse, is furnished

no later than three (3) days after the oral notice. The oral and written decision of an adverse determination shall include the following, in a manner calculated to be understood by the Member:

(1) The specific reason(s) for the appeal decision

(2) A reference to the specific plan provision(s) on which the decision is based

(3) A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request)

(4) A statement of the right to sue in federal court and information relating to the voluntary level of appeal to the Board, including a statement that such appeal will not impact the Member's rights to any other benefits under the Challenger Plan, the rules for filing such an appeal, and the Member's right to representation on appeal

(5) A statement indicating entitlement on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination

(6) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the plan to the Member's medical circumstances or a statement that such explanation will be provided at no charge upon request.

SECTION 7 – CONCURRENT CARE CLAIM, RECONSIDERATION OF PRIOR APPROVAL

a) A concurrent care claim means a claim regarding an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. A concurrent care claim is a reconsideration of a prior approval where the Challenger Plan advises a Member of a denial, reduction or termination of a previously approved request for treatment over a period of time or number of treatments.

b) The UPREHS Claims Administrator shall provide the Member with a written decision that shall include the following, in a manner calculated to be understood by the Member:

i) A statement of the specific reason(s) for the decision

ii) Reference(s) to the specific plan provision(s) on which the decision is based

iii) A description of any additional material or information necessary to perfect the claim and why such information is necessary

iv) A description of the plan provisions and time limits for appeal of the decision, and the right to obtain information about those procedures and the right to sue in federal court

v) A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request)

vi) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the plan to the Member's circumstances or a statement that such explanation will be provided at no charge upon request.

c) A concurrent-care claim, which is not an urgent care claim, that is an appeal from a concurrent-care determination by the Challenger Plan denying reducing, or terminating a

previously approved request for treatment over a period of time or number of treatments is subject to the following rules:

i) if the concurrent care claim is also a pre-service claim, which is not an urgent care claim, the claim should be made under the rules for appeals set forth in Article VIII, Section 3 , or

ii) if the concurrent care claim is also a post-service claim, the claim should be made under the rules for appeals set forth in Article VIII, Section 5.

d) A concurrent-care claim that is an appeal from a concurrent-care determination by the Challenger Plan denying, reducing, or terminating a previously approved request for treatment over a period of time or number of treatments is a pre-service claim, which is an urgent care claim, where the application of the time periods that otherwise apply to a pre-service claim under Article VIII, Section 3 could seriously jeopardize a Member's life or health or the ability of the Member to regain maximum function, or in the opinion of a physician with knowledge of the member's medical condition could cause severe pain, is subject to the following rules:

i) An claim appeal is made by a Member submitting a claim in writing or orally to:

UPREHS Appeals Administrator
P.O. Box 161020
Salt Lake City, Utah 84116-1020

ii) A written or oral claim appeal must include the following information:

(1) Member's identity

(2) Specific medical condition or symptom

(3) Specific treatment, service or good for which approval is requested

(4) Any reason why the appeal should be processed on a more expedited basis

e) The UPREHS Appeals Administrator will decide an appeal from an adverse initial determination as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt of the appeal.

i) The review by the UPREHS Appeals Administrator shall take into account all the information submitted by the Member, whether or not presented or available at the initial determination.

ii) The UPREHS Appeals Administrator shall give no deference to the initial determination.

iii) In the case of a claim denied on the grounds of medical judgment, the UPREHS Appeals Administrator shall consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal shall not be the same individual who was consulted, if any, regarding the initial determination or a subordinate of that individual.

f) The UPREHS Appeals Administrator may provide the Member with an oral decision, provided that a written decision, whether or not the decision is adverse, is furnished no later than three (3) days after the oral notice. The oral and written decision of an adverse determination shall include the following, in a manner calculated to be understood by the Member:

i) The specific reason(s) for the appeal decision

ii) A reference to the specific plan provision(s) on which the decision is based

iii) A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request)

iv) A statement of the right to sue in federal court and information relating to the voluntary level of appeal to the Board, including a statement that such appeal will not impact the Member's rights to any other benefits under the Challenger Plan, the rules for filing such an appeal, and the Member's right to representation on appeal

v) A statement indicating entitlement on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination

vi) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the plan to the Member's medical circumstances or a statement that such explanation will be provided at no charge upon request.

SECTION 8 – VOLUNTARY APPEAL TO BOARD

a) A Member whose claim has been denied pursuant to Article VIII, Section 1 – 7 is permitted, but not required, to appeal such denial to the Board, without imposition of any fees or costs.

b) An appeal to the Board is subject to the following rules:

i) An appeal is permitted only when the Member has fully exhausted the Member's rights under Article VIII, Sections 1 – 7.

ii) An appeal is made when a Member submits a written notice to:

Board of Trustees
P.O. Box 161020
Salt Lake City, Utah 84116-1020

iii) An appeal must be filed within ninety (90) days of the Member's receipt of a written decision of adverse determination on appeal to the UPREHS Appeals Administrator.

iv) A Member's written appeal may include documents, comments, or other information in support of the appeal.

v) The Board will decide an appeal from an adverse determination made by the UPREHS Appeals Administrator prior to or at its next regularly scheduled meeting that is to be held at least sixty (60) days after receipt of the Member's appeal, unless the Board determines at such meeting that additional information is needed from the Member to resolve the appeal. In such event, the Member shall be so notified in writing and given a period of no less than forty-five (45) days in which to supply the Board with the necessary information. Whether or not the required information is provided by the Member, the Board shall decide the appeal prior to or at its next regularly scheduled meeting that is to be held at least sixty (60) days after the later of the receipt of such information or the expiration of the period given to the Member to provide the information.

vi) The review by the Board shall take into account all the information submitted by the Member, whether or not presented or available at the initial determination.

vii) The Board shall give no deference to the determinations by the UPREHS Claims Administrator or UPREHS Appeals Administrator.

viii) In the case of a denial by the UPREHS Appeals Administrator on the grounds of medical judgment, the Board shall consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal shall not be the same individual who was consulted, if any, by the UPREHS Claims Administrator or the UPREHS Appeals Administrator or a subordinate of that individual.

ix) The Board shall provide the Member with a written decision, if the decision is adverse. The written decision of an adverse determination shall include the following, in a manner calculated to be understood by the Member:

(1) The specific reason(s) for the appeal.

(2) A reference to the specific plan provision(s) on which the decision is based

(3) A statement disclosing any internal rule, guideline, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request)

(4) A statement of the right to sue in federal court

(5) A statement indicating entitlement on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination

(6) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the plan to the Member's medical circumstances or a statement that such explanation will be provided at no charge upon request.

c) The Challenger Plan will not assert that a Member has failed to exhaust administrative remedies because the Member did not elect to file an appeal under this Article VIII, Section 8.

d) The Challenger Plan will treat any statute of limitations or other defense based on timeliness as tolled during the time that any appeal under this Article VIII, Section 8 is pending.

e) The Board reserves the right to dismiss any appeal under this Article VIII, Section 8 that it determines is not being prosecuted diligently by a Member. The Board will advise a Member in writing of any such dismissal.

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. UPREHS 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

UPREHS will provide access to medical and hospital records under their control upon presentation of a medical record release form signed by the Member or as otherwise provided by law. Provision of records by UPREHS is limited to applicable city county, state and/or federal law(s).

ARTICLE XI – SUBROGATION

a) In consideration of treatment or payment for treatment of a Member by UPREHS, said Member assigns, transfers and subrogates to UPREHS, to the extent of all expenditures made in behalf of said Member by UPREHS, 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 UPREHS Member authorizes UPREHS to sue, compromise or settle in the Member's name and UPREHS 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 UPREHS shall execute such written authority as UPREHS, in its sole judgment, deems necessary to enable UPREHS to exercise its right of subrogation granted herein.

b) 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, with respect to on-duty injuries, UPREHS 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, UPREHS 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 UPREHS' right to independently recover such expenditure as set forth in subparagraph (a) above.

ARTICLE XII – AMENDMENTS / TERMINATIONS

Except as provided in Article 21 of the bylaws of UPREHS, these rules and regulations may be amended as deemed necessary by the Board of Trustees. While UPREHS intends to continue the Challenger Plan indefinitely, it reserves the right to terminate or amend the Challenger Plan for any reason. If UPREHS terminates or amends the Challenger Plan, benefits under the Challenger Plan could cease or change. UPREHS may also increase the required dues at any time.

APPENDIX A – COORDINATION OF BENEFITS

a) The Challenger Plan 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 the Challenger Plan 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 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 Challenger Plan determines that it will coordinate with another plan, either the Challenger Plan 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 the Challenger Plan, the Challenger Plan 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 the Challenger Plan 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.

MEDICAID

Notwithstanding the foregoing, benefits paid on behalf of a Member will be made in accordance with any assignment of rights made by or on behalf of the Member that is required under a State's Medicaid law. The Challenger Plan will not take into account a Member's eligibility for Medicaid for purposes of enrollment or paying benefits under the Challenger Plan. To the extent payment has been made under Medicaid for medical assistance to a Member and the Challenger Plan has a legal liability to pay for such medical assistance, payment of benefits under the Challenger Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to such Member to such payment for benefits.

APPENDIX B – CONSOLIDATED OMNIBUS BUDGET RECONSILIATION ACT OF 1985 (COBRA)

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage available under the Challenger Plan. **This section generally explains COBRA continuation coverage, when it may become available to you and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. For additional information about your rights and obligations under the Challenger Plan and under federal law, you should contact UPREHS Customer Service at 1-800-547-0421, 801-595-4300 or RR 8-595-4300.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Challenger Plan coverage for you when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You could become a qualified beneficiary if coverage under the Challenger Plan is lost because of a qualifying event. Under the Challenger Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. You will become a qualified beneficiary if you lose your coverage under the Challenger Plan because either of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

WHEN IS COBRA COVERAGE AVAILABLE?

The Challenger Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, the employer must notify the Challenger Plan of the qualifying event.

HOW IS COBRA COVERAGE PROVIDED?

Once the Challenger Plan receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to a qualified beneficiary. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of employment or a reduction of the employee's number of hours of employment, COBRA continuation coverage generally lasts for up to a total of 18 months. If you are a qualified beneficiary who is determined by the Social Security Administration/Railroad Retirement Board to be disabled, within the first 60 days of continued coverage, and you notify the Challenger Plan in a timely fashion, you may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. Notice must be made in writing and addressed as follows: Union Pacific Railroad Employes Health Systems, P.O. Box 161020, Salt Lake City, Utah 84116-1020. The notice must be provided no later than 60 days after the latest of the following dates: 1) the date of the Social Security Administration/Railroad Retirement Board determination of the disability; 2) the date on which the qualifying event occurs that gives rise to your right to elect COBRA; or 3) the date on which coverage is lost as a result of a qualifying event. The notice must contain your name, account or Social Security number, and include a copy of the Social Security Administration/Railroad Retirement Board determination. The employee or any person representing the employee can provide the notice. The disability would have to have started at some

period before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. During the additional 11 months of continuation coverage, the premium for that coverage will be approximately 50% higher than it was during the preceding 18 months.

The affected individual receiving extended continuation coverage because of a disability determination must also notify the Challenger Plan within 30 days of any final determination by the Social Security Administration/Railroad Retirement Board that the individual is no longer disabled. Notice must be made in writing and addressed as follows: Union Pacific Railroad Employes Health Systems, P.O. Box 161020, Salt Lake City, Utah 84116-1020. The notice must contain your name, account or social security number, and include a copy of the Social Security Administration/Railroad Retirement Board determination. The employee or any person representing the employee can provide the notice.

PREMIUM FOR COBRA COVERAGE

You will be notified as to the amount of your required premium when you receive the notice of your rights to continue coverage. You will be required to pay the premium due, including any retro-active premiums within 45 days after the day continued coverage is elected. The required premium is adjusted each year to reflect actual and anticipated claims experience; thus, your required contribution may change during the continuation period. There is a grace period of 30 days for payment of the regularly scheduled premium.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call Healthcare Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act index.asp.

TERMINATION OF CONTINUATION COVERAGE

The law provides that your continuation coverage may be cut short for any of the following five reasons:

a) The employer no longer provides group health coverage for any of its employees;

b) The premium for your continuation coverage is not paid within 30 days of the due date;

c) You become covered after the date you elect COBRA coverage under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have;

d) You become entitled to Medicare benefits; or

e) You have the special extended disability continuation coverage and you are determined to be no longer disabled by the Social Security Administration or by the Railroad Retirement Board.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. The Challenger Plan reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

In no event will COBRA continuation coverage last beyond 29 months from the date coverage was lost under the Challenger Plan as a result of the qualifying event that originally made a qualified beneficiary eligible to elect coverage.

IF YOU HAVE QUESTIONS

Questions concerning the Challenger Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's, Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your rights, you should keep the Challenger Plan informed of any changes in your address. You should also keep a copy, for your records, of any notices you send to the Challenger Plan.

PLAN CONTACT INFORMATION

For general information about the Challenger Plan and COBRA continuation coverage, you may contact UPREHS Customer Service, P.O. Box 161020, Salt Lake City, Utah 84116-1020, or at 1-800-547-0421, 801-595-4300 or RR 8-595-4300.

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, pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee).

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 UPREHS for Members losing coverage under the UPREHS Challenger 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 Employes Health Systems
P.O. Box 161020
Salt Lake City, Utah 84116-1020

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
Benefits Department
1400 Douglas Street
Omaha, Nebraska 68179

SPECIAL ENROLLMENT RIGHTS

If an Active Employee declined coverage under the Challenger Plan at the time of initial eligibility because of alternate health care coverage but subsequently loses coverage under the other health plan, and such individual (a) was under a COBRA continuation provision and the coverage under such provision was exhausted or (b) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions to such coverage are terminated, then such Active Employee may become a Member by making an application for coverage under the Challenger Plan within thirty (30) days of the loss of such alternate health care coverage. Individuals who lose other coverage due to nonpayment of premium or for cause shall not become eligible for coverage under the Challenger Plan. Coverage under the Challenger Plan shall begin the first day of the calendar month following the enrollment request.

APPENDIX D – Information Required By the Employee Retirement Income Security Act of 1974 ("ERISA")

<table>
<tr><td>Name of Plan</td><td>Union Pacific Railroad Employes Health Plan (the "Plan")</td></tr>
<tr><td>Plan Sponsor</td><td>Union Pacific Railroad Company</td></tr>
<tr><td>Plan Identification Numbers</td><td>Employee Identification Number (EIN): 87-0427760
Plan Number (PN): H-4652</td></tr>
<tr><td>Plan Administrator</td><td>Union Pacific Railroad Employes Health Systems
P.O. Box 161020
Salt Lake City, UT 84116-1020
Tel: (801) 595-4300
Fax: (801) 595-4399</td></tr>
<tr><td>Type of Plan</td><td>Health Care Benefit Plan</td></tr>
<tr><td>Trustee</td><td>Zions First National Bank
102 S Main Street
Salt Lake City, UT 84101</td></tr>
<tr><td>Current Board of Trustees of the Plan</td><td>
<table>
<tr><td>M. A. Young, Chairman</td><td>B. R. Palmer</td></tr>
<tr><td></td><td>C. J. Schoner</td></tr>
<tr><td>W. J. Behrendt</td><td>G. Pankey</td></tr>
<tr><td>R. Brown</td><td>A. Nowlin</td></tr>
<tr><td>D. Hazlett</td><td>M. H. Williams</td></tr>
<tr><td>D. Smith</td><td>R. Orosco</td></tr>
</table>
</td></tr>
<tr><td>Operating Trustees</td><td>M. A. Young, Chairman
D. T. Butterfield, Chief Executive Officer
K. J. Potts, Chief Operating Officer</td></tr>
<tr><td>Agent for Service of Legal Process</td><td>Service of Legal Process may be made upon the Plan Administrator or any Trustee listed above.</td></tr>
<tr><td>Sources of Employer and Employee Contributions to the Plan</td><td>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.</td></tr>
<tr><td>Plan Year</td><td>Ends each year on December 31</td></tr>
<tr><td>Type of Administration of Health Care Benefits Provided by the Plan</td><td>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.</td></tr>
</table>

As a Member in the Union Pacific Railroad Employes 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 required the Plan Administrator to provide the materials and pay 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. However, before filing a law suit you must first exhaust all appeals required by the plan. If it should happen that Plan Fiduciaries misuse the Plans' 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington D.C. 20210.

UPREHS
Union Pacific Railroad Employee Health Systems
PO Box 161020 / Salt Lake City, Utah 84116-1020 / Phone (800) 547-0421 / Fax (801) 595-4399