BNSF ERISA Information For Employees Enrolled In HMO Options Under The BNSF Medical Program

Additional Information to Keep With Your HMO Booklet

When you enroll in an HMO option under the BNSF Medical Program, you will receive a booklet from the HMO. The information that follows includes the eligibility and enrollment rules that apply to all BNSF employees who enroll for Medical Program coverage, including those who enroll with an HMO. In addition, there is information on federal laws that apply to all employer sponsored group health plans.

Beginning on Page 13 of this material, you will find valuable information on your ERISA rights. You should read this information carefully. Not all HMOs operate the same, but these ERISA rules will apply no matter how the HMO operates.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans, including HMOs, 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 a 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 physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the birth. In any case, the HMO may not, under federal law, require that the attending physician or the expectant mother obtain authorization from the HMO for prescribing a length of stay not in excess of 48 hours (or 96 hours, where applicable). Your HMO must follow these rules. However, if your HMO booklets include more generous rules, the more generous rules will apply.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires that all group health plans, including HMOs, that provide medical and surgical benefits for a mastectomy also must provide coverage for:

• Reconstruction of the breast on which the mastectomy has been performed;

• Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

• Prostheses and coverage for any complications in all stages of mastectomy, including lymphedamus.

The Act requires that coverage be provided in a manner that is consistent with other benefits provided by the HMO. The coverage may be subject to annual deductibles and/or to copayments.

The Act prohibits any group health plan from:

• Denying a participant or a beneficiary eligibility to enroll or renew coverage in order to avoid the requirements of the Act;

• Penalizing, reducing, or limiting reimbursement to the attending provider (e.g. the attending physician, clinic or hospital) to induce the provider to give care that is inconsistent with the Act; and

• Providing monetary or other incentives to an attending provider to induce the provider to give care that is inconsistent with the Act.

Eligibility and Enrollment

Your Eligibility for Coverage

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

Dependent Eligibility

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

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

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

– your unmarried natural children;

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

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

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

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

• the child's graduation, or

• the child's 23rd birthday.

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

Eligible enrolled children who are mentally or physically disabled may retain coverage beyond age 19 (or age 23, if they are full-time students when they become disabled) if their disability occurred before reaching the Medical Program's maximum age. To be eligible for continued coverage, the child must be unmarried, must legally reside with you, must be incapable of self-sustaining employment and must be primarily dependent on you for financial support. To continue coverage for a disabled child, you must contact Sageo with proof of the disability within 60 days of the date the child turns age 19 (or age 23 if the child is a full-time student) and as requested from time to time thereafter.

Enrollment

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

• Your marriage, legal separation, divorce or annulment;

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

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

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

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

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

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

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

Giving Notice of a Family Status Event

If you have a Family Status Event, or if you want to enroll under the HIPAA rules (See HIPAA Special Enrollment Rules on pages 5-6), you can log on to www.sageo.com. You can also link to Sageo's web site from the BNSF Intranet site to make changes. If you prefer to use the phone, you can use the Sageo Resource Line by dialing 1-877-847-2436. If you do not request the change within 31 days of the event, you will not be allowed to make any changes until the next annual enrollment period unless you have a Special Enrollment event described on page 6.

First Enrollment

If you are a newly hired employee you must enroll within 31 days of your first day of employment. Your coverage will begin on the first day of employment provided you enroll on time. For newly eligible employees (e.g., employees promoted from union to salaried exempt positions), the effective date of coverage is the first day of the month following 30 days' classification as a regularly assigned full-time salaried employee. An exception applies to newly promoted salaried exempt employees whose promotion date is February 1. This group of employees will be covered effective March 1, provided the employee chooses a Medical Program option and enrolls on time.

Annual Enrollment

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

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

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

Electing the Opt-Out Option

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

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

HIPAA Special Enrollment Rules

You may enter the Program or add eligible Dependents, on a special enrollment date if you enroll through Sageo within 31 days of the occurrence of one of the following events:

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

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

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

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

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

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

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

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

Benefit Changes Due to Relocation or Closing of an HMO

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

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

Continuation of Coverage

Family and Medical Leaves of Absence

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

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

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

• For your own serious health condition.

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

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

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

Other Approved Leaves of Absence

If you take an approved leave of absence other than an FMLA leave — and your leave is a paid leave — for the first 90 days, your pay will be reduced by the contribution required for the Medical Program coverage in effect on the date prior to the start of your leave. If your leave exceeds 90 days, your Medical Program coverage will end and you will receive a COBRA continuation notice.

If your approved leave is unpaid, your coverage will continue for 90 days and you will be required to pay your contributions directly to Sageo until you return to active pay status. At the end of 90 days, Medical Program coverage will end and you will receive a COBRA continuation notice.

Military Leaves

If you are absent from work due to military service, you may elect to continue coverage under the HMO option (including coverage for enrolled Dependents) for up to 18 months from the first day of absence (or, if earlier, until the day after the date you are required to apply for or return to active employment with your Employer under the Uniformed Services Employment and

Reemployment Rights Act of 1994 [USERRA]). Your contributions for continued coverage will be the same as for similarly situated active participants in the Program.

Whether or not you continue coverage during military service, you may reinstate coverage under the HMO option you elected on your return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Program, except to the extent that you had not fully completed any required waiting period prior to the start of military service.

Continuation of Coverage Under COBRA

(Consolidated Omnibus Budget Act of 1985 as Amended)

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

Eligibility

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

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

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

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

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

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

• Your death.

• Your divorce or legal separation.

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

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

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

Notification

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

• the date you receive the form, or

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

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

• the date of such event, or

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

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

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

• the date you receive the form, or

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

Cost

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

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

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

Duration

COBRA continuation coverage can be extended for:

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

your Dependents may elect COBRA for the longer of 36 months from your prior Medicare entitlement date, or 18 months from the date of your termination or reduction in hours.

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

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

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

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

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

• Fails to make required contributions when due.

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

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

ERISA Information Notice

This ERISA Information Applies To BNSF Employees And Dependents Enrolled For HMO Coverage

The Employee Retirement Income Security Act (ERISA) is a federal law that grants you certain rights because you are participating in an employer sponsored group health plan. Your rights under ERISA are described beginning on Page 15 under YOUR ERISA RIGHTS.

When you are enrolled in an HMO, the HMO requires that you follow certain internal appeal procedures (sometimes called g*rievance procedures*) when you request medical treatment or referral to a specialist for medical treatment and your request is denied by the HMO. You must follow these internal *grievance procedures* in order to receive a fair hearing from the HMO.

When you exhaust the internal *grievance procedures*, some HMOs might have final appeal rules that require binding arbitration, or that limit your rights to go to court. Some HMOs might require that you submit your appeal to an "independent reviewer". These final appeal rules do not always comply with ERISA. The following is a list of HMO *grievance procedure* appeal rules **that do not comply with ERISA**. If you have reached a level of appeal in the HMO that requires you to do one of the following, you should know that the rules on Page 15 under YOUR ERISA RIGHTS will over-ride the HMO requirements.

No HMO may require you to do the following.

1. No HMO may require you to submit to binding arbitration or to binding mediation. If your HMO booklet advises that you must submit to binding arbitration or binding mediation after you exhaust the HMO *internal grievance procedures* you should know this rule does not comply with ERISA. If you submit to binding arbitration or binding mediation, you may be giving up the right you have under ERISA to sue the HMO in federal court. If you have a serious claim, you should check with legal counsel before you submit to binding arbitration or binding mediation with the HMO.

2. No HMO can make the statement that by virtue of becoming a member of the HMO you have agreed to give up any rights you have to sue, including an "constitutional rights" or any "ERISA rights".

3. No HMO may require you to pay for any *internal grievance or appeal procedure*. If the HMO booklet tells you that you must pay for part or all of any type of fees involved in a grievance procedure, arbitration, mediation, or any legal fees, you should know that ERISA does not allow this type of charge.

4. No HMO may require that you accept the decision of an independent reviewer on a benefit denial appeal. The HMO may be required to submit your claim to an independent reviewer under state law, and you can agree to abide by the independent reviewer's decision if you want to do so. However, before you agree ahead of time to accept the decision of an independent

reviewer make certain you read the ERISA information on Page 15, first, because you may be giving up your right to sue for the benefit under ERISA.

5. Some HMOs may require that you go through two levels of internal grievance procedures before reaching the appeal level. This is a good procedure because it means your claim is being fully reviewed. However, these two levels of appeal may not exceed, in total, 120 days under ERISA.

6. If you find that you want to exercise YOUR ERISA RIGHTS as described on Page 15, you should not wait too long after the HMO gives you its final decision when you go through the grievance procedure. This is because, depending on the length of time that has gone by since you first requested the HMO benefit, there may be a time limit on your ability to take action under YOUR ERISA RIGHTS.

All HMOs are subject to state regulation. If you have a complaint about an HMO you can contact the state insurance department listed in your HMO Membership booklet. Remember, even when you contact the state insurance department with a complaint, you still have ERISA rights as explained on Page 15.

YOUR ERISA RIGHTS

Your ERISA Rights

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

Receive Information About Your HMO Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Medical Program and the HMO. The people who operate the Medical Program, called fiduciaries, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. When you are enrolled in an HMO, the HMO makes benefit determinations under the HMO contract. Because the HMO has control over benefit determinations, the HMO is acting as a fiduciary when you request review of the HMO's benefit determination under the HMO *grievance procedures*.

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Program Administrator or the HMO and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Program Administrator or, if the documents are under the control of the HMO, the HMO to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons

beyond the control of the Program Administrator or HMO. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

Assistance With Your Questions

If you have any questions about the HMO option you chose, you should contact the HMO first. If the HMO is not able to answer your question, you should contact the Program Administrator.

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

The next page lists the PWBA area offices.

Office Of The Pension And Welfare Benefits Administration, U.S. Department of Labor

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

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

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

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

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

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

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

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

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

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

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

St. Louis District Office
815 Olive Street
Room 338
St. Louis, MO 63101-1559
Phone: 312/539-2691

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

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

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

Administrative Information

Cost of Plan Benefits

You and your Employer share the full cost of the HMO coverage option. You pay your cost of coverage on a before-tax basis. There is no trust or fund. Your share of the cost and your Employer's contribution are sent directly to the HMO.

Plan Name and Number

The HMO option is offered under the BNSF Medical Program, a participating program in the Burlington Northern Santa Fe Group Benefits Plan, a consolidated ERISA welfare benefits plan that files its annual return under Plan Number 501.

Company and Employer

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

Company Name and Identification Number

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

Plan Administrator and Agent for Service of Legal Process

The Plan Administrator's name, address and telephone number are as follows:

Employee Benefits Committee
c/o The Burlington Northern and Santa Fe Railway Company
2500 Lou Menk Drive
Fort Worth, Texas 76131
817-352-3680

The agent for service of legal process is:

Mr. Jeffrey R. Moreland
Executive Vice President, Law & Chief of Staff
2650 Lou Menk Drive
Fort Worth, Texas 76131

The BNSF Employee Benefits Committee is the Program Administrator of the Medical Program. The HMO option you have chosen has the HMO as Plan Administrator. The HMO has discretionary authority to interpret and apply HMO contract provisions relating to the delivery of HMO benefits. The BNSF Employee Benefits Committee retains the discretionary authority to determine whether an Employee is eligible for initial or continued enrollment in the BNSF Medical Program. The HMO Plan Administrator's discretionary authority includes the right to interpret the provisions of the HMO contract for purposes of resolving any inconsistency or ambiguity, correcting any error, or supplying information to correct any omission relating to HMO benefits.

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

Claims Administrator and Named Fiduciary

Each HMO acts as Claims Administrator for its own HMO contract. When an HMO makes benefit determinations on an appeal of a full or partial denial of HMO benefits, the HMO acts as a named fiduciary under ERISA. Following is a listing of the HMOs offered under the BNSF Medical Program.

Aetna DMO
Aetna
P.O. Box 14066
Lexington, KY 40512-4066
Phone: 877-238-6200

Kaiser HMOs
Kaiser Foundation Health Plan, Inc.
FSCR/Special Reserves
P.O. Box 23280
Oakland, CA 94623
Phone: 800-464-4000 California-Northern & Southern
800-632-9700 Colorado

Group Health Cooperative HMO
Group Health Options, Inc.
P.O. Box 34588
Seattle, WA 98124-1588
Phone: East: 888-742-3542
Phone: West: 888-901-4636

Coventry HMOs
Coventry Health Care of Kansas
P.O. Box 7109
London, KY 40742
Phone: 800-624-8822

PacifiCare HMOs (for both locations)
PacifiCare of California
4835 LBJ Freeway, Suite 1100
Dallas, TX 75244
Phone: 800-624-8822

Program Year

The Program Year is the calendar year.

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